

Shaping Parental Authority over Children’s Bodies

ALICIA OUELLETTE*

INTRODUCTION.....	956
I. SCULPTING, SHAPING, AND SIZING CHILDREN: FOCUS CASES.....	959
A. WESTERNIZING ASIAN EYES.....	960
B. HORMONES FOR STATURE.....	961
C. LIPOSUCTION ON A TWELVE YEAR OLD.....	963
D. GROWTH STUNTING.....	964
II. THE LAW, MEDICINE, PARENTAL RIGHTS, AND CHILDREN’S BODIES.....	966
A. BACKGROUND LAW.....	966
B. APPLICATION IN SHAPING CASES.....	969
C. ROOM FOR REGULATION.....	971
III. WHAT IS REALLY WRONG WITH MEDICAL AND SURGICAL SHAPING OF CHILDREN?.....	973
A. THE NONSUBORDINATION PRINCIPLE AS A LIMIT ON INDIVIDUAL RIGHTS.....	974
B. CHILDREN AS PERSONS, PARENTAL RIGHTS.....	977
C. MEDICAL AND SURGICAL SHAPING OF CHILDREN IS DIFFERENT.....	981
IV. CONCERNING THE CHILD: ANOTHER VIEW OF PARENTHOOD.....	985
A. ALTERNATIVE MODELS.....	987
B. COMMON PRINCIPLES.....	991
V. RECONSTRUCTING THE ROLE OF THE PARENT IN MEDICAL DECISION MAKING FOR CHILDREN.....	991
A. POWERS AND RESPONSIBILITIES OF TRUSTEES GENERALLY.....	994
B. POWERS AND RESPONSIBILITIES OF PARENTS CONCERNING CHILDREN’S HEALTH.....	996
VI. SHAPING RECONSTRUCTED.....	999
VII. PRACTICAL MATTERS, LIMITATIONS, AND FINAL THOUGHTS.....	1001

In the health-care setting, parental decisions to size, shape, sculpt, and mine children’s bodies through the use of nontherapeutic medical and surgical interventions are a matter of parental choice except in extraordinary cases involving grievous harm. This Article questions the assumption of parental rights that frames the current paradigm for medical decision making for children. Focusing on cases involving eye surgery, human growth hormone, liposuction, and growth stunting, I argue that by allowing parents to subordinate their children’s interests to their own, the current paradigm distorts the parent-child relationship and objectifies children in violation of the moral principle, deeply embedded in American legal tradition, that no person, even a parent, may subordinate the life, liberty, or body of another for his or

* Associate Professor of Law, Albany Law School; Professor of Bioethics, Union Graduate College/Mt. Sinai School of Medicine Program in Bioethics. Thanks to Kathy Cerminara, Ira Bloom, Tim Lytton, Jonathan Todres, Kelly Dineen, Molly Walker Wilson, the participants in Albany Law School’s Faculty Scholarship Workshop, and the participants in the St. Louis University School of Law Faculty Workshop for their thoughtful comments on drafts of this paper. Thanks also to Karen Schiavone and Andrew Zacher for superb research assistance.

her own purposes. I propose an alternative. Pushing analogies developed in family law and moral philosophy to respect children as complete but vulnerable human beings, I develop a trust-based construct of the parent-child relationship, in which the parents are assigned trustee-like powers and responsibilities over a child's welfare and future interests and are charged with fiduciary-like duties to the child. Application of the trust-based construct in the health-care setting separates medical decisions that belong to parents from decisions that belong to children and those that should be made by a neutral third party.

INTRODUCTION

U.S. law allows parents extraordinary power over their children's bodies. Parents have used that power to westernize the eyes of their adoptive Asian children,¹ to modify the facial features of children with Down Syndrome,² to inject human growth hormone (HGH) into healthy children,³ to enlarge the breasts of or suck the fat from teenagers,⁴ to attenuate the growth and remove the reproductive organs of a child with disabilities,⁵ and to remove bone marrow from a nine-year-old girl for use by a brother

1. Alicia Ouellette, *Eyes Wide Open: Surgery to Westernize the Eyes of an Asian Child*, HASTINGS CENTER REP., Jan.–Feb. 2009, at 15, 15; Sandy Kobrin, *Asian-Americans Criticize Eyelid Surgery Craze*, WOMEN'S ENEWS, Aug. 15, 2004, <http://www.womensenews.org/article.cfm/dyn/aid/1950>.

2. See, e.g., Shlomo Kravetz, Aron Weller, Rivka Tennenbaum, David Tzuril & Yael Mintzker, *Plastic Surgery on Children with Down Syndrome: Parent's Perceptions of Physical, Personal, and Social Functioning*, 13 RES. IN DEVELOPMENTAL DISABILITIES 145 (1992); Len Leshin, *Plastic Surgery in Children with Down Syndrome*, DOWN SYNDROME: HEALTH ISSUES (2000), <http://www.ds-health.com/psurg.htm>.

3. See David B. Allen & Norman Fost, *hGH for Short Stature: Ethical Issues Raised by Expanded Access*, 144 J. PEDIATRICS 648 (2004); Michael Freemark, Editorial, *Growth Hormone Treatment of "Idiopathic Short Stature": Not So Fast*, 89 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3138 (2004); Linda D. Voss, *Growth Hormone Therapy for the Short Normal Child: Who Needs It and Who Wants It? The Case Against Growth Hormone Therapy*, 136 J. PEDIATRICS 103, 103 (2000).

4. See Mary Duenwald, *How Young is Too Young to Have a Nose Job and Breast Implants?*, N.Y. TIMES, Sept. 28, 2004, at F5; Marina Pisano, *Liposuction for Girl, 12, Stirs Debate*, SAN ANTONIO EXPRESS-NEWS, Dec. 5, 2006, at 1C, available at http://www.mysanantonio.com/life/MYSA120506_1P_lipo_1e5605b_html.html; Diana Zuckerman & Anisha Abraham, *Teenagers and Cosmetic Surgery: Focus on Breast Augmentation and Liposuction*, 43 J. ADOLESCENT HEALTH 318 (2008); Susan Kriemer, *Teens Getting Breast Implants for Graduation*, WOMEN'S ENEWS, June 6, 2004, <http://www.womensenews.org/article.cfm/dyn/aid/1861/context/cover/>; Cynthia McFadden & Deborah Apton, *Like Brother, Like Sister? More Teens Getting Controversial Surgery*, ABC NEWS, Nov. 15, 2007, <http://abcnews.go.com/Nightline/DiabetesResource/story?id=3870671&page=1>.

5. See Daniel F. Gunther & Douglas S. Diekema, *Attenuating Growth in Children with Profound Developmental Disability: A New Approach to an Old Dilemma*, 160 ARCHIVES PEDIATRIC & ADOLESCENT MED. 1013, 1014 (2006); DAVID R. CARLSON & DEBORAH A. DORFMAN, WASH. PROT. & ADVOCACY SYS., INVESTIGATIVE REPORT REGARDING THE "ASHLEY TREATMENT" (2007), available at <http://www.disabilityrightswa.org/news-1/Investigative%20Report%20Regarding%20the%20Ashley%20Treatment.pdf>.

who sexually abused her.⁶ To be sure, physicians or surgeons are the ones who physically modify the child's body⁷ but they do so as agents of parents. And, in the case of elective interventions, it is the parents who seek out medical or surgical modifications, find a willing provider, and give their consent to size, shape, sculpt, or mine⁸ their children's body for social, aesthetic, familial, or cultural reasons. I call these "shaping cases,"⁹ and I find them troubling.

In bioethics and law, the traditional academic response to troubling cases involving children is an in-depth analysis of the facts of a particular case or the intricacies of a particular intervention to determine whether the intervention at issue is so harmful or potentially harmful as to justify limiting parental choice.¹⁰ Indeed, I have conducted harm-based analyses on some of the cases mentioned above.¹¹ The typical analysis weighs the risks of harm against the benefits of the procedure. Much ink is spilled identifying harms and debating their significance.¹² Application of a harm-based

6. Douglas J. Opel & Douglas S. Diekema, *The Case of A.R.: The Ethics of Sibling Donor Bone Marrow Transplantation Revisited*, 17 J. CLINICAL ETHICS 207, 208–09 (2006) (describing a case in which a sibling was forced to donate bone marrow to save the life of a brother who sexually abused her).

7. See *infra* Part III for an explanation about the relative responsibility of parents and physicians in medical decision making for children.

8. A child's body is mined when it is used as a source of a valuable natural resource such as bone marrow, an organ, or skin.

9. The name is borrowed from the Hastings Center, a major bioethics research institute, which coined the term "shaping children" to describe the use of surgical interventions designed with the purpose of "normalizing" child appearance. See Eric Parens, *Thinking About Surgically Shaping Children*, in *SURGICALLY SHAPING CHILDREN: TECHNOLOGY, ETHICS AND THE PURSUIT OF NORMALITY*, at xiii (Eric Parens ed., 2006). I use the term "shaping cases" slightly differently. Unlike the Hastings Center, which includes surgery to repair a cleft lip or palate as a shaping case, I include as shaping cases only those involving the use of surgical or medical intervention that provide no medical, therapeutic, or functional benefit to the child. I would argue that surgery for a cleft lip or palate restores function to the child's face by allowing the face to perform as intended as a tool of social entry.

10. See, e.g., Dov Fox, *Safety, Efficacy, and Authenticity: The Gap Between Ethics and Law in FDA Decisionmaking*, 2005 MICH. ST. L. REV. 1135; Opel & Diekema, *supra* note 6, at 207; Therese Powers, Note, *Race for Perfection: Children's Rights and Enhancement Drugs*, 13 J.L. & HEALTH 141 (1998); Vita Maria Salvemini, Note, *Idiopathic Short Stature or Just Plain Short: Why the Federal Government Should Regulate the Administration of Human Growth Hormone to Healthy Children*, 38 GA. L. REV. 1105 (2004); Samuel J. Tilden, *Ethical and Legal Aspects of Using an Identical Twin as a Skin Transplant Donor for a Severely Burned Minor*, 31 AM. J.L. & MED. 87 (2005).

11. See Ouellette, *supra* note 1, at 15; Alicia Ouellette, *Growth Attenuation, Parental Choice, and the Rights of Disabled Children: Lessons from the Ashley X Case*, 8 HOUSTON J. HEALTH L. & POL'Y 207 (2008), available at http://www.law.uh.edu/hjhlp/Issues/Vol_82/Ouellette.pdf [hereinafter Ouellette, *Lessons from the Ashley X Case*].

12. See, e.g., Mark S. Frankel & Cristina J. Kapustij, *Enhancing Humans*, in *FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS* 55 (Mary Crowley ed., 2008) (providing an analysis of the harms associated with enhancement technologies); Nancy Press, *Genetic Testing and Screening*, in *FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS*, *supra*, at 73

analysis is a valuable exercise. It ensures consideration of beneficence and justice as a counterbalance to autonomy in ethical analysis. The debates about harm also broaden our understanding of the physical, moral, and psychological stakes for children, as well as fairness and justice implications for society, of specific medical interventions.¹³ But the debates start by assuming parental rights to intervene, an assumption that effectively limits the debate to value judgments about the results of, or benefits gained by, a particular intervention.

This Article takes a different tack. Instead of focusing on a single case or intervention, I focus on shaping cases generally. Instead of identifying and weighing the harm or potential harms at stake for children, I ask what shaping cases tell us about the contours of the relationship between parents and children. In other words, I focus not on the ends sought by parents, but on the “human disposition [that shaping of children] expresses and promotes.”¹⁴ I adopt this approach because I believe that the real problem with shaping cases lies in the assertion of parental power involved and the medical provider’s acquiescence to it, and I believe that offering an alternative frame for discourse about medical decision making for children that questions, rather than assumes, parental power may allow health law and bioethics to develop decision-making processes that better protect children than does the traditional harm-based framework.

An examination of shaping cases from the perspective of the parent-child relationship reveals that shaping interventions are a product of a medical ethos and “social world that prizes mastery and control”¹⁵ allowing parents to assert their will onto their child in a way that may disrespect the child as a human being. Support for this exercise of parental power is rooted in an understanding of children’s bodies as a form of property over which the parents have a possessory interest. Such a construct distorts the parent-child relationship and objectifies children. I propose an alternative. Building on models of the parent-child relationship developed in family law and moral

(discussing the benefits and harms of genetic testing); John William McDermott, Note, *Growth Attenuation in the Profoundly Developmentally Disabled: A Therapeutic Option or a Socioeconomic Convenience?*, 32 SETON HALL LEGIS. J. 427 (2008) (describing the harms of parental autonomy in child-rearing decisions that involve invasive medical procedures); Christine Ryan, Note, *Revisiting the Legal Standards That Govern Requests to Sterilize Profoundly Incompetent Children: In Light of the “Ashley Treatment,” Is a New Standard Appropriate?*, 77 FORDHAM L. REV. 287 (2008) (discussing the risks and benefits of the “Ashley Treatment”).

13. See, e.g., Hazel Glenn Beh & Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?*, 7 MICH. J. GENDER & L. 1, 56–59 (2000) (analyzing the uncertain long-term outcome of surgical treatment for intersex children and its impact on the children’s right to an open future); Karen Gruney, *Sex and the Surgeon’s Knife: The Family Court’s Dilemma . . . Informed Consent and the Specter of Iatrogenic Harm to Children With Intersex Characteristics*, 33 AM. J. L. & MED. 625 (2007) (describing the physical, psychological, and social implications of medical interventions for intersex children); Salvemini, *supra* note 10, at 1121–33 (exploring the risks of HGH treatment for healthy children).

14. Michael J. Sandel, *The Case Against Perfection: What’s Wrong with Designer Children, Bionic Athletes, and Genetic Engineering*, in ETHICAL ISSUES IN MODERN MEDICINE: CONTEMPORARY READINGS IN BIOETHICS 890, 894 (7th ed. 2009).

15. MICHAEL J. SANDEL, *THE CASE AGAINST PERFECTION: ETHICS IN THE AGE OF GENETIC ENGINEERING* 86 (2007).

philosophy, I suggest a trust-based construct of the parent-child relationship for medicine, in which the parent has trustee-like powers and responsibilities over a child's welfare and developing rights, as well as fiduciary-like duties to the child.

Part I of this Article describes cases in which parents exercised their power to shape their children through elective medical and surgical interventions: a case involving a white father who used surgery to reshape the eyes of his adopted Asian child; another in which parents used human growth hormone to add a few inches onto the adult height of their young son; a third in which a mother consented to liposuction for her twelve-year-old daughter; and the case of Ashley X, a young girl with profound disabilities whose parents elected to stunt her growth and remove her breasts and uterus in order to continue caring for her at home. Part II sets forth the legal parameters currently governing medical decision making for children. Part III makes the case that the medical or surgical shaping of children is problematic because it objectifies children's bodies based on a distorted understanding of the parent-child relationship as one in which the parent has possessory rights over a child's body. Part IV explores, from the family law perspective, an understanding of an adult's relationship with children as one of trusteeship, not ownership. Part V argues for a conceptual reconstruction of the parent-child relationship in medical decision making for children that adopts from family law and moral philosophy the notion of a parent as a trustee of the child's welfare and future interests. Part VI applies the trust-based model to the four focus cases to show that importing a trust-based model of parenting into the health-care setting can help distinguish parental choices that belong to the parent from those that should be reserved for the child and those that cannot be entrusted to either parent or child. Finally, Part VII acknowledges the limitations of a trust-based approach.

I. SCULPTING, SHAPING, AND SIZING CHILDREN: FOCUS CASES

The use of physical interventions to size and shape children is not new. For centuries parents bound the feet of their young daughters to keep them dainty.¹⁶ With the help of doctors, parents have stunted the growth of tall girls by administering high doses of estrogen,¹⁷ used surgery to "correct" ambiguous genitalia,¹⁸ and lengthened limbs on dwarf children.¹⁹ In some cultures, parents elect to cut the genitals of young

16. See DOROTHY KO, *CINDERELLA'S SISTERS: A REVISIONIST HISTORY OF FOOTBINDING* (2005); WANG PING, *ACHING FOR BEAUTY: FOOTBINDING IN CHINA* (2000). For an excellent historical overview of surgeries used in different cultural contexts, see KATHY DAVIS, *DUBIOUS EQUALITIES & EMBODIED DIFFERENCES: CULTURAL STUDIES ON COSMETIC SURGERY* (2003).

17. SUSAN COHEN & CHRISTINE COSGROVE, *NORMAL AT ANY COST: TALL GIRLS, SHORT BOYS, AND THE MEDICAL INDUSTRY'S QUEST TO MANIPULATE HEIGHT* 3–51 (2009); WILLIAM N. TAYLOR, *HORMONAL MANIPULATION: A NEW ERA OF MONSTROUS ATHLETES* 107–08 (1985).

18. Alice D. Dreger, *A History of Intersexuality: From the Age of Gonads to the Age of Consent*, 9 J. CLINICAL ETHICS 345, 349–50 (1998). Many first person narratives recounting individual traumas are contained in *INTERSEX IN THE AGE OF ETHICS* (Alice D. Dreger ed., 1999).

19. E.g., Emily Sullivan Stanford, *My Shoe Size Stayed the Same: Maintaining a Positive Sense of Identity with Achondroplasia and Limb-Lengthening Surgeries*, in *SURGICALLY SHAPING CHILDREN*, *supra* note 9, at 29.

girls to conform to cultural norms.²⁰ This section briefly describes four modern cases in which parents elected to shape, sculpt, and size their children's bodies through elective surgical and medical interventions. Choosing the focus cases for the Article was difficult.²¹ The four I discuss, eye shaping, hormones for height, liposuction, and growth attenuation, represent a good cross section of the shaping work that is currently being done on or to children. The four cases vary in important ways. They range from the frivolous to the profound. They involve young and older children, adopted and natural-born children, and fully capacitated and profoundly disabled children. Each of the distinctions between the cases—from the intervention's intrusiveness to the child's age to the child's mental capacity—could arguably make a moral, ethical, or legal difference in the analysis of an individual case.

I want to suggest the opposite: the similarities between these four very different cases are more important than the differences, and the things that make them similar should make a difference in medicine and in the law. How are these cases the same? These are true shaping cases. The purpose of the procedures was to modify the child's body for aesthetic, social, or cultural reasons, not to address or correct an underlying illness or physical impairment. They were all products of parental judgments about a child's best interests, but the interventions were in no way therapeutic.²² They were medically unnecessary, physically invasive, and undeniably risky. They were, by definition, elective, and were effected at the parent's request, not on the recommendation of a physician. Another commonality between the cases is that none is reported in case law. My reports about them come from serendipity, medical journals, and the Internet.²³

A. Westernizing Asian Eyes

I heard about the first case while attending a presentation at a local hospital. There, a white plastic surgeon spoke glowingly about surgery he elected for his adopted Asian daughter. She came to his family with eyes that he deemed problematic because, like the eyes of many people of Asian descent, his daughter's eyes lacked a fold in the upper eyelid. As a result, he thought she looked sleepy and he was concerned that her

20. See L. Amede Obiora, *Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign Against Female Circumcision*, 47 CASE. W. RES. L. REV. 275, 277 (1997).

21. Early drafts of the Article included a case involving a parent's decision to make a minor child a skin donor for a sibling. I replaced that case with the HGH case because the physical risks to the child in the HGH case are arguably lower than the risks in the other cases. The skin donation case involved physical risks comparable to liposuction and eye-shaping surgery.

22. Therapeutic interventions are those aimed at preventing or treating disease or injury, or returning functionality to what is normal for the species. See ROBERT M. VEATCH, *THE BASICS OF BIOETHICS* 155–57 (2d ed. 2000); Lisa Fishbayn, “*Not Quite One Gender or the Other*”: *Marriage Law and the Containment of Gender Trouble in the United Kingdom*, 15 AM. U. J. GENDER SOC. POL'Y & L. 413, 440 (describing the purpose and history of categorizing surgeries as “therapeutic”).

23. Although I am primarily concerned about whether the power to elect the procedures is one that should rest with parents in the first place, my case descriptions include a brief synopsis of the risks and benefits. The alternative in all the cases was to do nothing, as none of the features altered threatened the child's physical health.

eyes closed completely when she smiled. He proudly reported that he had solved the problem by having his daughter's eyes surgically shaped through a procedure called blepharoplasty. He was thrilled with the results. His beautiful daughter now has big round eyes that stay open and shine, even when she smiles, and make her look more like her new western family. The adoptive father seemed certain that his decision to use surgery to shape his daughter's eyes would improve her life.²⁴

Although blepharoplasty is among the most common procedures performed by plastic surgeons in the United States,²⁵ it carries risks. Originally designed "specifically to westernize the eyelid at the patient's request,"²⁶ the procedure is done on an outpatient basis. After the patient is sedated and anesthetized, the surgeon makes an incision above the eyelid and removes excessive skin, tissue under the skin, and fat pads.²⁷ The surgeon then sutures the incision and packs the eye with a light dressing. Once the wound heals, the incision disappears in the newly formed crease. In addition to the usual risks of surgery, eye-shaping surgery poses the risk of hematoma, asymmetry, and drooping.²⁸ Recovery may be uncomfortable. A woman who had the procedure as an adult said that after the operation "she had to sleep in a semi-standing position and 'when you lay down, it feels like the swelling is burying you.'"²⁹

B. Hormones for Stature

In the summer of 2004, the Food and Drug Administration (FDA) approved HGH treatments for children who are very short but otherwise healthy.³⁰ Although the FDA approved the use of HGH in healthy children only when the child's predicted adult height is at or below five feet for females, and five feet, four inches for males, or 2.25 standard deviations below the mean for the child's age and sex,³¹ the FDA decision

24. I described the same case in a short essay in the Hastings Center Report. Ouellette, *supra* note 1. Some of the information reported here is copied from that paper.

25. The American Society of Plastic Surgeons reports that eyelid surgery was performed 221,000 times in 2008. See AM. SOC'Y OF PLASTIC SURGEONS, 2009 REPORT OF THE 2008 STATISTICS: NATIONAL CLEARINGHOUSE OF PLASTIC SURGERY STATISTICS 7 (2009). Of those, 2072 procedures involved children between thirteen and nineteen years old. *Id.* at 12. The American Society of Plastic Surgeons does not keep statistics on the use of cosmetic surgeries on children under the age of thirteen. *Id.*

26. Charles S. Lee, *Blepharoplasty, Asian*, Emedicine, (2000), <http://www.emedicine.com/plastic/topic425.htm>; see also ELIZABETH HAIKEN, *VENUS ENVY: A HISTORY OF COSMETIC SURGERY 200-09* (1997) (describing the history of surgeries designed to westernize Asian features).

27. See Lee, *supra* note 26; see also John A. McCurdy, *Upper Blepharoplasty in the Asian Patient: The 'Double Eyelid' Operation*, 13 FACIAL PLAST. SURG. CLIN. NORTH AM. 47 (2005).

28. FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, 195 (Ira D. Papel et al. eds., 2d ed. 2002).

29. Christina Valhouli, *Asian Eyes: Some Turn to Glue or Surgery for a New "Look"*, SALON, Feb. 16, 2000, http://archive.salon.com/health/feature/2000/02/16/asian_eyes/index.html.

30. Food and Drug Admin., *FDA Approves Humatrope for Short Stature*, July 25, 2003, DRUGS.COM, <http://www.drugs.com/news/fda-approves-humatrope-short-stature-3357.html>.

31. *Id.*

does not regulate off-label prescription of HGH to children who do not fall within the FDA guidelines.³²

As a result, pediatricians today “hear parents ask for [H]GH because their son (and it’s usually sons) is as ‘short as I was in grade school,’ or ‘is the shortest one on the team.’”³³ Other parents “are seeking the drug—and no doubt obtaining it—for use in children who are of normal height and even for use in some who are tall, in the hopes that the drug will enable them to grow tall enough to become successful basketball players.”³⁴ Although some doctors refuse parental requests for HGH for healthy children, others defer to parental choice.³⁵ Thus a parent with financial means who can find a willing provider can administer HGH to his son to give him a better shot at making the varsity basketball team.

A course of treatment with HGH requires subcutaneous injections three to six times a week over the course of four or five years.³⁶ On average, the hundreds of injections will increase a child’s adult height by about one and one-half half inches.³⁷ The treatment will not make a short person tall; a child who would have been five feet tall as an adult without the injections would likely be five feet, one and one-half inches or five feet, two inches after treatment. And the treatment’s long-term risks are not well understood. It is clear that the treatment may cause musculoskeletal pain and aggravation of kidney problems.³⁸ It poses long-term risks of diabetes, hypertension, and cancer.³⁹

In addition to physical risks, the artificially administered HGH may cause children psychological or psychosocial harm. Although parents and physicians often believe that giving a child an inch or two extra of adult height will increase a child’s self-

32. “Off-label use” is the use or prescription of a medical device or drug for a purpose that is legal but has not received FDA approval. See James E. Beck & Elizabeth D. Azari, *FDA, Off-Label Use and Informed Consent: Debunking Myths and Misconceptions*, 53 *FOOD & DRUG L.J.* 71, 71–76 (1998).

33. Rahul K. Parikh, *Growth Hormone for Kids: Normal Boys and Girls are Taking Growth Hormone for Being Short. That’s a Bad Prescription.*, SALON, Oct. 31, 2008, 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).

34. Maxwell J. Mehlman, *How Will We Regulate Genetic Enhancement?*, 34 *WAKE FOREST L. REV.* 671, 679 (1999) (explaining that obtaining statistics on such off label uses is impossible).

35. See *id.*; see also Salvemini, *supra* note 10, at 1107–08 (collating statistics about the use of HGH in healthy children).

36. PHYSICIAN’S COMM. FOR RESPONSIBLE MED., CONCERNS ABOUT GROWTH HORMONE EXPERIMENTS IN SHORT CHILDREN, available at http://www.pcrm.org/resch/PDFs/hum_hormone.pdf; David B. Allen & Norman C. Fost, *Growth Hormone Therapy for Short Stature: Panacea or Pandora’s Box*, 117 *J. PEDIATRICS* 16, 19 (1990).

37. See Ellen Werber Leschek, Susan R. Rose, Jack A. Yanovski, James F. Troendle, Charmian A. Quigley, John J. Chipman, Brenda J. Crowe, Judith L. Ross, Fernando G. Cassorla, Werner F. Blum, Gordon B. Cutler, Jr. & Jeffrey Baron, *Effect of Growth Hormone Treatment on Adult Height in Peripubertal Children with Idiopathic Short Stature: A Randomized, Double-Blind, Placebo-Controlled Trial*, 89 *J. CLINICAL ENDOCRINOLOGY & METABOLISM* 3140, 3145 (2004).

38. Salvemini, *supra* note 10, at 1123–25.

39. See *id.*

esteem and social status, the evidence is to the contrary. Studies show that in the long run, the psychosocial adaptation and self-esteem of treated children is comparable to a placebo group, and repeated injections increase the child's negative self-image and associated stigmatization of height as a defining feature of the child's existence.⁴⁰

C. Liposuction on a Twelve Year Old

Brooke Bates was twelve years old when her parents persuaded a plastic surgeon to use liposuction to remove thirty-five pounds of fat and fluid from her body.⁴¹ Brooke and her parents were initially thrilled with the results, but the surgery did not keep Brooke from putting weight back on. When the weight returned in less than a year, the parents returned Brooke to the operating room for a tummy tuck.⁴² A year later, her parents took her to Mexico for gastric lap band surgery after their family doctor advised against the procedure.⁴³

Brooke may be the youngest known person to have been shaped by liposuction,⁴⁴ but she is not the only child on whom the procedure has been used. The American Society of Plastic Surgeons reports 3979 cases of liposuction on patients between the ages of thirteen and nineteen in 2008.⁴⁵ Liposuction is not an effective treatment for obesity in any patient, adult or child.⁴⁶ Clinical studies have demonstrated that lipoplasty does not reduce the risk of heart disease or diabetes and that it does not increase metabolism.⁴⁷ It is an intervention designed to sculpt contours into a person's body by removing pockets of fat.⁴⁸ The surgery itself poses the risk of infection, embolism, puncture wounds in the organs, seroma, nerve compression, changes in

40. See *id.* at 1124; Linda D. Voss, *Is Short Stature a Problem? The Psychological View*, 155 EUR. J. ENDOCRINOLOGY 39, 42–43 (2006). For a fascinating explanation of how attention to a condition may make a condition stigmatizing and, therefore, a negative factor in a child's self-esteem, see Brenda Major & Laurie T. O'Brien, *The Social Psychology of Stigma*, 56 ANN. REV. PSYCHOL. 393, 394 (2005) (explaining, among other things, how stigma is an attribute that discredits an individual "reducing him or her from a whole and usual person to a tainted and discounted one"). For a fascinating account of the lingering psychosocial effects of HGH treatment on a child with a hormonal deficiency, see David Davis, *Growing Pains*, http://www.mad-cow.org/dec_early_news.html.

41. Allison Adato, Anne Lang & Darla Atlas, *Too Young for Lipo?*, PEOPLE, Nov. 13, 2006, at 131, available at <http://www.people.com/people/archive/article/0,,20059928,00.html> (explaining that plastic surgeon Robert Ersek only capitulated to the parents' request for surgery after learning that the father was sick with cancer).

42. *Id.* at 133.

43. *Too Young? Teen Gets Stomach Band After Lipo*, ABC NEWS.COM, Aug. 15, 2007, <http://abcnews.go.com/GMA/OnCall/Story?id=3481336&page=1>.

44. Adato et al., *supra* note 41, at 132.

45. See AM. SOC'Y OF PLASTIC SURGEONS, *supra* note 25, at 12.

46. See Adato et al., *supra* note 41, at 132.

47. E.g., Samuel Klein, Luigi Fontana, V. Leroy Young, Andrew R. Coggan, Charles Kilo, Bruce W. Patterson & B. Selma Mohammed, *Absence of an Effect of Liposuction on Insulin Action and Risk Factors for Coronary Heart Disease*, 350 N. ENG. J. MED. 2549 (2004).

48. Adato et al., *supra* note 41

sensation, swelling, skin necrosis, burns, fluid imbalance, toxicity from anesthesia, and even death.⁴⁹

D. Growth Stunting

The case of Ashley X may be the most highly debated of the shaping cases discussed in this Article. Ashley X was a patient at the University of Washington's Children's Hospital and Regional Medical Center in 2004.⁵⁰ Ashley had profound developmental disabilities of unknown etiology.⁵¹ For reasons the doctors could not explain, her mental development had never advanced beyond that of an infant.⁵²

When Ashley was six years old, her parents began to fear for their daughter's long-term future.⁵³ Future growth would, the parents feared, make it impossible for them to care for their daughter at home.⁵⁴ The parents consulted Ashley's physicians about their options.⁵⁵ Her mother suggested a plan for growth attenuation and surgical stunting of Ashley's sexual development.⁵⁶ The plan had three main components. The doctors would perform a hysterectomy, a mastectomy,⁵⁷ and administer high doses of estrogen.⁵⁸ The hysterectomy would prevent Ashley from menstruating; the mastectomy would prevent her from developing mature breast tissue; and the estrogen therapy would prevent her from reaching her projected adult height and weight.⁵⁹ The goal of the procedures was to keep Ashley in a child-sized body to allow the parents to

49. Food & Drug Admin., *What Are the Risks or Complications Associated with Liposuction?*, <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/SurgeryandLifeSupport/ucm070191.htm>.

50. For a more thorough description of Ashley's case, see Ouellette, *Lessons from the Ashley X Case*, *supra* note 11, at 210–17. The case was initially made public by Ashley's doctors. See Gunther & Diekema, *supra* note 5, at 1014.

51. Gunther & Diekema, *supra* note 5, at 1014.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. See CARLSON & DORFMAN, *supra* note 5, at 7. Ashley's parents refer to the mastectomy part of the intervention by the more benign sounding "breast bud removal." Ashley's Mom and Dad, *The "Ashley Treatment": Towards a Better Quality of Life for "Pillow Angels"*, Mar. 25, 2007, at 5, <http://pillowangel.org/Ashley%20Treatment%20v7.pdf> [hereinafter Parents' Blog]. The Children's Hospital Ethics Committee, however, described the protocol in its ethics opinion regarding this intervention as a "mastectomy." DAVID R. CARLSON & DEBORAH A. DORFMAN, WASH. PROT. & ADVOCACY SYS., INVESTIGATIVE REPORT REGARDING THE "ASHLEY TREATMENT" app. I (2007) (Exhibit L: Special CHRMC Ethics Committee Meeting/Consultation (May 2004)), available at http://www.disabilityrightswa.org/news-1/Investigative%20Report%20Regarding%20the%20Ashley%20Treatment_Exhibits%20K%20-%20T.pdf [hereinafter Committee Meeting].

58. CARLSON & DORFMAN, *supra* note 5, at 7.

59. *Id.* at 11–12.

continue to take care of her at home.⁶⁰ The parents did not want Ashley's care "in the hands of strangers."⁶¹

The physicians supported the parents' choice, but recognized that the intervention was unprecedented.⁶² As a result, they referred the case to the hospital's ethics committee,⁶³ which met with the family, Ashley, and Ashley's doctors "for over an hour."⁶⁴ The committee considered the potential risks and benefits of each of the three main components of the proposed intervention and ultimately reached consensus that the administration of high dose estrogen, hysterectomy, and mastectomy were all ethically appropriate: "[I]t was the consensus of the Committee members that the potential long term benefit to Ashley herself outweighed the risks; and that the procedures/interventions would improve her quality of life, facilitate home care, and avoid institutionalization in the foreseeable future."⁶⁵ Having identified no reason to interfere with parental authority, the committee left the decision to proceed in the parents' hands.⁶⁶ Ashley's parents consented, and the interventions were implemented without judicial review.⁶⁷ The surgeons removed Ashley's uterus and her breast buds in an "uneventful" surgery.⁶⁸ They also removed her appendix⁶⁹ and administered several courses of high dose estrogen.⁷⁰

Each intervention carried physical risks. The potential risks of high dose estrogen included "increased potential for deep vein thrombosis, possible weight gain, [and] possible nausea."⁷¹ The risks of a hysterectomy include "anesthesia, surgery[,] and post-operative recovery period, with the additional short term discomfort and suffering."⁷² The physical risks of mastectomy were "minimal" at the time of Ashley's surgery because her breast development was "rudimentary."⁷³

60. *Id.*

61. Gunther & Diekema, *supra* note 5, at 1014.

62. *See id.*

63. *Id.*

64. Committee Meeting, *supra* note 57.

65. *Id.*

66. *See id.*

67. *See* CARLSON & DORFMAN, *supra* note 5, at 14. The hospital later admitted that it erred by failing to seek judicial review of the decision to remove Ashley's uterus. Carol M. Ostrom, *Children's Hospital Says It Should Have Gone to Court in Case of Disabled 6-Year-Old*, SEATTLE TIMES.COM, May 8, 2007, http://seattletimes.nwsourc.com/html/localnews/2003698112_webchildrens08m.html. Ashley's physicians and the surgeon who performed the hysterectomy relied on the opinion of Ashley's parents' lawyer that court review was unnecessary because sterilization was not the sole purpose of the procedure. *See* CARLSON & DORFMAN, *supra* note 5, at 14.

68. Gunther & Diekema, *supra* note 5, at 1014.

69. Parents' Blog, *supra* note 57, at 5 ("The surgeon also performed an appendectomy during the surgery, since there is a chance of 5% of developing appendicitis in the general population, and this additional procedure presented no additional risk. If Ashley's appendix acts up, she would not be able to communicate the resulting pain. An inflamed appendix could rupture before we would know what was going on, causing significant complication.")

70. *See* Gunther & Diekema, *supra* note 5, at 1014.

71. Committee Meeting, *supra* note 57.

72. *Id.*

73. *Id.*

II. THE LAW, MEDICINE, PARENTAL RIGHTS, AND CHILDREN'S BODIES

The focus cases involved the use of medicine, hormones, or surgery to modify a child's body despite the absence of a medical need for modification. The interventions all caused the child some kind of physical damage and they were all optional. That shaping procedures are invasive, irreversible, potentially dangerous, and done for reasons other than therapy makes them different from other parental decisions that shape a child.⁷⁴ But current law does not recognize that difference. None of the shaping cases described in the previous section went to court. Only one was the subject of any legal regulation.⁷⁵ Although they raise questions about parental rights, parental obligations, and child rights, the law is essentially indifferent to shaping cases.

A. Background Law

U.S. law recognizes the right of competent adults to make their own medical decisions.⁷⁶ Grounded in constitutional and common law, the right to choose among medical options allows people to refuse treatment, even lifesaving treatment, and to elect treatment, even dangerous cosmetic procedures. Children are obviously not competent adults. While ethicists insist that young children must assent and teenagers consent to medical procedures,⁷⁷ the law places decisionmaking for children squarely in their parents' or guardians' hands with very few exceptions.⁷⁸ The general rule, applicable in almost all situations, is that a parent is free to sort among alternatives and elect the course of treatment based on his or her assessment of the child's best

74. See *infra* Part III.C.

75. Washington law arguably required court review of the decision to perform a hysterectomy on Ashley. A decision of the Washington Supreme Court requires court review of decisions to sterilize people with developmental disabilities. *In re Guardianship of Hayes*, 608 P.2d 635, 640 (Wash. 1980). There is some debate about the application of that case to Ashley's case because her parents were not seeking to sterilize Ashley but to decrease the risks of thrombosis caused by the estrogen treatment and to prevent Ashley from becoming upset at the sight of her own menstrual blood. But following the media storm of attention on Ashley's case, the hospital admitted it should have sought court review of the decision to remove Ashley's uterus. See Ostrom, *supra* note 67. As I have argued before, however, the need for court review of the hysterectomy in Ashley's case is somewhat beside the point. Such review would not likely have changed the outcome in Ashley's case, and it will not be required in future growth attenuation cases on boys or cases involving only high dose estrogen. See Ouellette, *Lessons from the Ashley X Case*, *supra* note 11, at 229.

76. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–80 (1990) (recognizing the right of a competent adult to make her own health-care decisions, but upholding state regulations over decisionmaking for incompetent adults).

77. See, e.g., 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 (2005); Andrew Popper, *Averting Malpractice by Information: Informed Consent in the Pediatric Environment*, 47 DEPAUL L. REV. 819, 832 (1998); Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 148–52 (2000).

78. For a discussion of the exceptions, see *infra* text accompanying notes 95–101.

interests.⁷⁹ In other words, parental decisions to use medically unnecessary surgeries for aesthetic or social reasons are treated like parental decisions to attend church or select a school.⁸⁰ As a practical matter, the law allows parents with financial means⁸¹ and access to a willing provider to make and implement decisions to size or sculpt their children.

The broad discretion afforded parents in medical cases is rooted in family autonomy. The Supreme Court has recognized the “family as a unit with broad parental authority over minor children”⁸² in which the parents have the authority to raise children as the parents see fit. The right to familial autonomy allows parents to make most decisions about the care and keeping of children without government oversight or interference.⁸³ Of course, parental rights are not unfettered. Although “custody, care, and nurture of the child reside first in the parents,”⁸⁴ parental rights are tempered by children’s rights and interests and the states’ interests in children’s health and safety. As a result, states may intervene on behalf of abused or neglected children,⁸⁵ limit parental authority to send their children to work,⁸⁶ and require that children be vaccinated.⁸⁷

79. See *Parham v. J.R.*, 442 U.S. 584, 602–03 (1979); see also *infra* Part II.C.

80. See *Parham*, 442 U.S. at 603–04.

81. Parents pay for elective cosmetic procedures out of pocket. Ashley’s health insurer paid for her care. CARLSON & DORFMAN, *supra* note 5, at 15 (citing Parents’ Blog, *supra* note 57, at 6).

82. *Parham*, 442 U.S. at 602.

83. “Choices about marriage, family life, and the upbringing of children are among associational rights this 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) (quoting *Boddie v. Connecticut*, 401 U.S. 371, 376 (1971)). Parents therefore have a constitutionally protected liberty interest in the care, custody, and management of their children. *Santosky v. Kramer*, 455 U.S. 745, 753–54 (1982); see also *Stanley v. Illinois*, 405 U.S. 645, 649–52 (1972) (“The rights to conceive and to raise one’s children have been deemed ‘essential,’ ‘basic civil rights of man’” (quoting *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923))); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (“[T]he custody, care and nurture of the child reside first [with] the parents.”); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (stating that the liberty 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); *Van Emrik v. Chemung County Dep’t of Soc. Servs.*, 911 F.2d 863, 867 (2d Cir. 1990).

84. *Prince*, 321 U.S. at 166.

85. The state has a profound interest in the welfare of the child, particularly his or her being sheltered from abuse. In “‘emergency’ circumstances,” *Hurlman*, 927 F.2d at 80 (citing *Robison v. Via*, 821 F.2d 913, 921 (2d Cir. 1987)), a child may be taken into custody by a responsible state official without court authorization or parental consent. “Emergency circumstances mean circumstances in which the child is immediately threatened with harm.” *Id.* (citing *Robison v. Via*, 821 F.2d 913, 922 (2d Cir. 1987)). “[T]he mere ‘possibility’ of danger” is not enough. *Id.* at 81. If it were, 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); *Robison*, 821 F.2d at 920.

86. See, e.g., *Wisconsin v. Yoder*, 406 U.S. 205, 226–29 (1972) (holding that while the state had a compelling interest in “universal compulsory education,” Amish children were

In areas of law outside health care, children's rights and voices are taking on increasingly important roles.⁸⁸ Indeed, in some areas of family law, children's rights and welfare trump parental rights.⁸⁹ Legal theorists describe a shift in the law's understanding of the parent-child relationship from a traditional hierarchical model to other models that give varying levels of respect to children as autonomous beings.⁹⁰ The traditional hierarchical model of family is firmly ensconced in the health-care setting, however. The Supreme Court has made clear that despite the impact on a child's liberty interest, parents "can and must" make medical judgments for children.⁹¹ State statutes give parents the power to consent to medical, surgical, dental, and psychiatric treatment.⁹² In most cases, the child's wishes are essentially irrelevant.⁹³ As the Supreme Court stated: "The fact that a child may balk at hospitalization or

allowed to quit schooling and begin working after graduating eighth grade because of their parents' religious belief in preparing for 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) (citing *Breed v. Jones*, 421 U.S. 519 (1975); *Goss v. Lopez*, 419 U.S. 565 (1974); *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503 (1969); *In re Gault*, 387 U.S. 1 (1967)).

87. *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) (deciding that a statute mandating compulsory vaccination for schoolchildren was within the state's police power to regulate public health).

88. *E.g.*, *In re Gault*, 387 U.S. at 1–3 (requiring juvenile courts to afford children due process rights to counsel, notice, and cross examination); *Goss v. Lopez*, 419 U.S. 565, 584 (1974) (holding that children have a due process right to present their case before being suspended from school).

89. *E.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 899 (1992) (upholding Pennsylvania statute requiring a pregnant minor seeking an abortion to obtain consent of one parent or guardian, or to seek judicial bypass of consent requirement); *In re Appeal in Pima County Juvenile Severance Action No. S-113432*, 872 P.2d 1240 (Ariz. Ct. App. 1994) (holding that a child may petition to sever parental rights); *Peregood v. Cosmides*, 663 So.2d 665 (Fla. Dist. Ct. App. 1995) (granting a child standing to challenge adoption by his biological mother).

90. *E.g.*, Janet L. Dolgin, *The Fate of Childhood: Legal Models of Children and the Parent-Child Relationship*, 61 ALB. L. REV. 345, 373–78 (1997) (describing three models through which the courts evaluate decision making within the parent-child relationship: the traditional model, where parents are in exclusive control over their children's decisions; the transforming-traditional model, where there are exceptions to the parents' exclusive control in certain situations; and the individualist model, where children "become free to make their own decisions and bear responsibility for the consequences of their actions"); *see also infra* Part IV (discussing the application of alternative models to medical decision making).

91. *Parham v. J.R.*, 442 U.S. 584, 603 (1979).

92. *E.g.*, N.Y. PUBLIC HEALTH LAW §2504(2) (McKinney 2009).

93. *See, e.g., Parham*, 442 U.S. at 603 ("Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment."); *Powers v. Floyd*, 904 S.W.2d 713, 714 (Tex. Ct. App. 1995) (holding that the mother had the power to consent to an abortion for her daughter and that the physician had no duty to disclose the nature of the procedure to the daughter).

complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority to decide what is best for [the] child."⁹⁴

Of course, parental discretion over medical treatment is limited in some medical cases. Parents are not always free to refuse life-sustaining treatment for a child,⁹⁵ and parents' say over a minor's decision to have an abortion is limited.⁹⁶ Some states give children the right to decide about contraception and drug treatment,⁹⁷ and others give decision-making power to mature and emancipated minors.⁹⁸ Parental rights are also limited with respect to particular medical choices. For example, federal law prohibits genital cutting⁹⁹ and limits parental authority to enroll children in experimental protocols,¹⁰⁰ and some states subject parental decisions to sterilize or institutionalize a child to review by a neutral third party or court.¹⁰¹

B. Application in Shaping Cases

Parental choice is the rule in shaping cases. The exceptions do not apply. The use of shaping interventions does not deprive a child of lifesaving treatments or involve drug treatment, abortion, or institutionalization. Although shaping interventions implicate a child's rights to bodily integrity, they do so no more than other cases involving the use of medical and surgical interventions. And where a parent chooses to use medicine or surgery for a child (as opposed to when a parent refuses medicine or surgery) courts are generally unwilling to consider the child's best interests when the desired intervention has the support of even one licensed medical provider.¹⁰²

94. *Parham*, 442 U.S. at 604.

95. *See, e.g.*, *Custody of a Minor*, 379 N.E.2d 1053 (Mass. 1978) (ordering a child undergo chemotherapy over the parents' objections because the treatment had minimal side effects compared to the alternative of not providing treatment, and would save the child from certain death within months); ALAN MEISEL & KATHY CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* §§ 9.01–10.12 (3d. ed. 2004) (discussing cases in which parents have been allowed to withhold care and special rules applicable to seriously ill newborns).

96. *E.g.*, *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976) (finding unconstitutional a state statute that granted parents an absolute veto over a minor child's decision to have an abortion).

97. *See generally* Schlam & Wood, *supra* note 77, at 165–66.

98. Schlam & Wood, *supra* note 77, at 165.

99. 18 U.S.C. § 116 (2006).

100. 45 C.F.R. §§ 46.401–409 (2008) (requiring Institutional Review Board approval of research protocols involving children and strictly limiting non-therapeutic research protocols that parents may elect for their children).

101. *E.g.*, WASH. REV. CODE § 11.92.043(5) (West 2007); *In re Guardianship of Hayes*, 608 P.2d 635, 641 (Wash. 1980).

102. *See In re Hofbauer*, 393 N.E.2d 1009 (N.Y. 1979) (holding that the court would not interfere with parents' decision to forgo conventional chemotherapy for their eight-year-old son who suffered from Hodgkin's disease and treat him with laetrile and a special diet instead because a single provider supported their choice); *In re Hudson*, 126 P.2d 765 (Wash. 1942) (holding that the mother was free to refuse surgery to remove her child's deformed arm despite the recommendation by two physicians that it should be removed for the child's health because both courses of action entailed risk).

Thus, the extent to which the parental-choice system actually protects a child's best interests is highly dependent on parental and medical judgment. In exercising their judgment, doctors are highly deferential to parental choice. As one well-known physician ethicist teaches, the real question in medical cases involving children is not identifying which medical alternatives represent the best interests of the child but rather "identifying a harm threshold below which parental decisions will not be tolerated."¹⁰³ The applicable "harm threshold" varies from physician to physician. Although many doctors refuse to participate in ethically questionable or potentially risky interventions, other physicians are tolerant of physical risk for social or aesthetic benefit. Risk-taking and deferential doctors are free to carry out parental wishes unless the parental decision directly imperils a child's life, reproductive rights, or physical freedom. As a result, a parent who has found a willing medical provider is essentially free to shape his or her child.

The requirement that parents find a willing provider is hardly an obstacle to the exercise of shaping power. Cosmetic surgeons are especially likely to meet the demands of parents for invasive shaping interventions. Unlike pediatricians who measure appropriate medical options by weighing the medical efficacy of a proposed intervention, cosmetic or plastic surgeons are, due to the very nature of their practice, unconcerned with medical efficacy. Plastic surgery's goal is aesthetic and social improvement. The American Academy of Facial Plastic and Reconstructive Surgery code of ethics says only that "[a] member must not perform a surgical operation that is not calculated to improve or benefit the patient."¹⁰⁴ The degree to which cosmetic or social interventions benefit a patient is in the eye of the beholder. The shaping procedures used on all four children in the focus cases were calculated by the parents to improve or benefit their children, and providers were willing to provide each intervention. So long as some providers believe that such subjective aesthetic, social, or familial improvements justify the use of shaping interventions on children, courts are unlikely to interfere with parental choices to use them.

That is not to say that no court would ever find the affirmative use of cosmetic shaping procedure on a child abusive. Imagine, for example, a parent who had been transformed through extreme plastic surgeries into something resembling a lizard.¹⁰⁵ Now imagine that our lizard man had a child, and he wanted his child to look more like him, to be a lizard boy. If the father found a plastic surgeon to split his child's tongue,¹⁰⁶ the father's actions might well be deemed abusive (and the surgeon's a

103. Douglas S. Diekema, *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, 25 THEORETICAL MED. & BIOETHICS 243, 243 (2004).

104. AM. ACAD. OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, CODE OF ETHICS 8 (2000), http://www.aafprs.org/Code_Of_Ethics.pdf.

105. See, e.g., The Lizardman, <http://www.thelizardman.com/> (showing picture of man surgically modified to look like a lizard); Infoplasticsurgery.com, Tongue Splitting Surgery, <http://www.infoplasticsurgery.com/facial/tonguesplitting.html> (advertising a board certified plastic surgeon who provides tongue splitting surgery in a nonjudgmental atmosphere); Unusual Goals: Extreme Plastic Surgery, <http://www.plastic-surgeon-directory.com/extreme-plastic-surgery.html> (describing procedures done to effectuate a man's desire to look like a lizard, such as having five Teflon horns subdermally implanted above each of his eyes to form horned ridges, four of his teeth filed into sharp fangs, and his tongue bifurcated).

106. Take, for example, Dr. Jean Loftus, who provides tongue-splitting services "to ensure

ground for professional discipline) because, under all objective standards, splitting a person's tongue will jeopardize his health and welfare by interfering with the ability to eat and by inflicting a stigmatizing condition. By contrast, eye-shaping surgery and liposuction are medically accepted interventions. Given the near complete deference courts afford medical providers and parents over medical judgments, it is unlikely a court would find the provision of these popular services to be abusive or grounds for professional discipline.

C. Room for Regulation

The broad discretion given parents to shape their children's bodies through medically unnecessary medical and surgical interventions is not constitutionally mandated. The same concerns that justify limitations on parental discretion over involuntary institutionalization and sterilization of minors—the magnitude of the potential harm, the potential conflict of interest on the part of the parents, and the potential for abuse of the interventions¹⁰⁷—would justify limiting parental authority in shaping cases.

As discussed, parental rights over care and custody of children are not unlimited. They must be balanced against children's rights and states' interests in protecting children. The Supreme Court clarified the delicate balance between parental rights and child rights when it comes to medical decision making for a child in *Parham v. J.R.*¹⁰⁸ Although *Parham* is frequently cited as a strong authority for parental rights and as the case that reversed the trend toward protecting children's rights, it is actually a case in which the Court found enough risk of error in parental judgment about what is in a child's best interests that it held that the constitution *required* procedural protections for the child before the parental decision could be implemented.¹⁰⁹

In *Parham*, the Court considered a challenge to a Georgia law that allowed parents to institutionalize children with psychiatric illness.¹¹⁰ The plaintiff was a six-year-old boy whose mother resorted to forced institutionalization after her efforts to manage the child at home failed.¹¹¹ A lawsuit was instituted on the child's behalf alleging that he had a due process right to a full adversarial hearing before his constitutional right to

safety for the public. Unless this procedure is offered by a reputable surgeon, those seeking it may be forced to have it in unclean and unsafe environments." *Infoplasticsurgery.com, supra*, note 105.

107. *Parham v. J.R.*, 442 U.S. 584, 604 (weighing risk of harm to child and potential for abuse as relevant factors for overriding parental choice); *In re Guardianship of Hayes*, 608 P.2d 635, 641 (Wash. 1980) (holding that parent did not have authority to consent to sterilization of her minor daughter because sterilization impinged significantly and permanently on fundamental liberty interests of the child; rather, the child had to be represented by an independent third party in an adversarial hearing to establish whether sterilization was appropriate); *Hart v. Brown*, 289 A.2d 386 (Conn. Super. Ct. 1972) (holding that parents could consent to kidney transplant from one identical twin to the other where transplant was necessary for survival of one twin, risks were negligible, and parents' motivation had been reviewed by neutral third parties, including the court).

108. 442 U.S. 584 (1979).

109. *See id.* at 606–08.

110. *Id.* at 584.

111. *See id.* at 589–90.

liberty could be restrained.¹¹² The trial court agreed with the child rights advocates, but the Supreme Court reversed.¹¹³ The Supreme Court recognized that medical interventions implicate children's liberty interests,¹¹⁴ but also made it clear that the child's rights are, in most cases, coextensive with the parents' rights over the child.¹¹⁵ Thus, the Court said the primary right to make medical decisions rests with the parent, and parents are entitled to a presumption that their decisions are in the best interests of the child.¹¹⁶ But, the Court also recognized expressly "[t]hat some parents 'may at times be acting against the interests of their children.'"¹¹⁷

In the case of forced institutionalization of the child, the Court found good reason to reverse the presumption that parents act in a child's best interests. Concerned with the possibility that parental choices to institutionalize children may be made to benefit an overwrought parent rather than the child, the Court turned to "consideration of what process protects adequately the child's constitutional rights by reducing risks of error without unduly trenching on traditional parental authority."¹¹⁸ The Court concluded that "[t]he risk of error inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied."¹¹⁹

Thus, despite its notoriety as a parents' rights case, *Parham* clearly stands for the proposition that states may—and sometimes must—act to protect children from their parents' medical decisions, especially when the parents' interests may not be coextensive with the child's.¹²⁰ In shaping cases, the parents' interests cannot be

112. *Id.* at 584.

113. *Id.* at 585.

114. *Id.* at 600–01; *see also* *Sell v. United States*, 539 U.S. 166, 176 (2003) ("[I]nvoluntary medical treatment raises questions of clear constitutional importance."); *Riggins v. Nevada*, 504 U.S. 127, 133–34 (1992); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990); *Washington v. Harper*, 494 U.S. 210, 221–22 (1990); *Winston v. Lee*, 470 U.S. 753, 759 (1985) (finding "[a] compelled surgical intrusion into an individual's body . . . implicates expectations of privacy and security" of great magnitude).

115. *Parham*, 442 U.S. at 601–02.

116. *Id.* at 602.

117. *Id.* (quoting *Bartley v. Kremens*, 402 F. Supp. 1039, 1047–48 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. 119 (1977)).

118. *Id.* at 606.

119. *Id.*

120. *See id.*; *see also* WASH. REV. CODE § 11.92.043(5) (West 2007) (requiring independent third-party review of parental decisions to sterilize or institutionalize their children); *Hart v. Brown*, 289 A.2d 386 (Conn. Super. Ct. 1972) (holding that parents could consent to kidney transplant from one identical twin to the other where transplant was necessary for survival of one twin, risks were negligible, and parents' motivation had been reviewed by neutral third parties, including the court); *Little v. Little*, 576 S.W.2d 493 (Tex. Civ. App. 1979) (authorizing parental consent to kidney transplant from the daughter, a fourteen-year-old with Down syndrome, to the son, suffering from end-stage renal disease, because the son would continue to deteriorate without the transplant and the daughter would receive psychological benefits from donation); *In re Guardianship of Hayes*, 608 P.2d 635, 641 (Wash. 1980) (holding that parent did not have authority to consent to sterilization of her minor daughter because sterilization impinged significantly and permanently on fundamental liberty interests of the child; rather, the

assumed to be coextensive with the child's. Shaping procedures are physically invasive, carry with them significant risk, and may be used to satisfy the parents' aesthetic or social preference. As a result, restricting medical or parenting practices to prevent the misuse of shaping interventions is necessary to protect children.

III. WHAT IS REALLY WRONG WITH MEDICAL AND SURGICAL SHAPING OF CHILDREN?

There is much at stake for children subjected to medical or surgical shaping. There is physical harm—skin is cut or pierced; tissue or organs are removed; and bodies are anesthetized or injected with hormones. There is physical risk of nerve damage, cancer, diabetes, hypertension, and death, and there is a psychological risk of stigma and injury to identity. And there may be harm to the children's communities, such as the creation of a permanent underclass and misallocation of precious health-care resources. In any other context, cutting, piercing, and injecting children would constitute abuse,¹²¹ but in shaping cases the interventions are presumed to be in the children's best interests because parents and doctors are involved.¹²² Even so, the harm-based analysis traditionally applied to evaluate the appropriateness of particular medical interventions for children—the search for harm so grievous as to justify overriding parental choice—could well justify the regulation of certain shaping procedures. For example, the physical risks and stigmatizing effects of daily HGH injections arguably outweigh the benefits from an additional inch or two of height.¹²³ Justice concerns and moral harms weigh against the growth attenuation interventions used on Ashley.¹²⁴ These harms are

child had to be represented by an independent third party in an adversarial hearing to establish whether sterilization was appropriate).

121. The U.S. Department of Health and Human Services (HHS) defines abuse as the infliction of “physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child.” CHILD WELFARE INFORMATION GATEWAY, WHAT IS CHILD ABUSE AND NEGLECT? 2 (2008), available at <http://www.childwelfare.gov/pubs/factsheets/whatiscan.pdf>. HHS regulations further provide that an “injury is considered abuse regardless of whether the caretaker intended to hurt the child.” *Id.* Cutting a child's eyelids, injecting drugs hundreds of times, cutting a child's abdomen, and removing tissue or organs all fall within this definition.

122. “[E]ven though it otherwise meets the definition of abuse, it is permissible to cut a child in the context of a surgical procedure when the intrusion is designed to alleviate the patient's own greater physical harm.” Doriane L. Coleman, *The Legal Ethics of Pediatric Research*, 57 DUKE L.J. 517, 553 (2007).

123. See Fox, *supra* note 10, at 1144–46, 1153–59, 1193–96 (arguing for regulation on this basis).

124. See, e.g., William Peace, *Protest from a Bad Cripple: Ashley Unlawfully Sterilized*, COUNTERPUNCH, May 26, 2007, <http://counterpunch.org/peace05262007.html> (asking “[w]hat is next? Amputate the legs of paralyzed people because they are at risk for skin problems and blood clots?”); William Peace, *Protest from a Bad Cripple: The Ashley Treatment and the Making of a Pillow Angel*, COUNTERPUNCH, Jan. 18, 2007, <http://www.counterpunch.org/peace01182007.html> (arguing the Ashley case sends the message that “disabled people are not human—they are profoundly flawed and extreme measures will be taken to transform their bodies”); Dave Reynolds, *Advocates Speak Out and Call for Investigations over “Ashley Treatment”*, INCLUSION DAILY EXPRESS, Jan. 12, 2007, <http://www.inclusiondaily.com/archives/07/01/12/011207waashleyx.htm> (stating that “[b]enevolence’ and ‘good intentions’ have often

at least as consequential as those that justify limitations on the parental choice to enroll a child in nontherapeutic research protocols or to institutionalize a child.¹²⁵

It is my position, however, that a harm-based analysis is of limited use in shaping cases. First, harm-based analyses are necessarily procedure or case specific. Second, they have little traction in practice, especially when directed at the overuse or misuse of medical or surgical intervention (as opposed to underuse).¹²⁶ Third, and most importantly, harm-based arguments do not get to the root of the problem. They take as a given that, absent grievous harm or death, parents have a right to modify a child's body. The assumption of parental rights applies equally to medical or surgical modifications made to improve a child's health as it does to modifications made to satisfy a parent's own aesthetic or social preferences.

The assumption that parents have such broad powers over a child's body should be questioned.¹²⁷ No one other than a parent has the power to use a child's body for their own purposes, and the notion that a parent has a *right* to alter a child's body is inconsistent with principles deeply embedded in law and moral theory—that people are not property; that people are entitled to respect and dignity; and that no person has a right to exercise complete dominion over the body of another.¹²⁸

A. The Nonsubordination Principle as a Limit on Individual Rights

In order to assess the proper scope of parental rights, it is helpful to evaluate both the moral and legal status of adult persons generally and the extent to which the moral status of one person may limit the rights of another. Adults are human persons who

had disastrous consequences for the disability community. Throughout history, 'for their own good' has motivated and justified discrimination against [the disabled community]").

125. At stake for children in research protocols are physical and moral harm. See Gwendolyn Johnson, Grimes v. Kennedy Krieger Inst., Inc.: *The Court of Appeals of Maryland Distinguishes Special Relationships That May Arise to the Level of a Contractual Relationship Between Researchers and Non-Therapeutic Research Participants*, 9 U. BALT. J. ENVTL. L. 72, 72–73 (2001); Coleman, *supra* note 122, at 530–45. At stake for children who are institutionalized are confinement and stigma. See Parham v. J.R., 442 U.S. 584, 600–01 (1979).

126. Compare *In re Hofbauer*, 393 N.E.2d 1009 (N.Y. 1979) (holding that the court would not interfere with parents' decision to forgo conventional chemotherapy for their eight-year-old son who suffered from Hodgkin's disease and treat him with laetrile and a special diet instead), with *In re Sampson*, 278 N.E.2d 918 (N.Y. 1972) (ordering that a child undergo facial surgery and receive blood transfusions despite the mother's religious objection).

127. I am by no means the first person to question the traditional understanding of parenthood that underlies the current paradigm for medical decision making for children. See, e.g., Katharine T. Bartlett, *Re-Expressing Parenthood*, 98 YALE L.J. 293, 297–98 (1988) (describing the traditional view of "parenthood as exchange" and describing a new construction of the relationship between parent and child, away from parents' rights and towards 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 CAL. L. REV. 1371, 1374 (1994) (arguing that the "preferred justifications for parental rights are . . . 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" (emphasis in original)).

128. See Dwyer, *supra* note 127, at 1405 ("[I]t is illegitimate to construe an individual's rights to include an entitlement to exercise extensive control over another person, or *any* control over a non-consenting person apart from self-defensive measures." (emphasis in original)).

have a moral status that demands respect, dignity, and freedom from arbitrary treatment. The law respects that moral status by affording individuals rights to self-determination,¹²⁹ bodily integrity,¹³⁰ and freedom from confinement.¹³¹ The right to self-determination gives people broad power to direct the course of their own personal and professional lives.¹³² But the right to self-determination is not so broad as to allow its exercise to deny the moral status and corresponding rights of another person. While an individual has a constitutionally protected right to self-determination, that right is limited by the rights of other persons to bodily integrity, self-determination, and freedom from confinement.¹³³ In other words, a person's right to self-determination does not include a right to subordinate another person's life, liberty, or body for his own purposes.

Application of this "nonsubordination principle"¹³⁴ is clear with adults. The most obvious example, of course, is the Thirteenth Amendment's prohibition against slavery and involuntary servitude,¹³⁵ which the courts have interpreted to apply beyond the

129. *Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 572 (1972) (recognizing that "the liberty . . . guaranteed [by the Fourteenth Amendment] . . . denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized . . . as essential to the orderly pursuit of happiness by free men." (quoting *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923)) (alteration in original)).

130. *See, e.g., Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 849 (1992) ("[T]he Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood as well as bodily integrity . . .").

131. *E.g., 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 . . .").

132. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (stating that liberty includes the "right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized . . . as essential to the orderly pursuit of happiness by free men").

133. *See, e.g., W. Va. Bd. of Ed. v. Barnette*, 319 U.S. 624, 630 (1943) (noting that it is conflicts between the freedoms of one party and "rights asserted by any other individual . . . which most frequently require intervention of the State to determine where the rights of one end and those of another begin").

134. I am using this term to define the limitations that one person's liberty interests place on the exercise of another's. James G. Dwyer uses the term "non-subjection principle" in his article *Parents' Religion and Children's Welfare: Debunking the Doctrine of Parents' Rights*, Dwyer, *supra* note 127, at 1412, to define a similar concept. Others refer to nonsubordination theory and an antisubjugation principle to describe the law's abhorrence of castes and a principle which prohibits the systematic subordination of a particular group based on a single trait. *See, e.g., Owen M. Fiss, Groups and the Equal Protection Clause*, 5 PHIL. & PUB. AFF. 107, 157 (1976); *see also* LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1438, 1514 (2d ed. 1988) (referring to an "antisubjugation principle"); Erin E. Goodsell, *Toward Real Workplace Equality: Nonsubordination and Title VII Sex-Stereotyping Jurisprudence*, 23 WIS. J.L. GENDER & SOC'Y 41, 46 (2008) (applying nonsubordination theory to Title VII); Cass R. Sunstein, *The Anticaste Principle*, 92 MICH. L. REV. 2410, 2428-29 (1994) (arguing against laws that maintain second-class citizenship, or lower-caste status, for blacks or women).

135. U.S. CONST. amend. XIII, § 1 ("Neither slavery nor involuntary servitude, except as a

formal institution of slavery to “control by which the personal service of one man is disposed of or coerced for another’s benefit.”¹³⁶ The prohibition against slavery and involuntary servitude preserves the respect and dignity of one person at the expense of another’s liberty interests. For example, the right to contract is a protected liberty interest,¹³⁷ but courts routinely refuse to enforce specific performance of personal service contracts to avoid subjugating one person to the will of another.¹³⁸

The nonsubordination principle also plays a role in criminal and civil laws that prohibit physical abuse and battery.¹³⁹ No matter how powerful one person’s desire to force another to submit to his will, laws prohibiting abuse and battery limit a person’s right of self-determination by preventing him from subjugating another’s body for his own purposes.¹⁴⁰

The principle that one individual’s right to self-determination does not entitle that person to dominate another, and its converse, that every individual is entitled to full respect and dignity, is reflected in the modern understanding of the marital relationship. Although women were once denied the rights attendant their human status, the law’s evolving understanding of all persons as complete human beings has resulted in serious limits on the power of husbands to dominate their wives. Husbands can no longer rape their wives with impunity.¹⁴¹ In the abortion context, the “moral fact that a person belongs to himself and not to others nor to society as a whole,”¹⁴² means

punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.”)

136. *Bailey v. Alabama*, 219 U.S. 219, 241 (1911).

137. *Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 572 (1972) (acknowledging the individual right to contract as a liberty interest protected by the Fourteenth Amendment).

138. RESTATEMENT (SECOND) OF CONTRACTS § 367 cmt. a (1981) (“A court will refuse to grant specific performance of a contract for service or supervision that is personal in nature. The refusal is based in part upon the undesirability of compelling the continuance of personal association after disputes have arisen and confidence and loyalty are gone and, in some instances, of imposing what might seem like involuntary servitude.”).

139. *See, e.g.*, N.Y. PENAL LAW §§ 120.00–.12 (McKinney 2009) (prohibiting assault against another person); N.Y. PENAL LAW § 130.52 (McKinney 2009) (prohibiting forcible touching of another); CAL. PENAL CODE §§ 242.0–243.10 (West 2008) (prohibiting various forms of battery); *see also* *United States v. King*, 840 F.2d 1276, 1280–83 (1988) (“[A] parent’s contract allowing a third party to burn, assault or torture his child is void.”).

140. *See King*, 840 F.2d at 1283.

The Thirteenth Amendment prohibits an individual from selling himself into bondage, and it likewise prohibits a family from selling its child into bondage. The Western legal tradition prohibits contracts consenting in advance to suffer assaults and other criminal wrongs. They are void as against public policy. They do not insulate the wrongdoer from civil and criminal liability. Similarly a parent’s contract allowing a third person to burn, assault or torture his child is void.

Id. (citation omitted).

141. *E.g.*, *People v. Liberta*, 474 N.E.2d 567, 572–73 (N.Y. 1989) (“[n]owhere in the common-law world—[or] in any modern society—is a woman regarded as chattel or demanded by denial of a separate legal identity and the dignity associated with recognition as a whole human being.” (quoting *Trammel v. United States*, 445 U.S. 40, 52 (1980) (alterations in original))).

142. *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 777 n.5 (1986) (Stevens, J., concurring), *overruled in nonrelevant part* by *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

that a husband's right to direct his own reproductive destiny cannot extinguish a woman's right to make "choices central to personal dignity and autonomy."¹⁴³

The nonsubordination principle applies even to adults who are "naturally suited to governance by others[,]"¹⁴⁴ due to incapacity or incarceration. In *Cruzan*, for example, the Supreme Court denied the parents' claim that they possessed the right to decide to terminate life-sustaining treatment for their adult daughter, who lacked capacity to make her own decisions because of injuries sustained in an accident.¹⁴⁵ The Court reasoned that the decision whether to live or die is so personal to the individual affected, that the state need not "repose judgment on these matters with anyone but the patient."¹⁴⁶ In other words, a state could reasonably decide that certain decisions are so personal they belong to a particular individual only, even when the individual to whom they belong lacks capacity to make her own choices. Likewise, the Court has recognized that adults with profound retardation have protected interests in bodily safety and freedom from restraint that limit their caregivers' actions.¹⁴⁷ And despite the diminished liberty of prisoners, they retain "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment"¹⁴⁸ that prevents the state from exercising unrestrained dominion over their bodies.

B. Children as Persons, Parental Rights

Application of the nonsubordination principle to the parent-child relationship is complicated by the well-established right of parents to direct a child's upbringing.¹⁴⁹ Parental rights allow parents a degree of control over other persons that would be impermissible in any other relationship. But it would be a moral and legal mistake to assume that the law's recognition of parental rights entitles parents to control a child's body or to make decisions for a child that belongs to the child's adult self. Parental rights spring not from some ownership interest in the child, but from liberty interests in self-determination,¹⁵⁰ and a conception of "family privacy" that includes "not simply a

143. *Casey*, 505 U.S. at 851 (striking down spousal notification rule).

144. Dwyer, *supra* note 127, at 1416.

145. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

146. *Id.* at 286.

147. *Youngberg v. Romeo*, 457 U.S. 307 (1982) (finding constitutionally protected rights to reasonably safe confinement conditions and freedom from unreasonable bodily restraints where mentally retarded patient received injuries while involuntarily committed to a state institution).

148. *Washington v. Harper*, 494 U.S. 210, 221–22 (1990). "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Id.* at 229.

149. Parents have the rights "to bring up [a] child in the way he should go." *Prince v. Massachusetts*, 321 U.S. 158, 164 (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." *Id.* at 166. The "primary role of parents in the upbringing of their children is . . . established beyond debate as an enduring American tradition." *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972). *But see* Dwyer, *supra* note 127 (arguing that children's rights, rather than parents' rights, should be the focus of the law).

150. *See Doe v. Bolton*, 410 U.S. 179, 211 (1973) (Douglas, J., concurring) (stating that liberty in the Constitution implies "freedom of choice in the basic decisions of one's life

policy of minimum state intervention but also a presumption of parental autonomy.”¹⁵¹ Just as the right to self-determination is consistently limited by the rights and moral status of others, parental rights are also limited by the rights and moral status of children.¹⁵² As persons, children are entitled to whatever degree of respect and dignity their vulnerable status allows. “Our law views the child as an individual with the dignity and humanity of other individuals, not as property.”¹⁵³ Neither the custodial status, nor the biological relationship of parents to children, nor the zone of privacy that surrounds families gives parents a right to use, sacrifice, or invade a child’s body for their own purposes, or to make decisions for a child that belong to the adult the child will become.¹⁵⁴

Even the cases explicitly recognizing parental rights can be understood to apply the nonsubordination principle to limit the scope of parental powers in terms of the child’s future and present liberty interests. For example, when the Supreme Court upheld a child labor law against a challenge based in part on parental authority to direct the religious upbringing of a child, it famously explained that “[p]arents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”¹⁵⁵ Thus, the Court recognized parental power over the religious upbringing of a child but limited its reach at the point at which its assertion would interfere with the ability of the child to exercise her own rights in the future. Likewise, the well recognized power of parents to direct their children’s education¹⁵⁶ is not so broad as to allow parents to deny children

respecting . . . the . . . upbringing of children” (emphasis in original)).

151. *In re Marriage of Mentry*, 190 Cal. Rptr. 843, 848 (Cal. App. 1983); *see, e.g., Mentry*, 190 Cal. Rptr. at 847–48 (explaining that “[t]he vast majority of matters concerning the upbringing of children must be left to the conscience, patience, and self-restraint of father and mother. No end of difficulties would arise should judges try to tell parents how to bring up their children.”); *Custody of a Minor*, 379 N.E.2d 1053, 1062 (1978) (recognizing that “natural rights” of parents encompass “an entire ‘private realm of family life which must be afforded protection from unwarranted State interference’” (quoting *Quilloin v. Walcott*, 434 U.S. 246, 255–56 (1978))).

152. *See Custody of a Minor*, 379 N.E.2d at 1063 (“[W]here a child’s well-being is placed in issue, ‘it is not the rights of parents that are chiefly to be considered. The first and paramount duty is to consult the welfare of the child.’ On a proper showing that parental conduct threatens a child’s well-being, the interests of the State and of the individual child may mandate intervention.” (quoting *Purinton v. Jamrock*, 80 N.E. 802, 805 (Mass. 1907)) (footnote omitted)).

153. *United States v. King*, 840 F.2d 1276, 1283 (6th Cir. 1988) (citing *Ford v. Ford*, 371 U.S. 187, 193 (1962)).

154. *See id.* (“Neither religion nor parental consent can save the Salem witch trials of children or the sale of a daughter into prostitution or the Padrone system of child labor or the House of Judah system of child beatings.”).

155. *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

156. *See, e.g., Pierce v. Soc’y of Sisters*, 268 U.S. 510, 534–35 (1925) (recognizing the right of parents to send their school-age children to parochial or private schools); *Meyer v. Nebraska*, 262 U.S. 390, 401 (1923) (recognizing “the power of parents to control the education of their own”).

an education altogether.¹⁵⁷ Education, acknowledged the Court, promotes children's future autonomy by preparing "individuals to be self-reliant and self-sufficient participants in society,"¹⁵⁸ and compulsory education laws ensure that parents do not deny children the opportunity to become self-sufficient participants in society. And in *Parham*, where the Court emphasized parental rights to make medical choices for children, the Court limited parental power to ensure against erroneous imposition of unnecessary or improper medical treatment where there was a risk that exercise of parental power could subordinate the child's interest in freedom from unnecessary medical treatment and confinement to the parent's own interests in restraining a problem child.¹⁵⁹

The nonsubordination principle is further reflected in laws that authorize intervention on behalf of neglected or abused children,¹⁶⁰ prevent parents from withholding necessary medical treatment,¹⁶¹ curtail parental authority to sterilize their children,¹⁶² and limit parental power "to deny children exposure to ideas and experiences they may later need as independent and autonomous adults."¹⁶³ These laws all limit parental power at the point at which its exercise would subordinate the child's life or body to the parents' interests. The principle is most visibly at play in the laws regulating use of children as research subjects and in the few instances in which parental decisions to use one child as an organ or tissue donor for another have reached the courts.¹⁶⁴ Regardless of parental desire to inculcate children in a value system prizing altruism, or a desire to profit from their children's bodies, parents may not freely authorize the use of their children as subjects in nontherapeutic research protocols.¹⁶⁵ Applicable regulations were promulgated to protect children as persons

157. See *Leebaert v. Harrington*, 332 F.3d 134, 140–41 (2d Cir. 2003) ("[T]he scope of a parent's right to direct the . . . education of children . . . does not include a right to exempt one's child from school requirements.").

158. See *Wisconsin v. Yoder*, 406 U.S. 205, 221 (1972).

159. *Parham v. J.R.*, 442 U.S. 584, 607 (1979) (requiring a "probe [of] the child's background using all available sources, including but not limited to, parents, schools, and other social agencies. Of course, the review must also include an interview with the child").

160. *E.g.*, 42 U.S.C.A. § 5106g (2009) (defining child abuse); N.Y. SOC. SERV. LAW § 384-b (McKinney 2003 & Supp. 2010).

161. See, *e.g.*, *Jehovah's Witnesses v. King County Hosp.*, 278 F. Supp. 488, 498–508 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968).

162. See, *e.g.*, *Conservatorship of Valerie N. v. Valerie N.*, 707 P.2d 760 (Cal. 1985) (en banc) (denying a parent's right to sterilize an adult child without medical necessity); *Ruby v. Massey*, 452 F. Supp. 361, 367 (D. Conn. 1978) ("[Parents] may neither veto nor give valid consent to the sterilization of their children.").

163. *Parham*, 442 U.S. at 631 (Brennan, J., concurring in part and dissenting in part) (citing *Commonwealth v. Renfrew*, 126 N.E.2d 109 (Mass. 1955)); *cf.* *Meyerkorth v. State*, 115 N.W.2d 585 (Neb. 1962) (upholding a statute that set minimum requirements for teacher qualifications and student attendance against a freedom of religion challenge), *appeal dismissed*, 372 U.S. 705 (1963); *Auster v. Weberman*, 100 N.Y.S.2d 60 (Sup. Ct. 1950), *aff'd*, 102 N.Y.S.2d 418, *aff'd*, 302 N.Y. 855, *appeal dismissed*, 342 U.S. 884 (1951)).

164. See, *e.g.*, *Hart v. Brown*, 289 A.2d 386 (Conn. 1972).

165. 45 C.F.R. § 46.404–07 (2009) (restricting the use of healthy children in research to studies that involve no more than "minimal risk"); see also *Grimes v. Kennedy Krieger Inst., Inc.*, 782 A.2d 807, 843–44 (Md. 2001) (declaring invalid parental consent given to the use of

with moral and legal status in the wake of a public ethical debate¹⁶⁶ that began with the revelation that Nazi doctors experimented on children during World War II and reached a critical point when it was learned that healthy but developmentally disabled children at the Willowbrook School in New York were being fed the hepatitis virus as part of a study designed to understand the course of the disease and the possibilities for vaccination.¹⁶⁷ The debate about human experimentation gave rise to the National Commission for Protection of Human Subjects of Biomedical and Behavior Science's *Belmont Report*,¹⁶⁸ the document that establishes ethical parameters for experimentation on human subjects, and forms the basis of federal regulations. The

children in nontherapeutic research protocols involving more than minimal risk); *T.D. v. N.Y. State Office of Mental Health*, 650 N.Y.S.2d 173 (N.Y. App. Div. 1996) (invalidating state regulations that allowed more than minimal risk on children).

166. For a thorough discussion of the debate and the historical evolution of ethical codes governing human experimentation, see *BEYOND CONSENT: SEEKING JUSTICE IN RESEARCH* (Jeffrey P. Kahn, Anna C. Mastroianni & Jeremy Sugarman eds., 1998). For discussions focused on children in research, see LAINIE FRIEDMAN ROSS, *CHILDREN IN MEDICAL RESEARCH: ACCESS VERSUS PROTECTION* (2006); Randall Baldwin Clark, *Speed, Safety, and Dignity: Pediatric Pharmaceutical Development in an Age of Optimism*, 9 U. CHI. L. SCH. ROUNDTABLE 1 (2002); Rupali Gandhi, *Research Involving Children: Regulations, Review Boards and Reform*, 8 J. HEALTH CARE L. & POL'Y 264 (2005); Anna Gercas, *The Universal Declaration on Bioethics and Human Rights: Promoting International Discussion on the Morality of Non-Therapeutic Research on Children*, 27 MICH. J. INT'L L. 629 (2006); Clifton R. Gray, *The "Greater Good" . . . At What Cost?: How Non-therapeutic Scientific Studies Can Now Create Viable Negligence Claims in Maryland After Grimes v. Kennedy Krieger Institute, Inc.*, 32 U. BALT. L. REV. 73, 87–92 (2002); William G. Kelly, *Ericka and Myron: Canaries in the Mines*, 13 ALB. L.J. SCI. & TECH. 173 (2002); Loretta M. Kopelman, *Children as Research Subjects: Moral Disputes, Regulatory Guidance, and Recent Court Decisions*, 73 MOUNT SINAI J. MED. 596 (2006); Loretta M. Kopelman, *Minimal Risk as an International Ethical Standard in Research*, 29 J. MED. & PHIL. 351 (2004); Loretta M. Kopelman, *Pediatric Research Regulations Under Legal Scrutiny: Grimes Narrows Their Interpretation*, 30 J.L. MED. & ETHICS 38 (2002); Symposium, *Research with Children: The New Legal and Policy Landscape*, 6 J. HEALTH CARE L. & POL'Y 1 (2002); Jennifer Rosato, *The Ethics of Clinical Trials: A Child's View*, 28 J.L. MED. & ETHICS 362 (2000); Lainie Friedman Ross, *In Defense of the Hopkins Lead Abatement Studies*, 30 J.L. MED. & ETHICS 50 (2002); Efi Rubinstein, *Going Beyond Parents and Institutional Review Boards in Protecting Children Involved in Nontherapeutic Research*, 33 GOLDEN GATE U. L. REV. 251 (2003); David M. Smolin, *Nontherapeutic Research with Children: The Virtues and Vices of Legal Uncertainty*, 33 CUMB. L. REV. 621 (2002); William J. Wenner, *Does the Legal System Provide Adequate Protection for Children in Scientific Experiments? The Unanswered Question of Grimes v. Kennedy Krieger Institute*, 8 U.C. DAVIS J. JUV. L. & POL'Y 243 (2004).

167. See DAVID J. ROTHMAN & SHEILA M. ROTHMAN, *THE WILLOWBROOK WARS* 263 (1984).

168. NAT'L COMM'N FOR THE PROT. OF HUMAN SUBJECTS OF BIOMEDICAL & BEHAVIORAL RESEARCH, *THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH* (1978), available at <http://ohsr.od.nih.gov/guidelines/belmont.html>; see also *In re Brandt (The Medical Trial)*, 14 Ann. Dig. 296, 297–98 (Nuremberg, Germany, U.S. Military Trib. 1947); World Med. Ass'n [WMA], *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects* (June 1964) (amended 2000), available at <http://www.wma.net/en/30publications/10policies/b3/index.html>; 2 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW NO. 10, at 181–84 (1949), available at <http://ohsr.od.nih.gov/guidelines/nuremberg.html>.

Belmont Report requires special protections for children in human-subject research because they are particularly vulnerable to exploitation.¹⁶⁹

The nonsubordination principle also explains the willingness of courts to review parental decisions to use one child's body to save the life of another child. Although most such cases are decided without court involvement under the current paradigm of parental choice, there are exceptions. In such cases, courts become involved, despite the impact on parental choice, because the particular parental choice may well sacrifice the donor child's body to serve the interests of the parents and recipient child without corresponding benefit to the donor child. The courts confronting these cases have uniformly held that they will abide by the parents' choice only if the decision will, in fact, serve the donor child's best interests by preserving a close relationship with the recipient sibling.¹⁷⁰ In other words, courts will not countenance subjugation of the donor child's body for someone else's purposes.

Thus, parental rights are not so broad as to allow parents to subordinate a child's life or body for their own purposes. Understanding precisely how the nonsubordination principle applies within the parent-child relationship requires a clear understanding of the moral status and corresponding rights of children because it is the children's status and rights that define the limitations of parental self-determination. I am not prepared to offer a fully articulated theory of children's moral status and rights. But the law is clear on some points: neither a child's body nor certain choices are the province of parents. Children have strong interests in bodily integrity, safety, and freedom from bodily restraint,¹⁷¹ as well as "a substantial liberty interest in not being confined unnecessarily for medical treatment."¹⁷² Parents have no right to interfere with these interests for their own benefit. Children also have exclusive rights to make certain fundamental decisions for themselves, and parents cannot make choices that will deprive the child of the opportunity to make those choices as an adult. Thus, it is clear that nothing about being a parent gives a person the right to violate a child's body, and nothing about the fact of medical involvement changes the child's right to human respect.

C. Medical and Surgical Shaping of Children is Different

Parents make all kinds of decisions that shape their children. By exposing a child to music or art, parents help shape the child's cultural preferences. By reading to a young child or choosing special schools, parents help shape a child's intellectual development. By feeding a child a steady diet of fast-food dinners or implementing a

169. See *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*, *supra* note 168.

170. Michele Goodwin synthesizes these decisions in *My Sister's Keeper?: Law, Children, and Compelled Donation*, 29 W. NEW ENG. L. REV. 357, 386–402 (2007); see also Coleman, *supra* note 122.

171. Cf. *Youngberg v. Romeo*, 457 U.S. 307, 320 (1982) (recognizing rights as belonging to all persons regardless of capacity).

172. *Parham v. J.R.*, 442 U.S. 584, 600 (1979); cf. *Washington v. Harper*, 494 U.S. 210, 221–22 (1990) (recognizing a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment).

regular exercise program, parents help shape a child's body. These examples of parental shaping are not legally or morally problematic. In each, the parent is fulfilling a duty to care for a child. To be sure, parents use discretion in deciding how to meet the child's needs, but their authority to act is derived from their obligation to meet the child's basic needs.¹⁷³ In fulfilling their parental obligations, the exercise of discretion is entitled to presumptive deference as a matter of family privacy.¹⁷⁴

Medical treatment decisions also shape children. Surgically implanting a pin and casting a broken leg, for example, shapes a child's body; administering Dilantin to a child with a seizure disorder shapes a child's brain.¹⁷⁵ The power to make medical decisions for a child gives parents the kind of access to a child's body that they have in no other context. Yet parents "can and must" make decisions for a child when a child is sick or her body is not functioning properly.¹⁷⁶ Like other parental powers, the power to make medical decisions derives from parental obligations to meet the needs of the child.¹⁷⁷ The parent who consents to surgery for a broken leg or for the administration of seizure medicine is not subordinating the child's life or body for his or her own purposes. Rather, the parent's decision advances the child's long-term interest in bodily integrity even if that decision compromises the child's immediate interest in bodily integrity and freedom from confinement. Of course, parents sometimes make medical-treatment decisions that subordinate a child's life or health to other parental interests, such as religiously motivated refusals of lifesaving blood transfusions. Courts will override those decisions when the decision would result in a violation of the nonsubordination principle.¹⁷⁸

Parents also make decisions to use medicine for reasons other than treatment of a medical or functional need of a child. In such cases, the danger that a parent is

173. That parents have legal and moral obligations to meet the basic needs of children is beyond dispute. Parents have a "high duty[]" to recognize and prepare [their children] for additional obligations." *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925). They have a specific "'high duty' to recognize symptoms of illness and to seek and follow medical advice." *Parham*, 442 U.S. at 602.

174. *See, e.g., In re Marriage of Mentry*, 190 Cal. Rptr. 843, 847-48 (App. 1983) (applying the notion of family privacy); *Custody of a Minor*, 379 N.E.2d 1053, 1062 (Mass. 1978) (recognizing "an entire 'private realm of family life which must be afforded protection from unwarranted State interference.'" (quoting *Quilloin v. Walcott*, 434 U.S. 246, 255-56 (1978))).

175. *See* PFIZER, INFATABS (2009), available at http://www.pfizer.com/files/products/uspi_dilantin_infatabs.pdf.

176. *Parham*, 442 U.S. at 603.

177. *Custody of a Minor*, 379 N.E.2d at 1063.

[T]he parental right to control a child's nurture is grounded not in any "absolute property right" which can be enforced to the detriment of the child, but rather is akin to a trust, "subject to . . . [a] correlative duty to care for and protect the child, and . . . [terminable] by [the parents'] failure to discharge their obligations."

Id. (quoting *Richards v. Forrest*, 180 N.E. 508, 511 (Mass. 1932)) (all alterations except the first in original).

178. *See, e.g., Custody of a Minor*, 379 N.E.2d at 1053 (ordering a child to undergo chemotherapy); *Jehovah's Witnesses v. King County Hosp. Unit No. 1 (Harborview)*, 390 U.S. 598 (1968) (per curiam), *aff'g* 278 F. Supp. 488 (W.D. Wash. 1967) (overriding parental refusal to provide blood transfusions).

sacrificing a child's body for reasons unrelated to the child's welfare is acute. When parents elect to modify a child's body with medically unnecessary surgery or medical treatments, they turn a healthy child into a patient and compromise a child's interests in bodily integrity, safety, and freedom from confinement.¹⁷⁹ Such invasions of the child's liberty are justified only if necessary to meet the child's needs. Medically unnecessary interventions might meet the needs of a child, but they might not. They might instead be a matter of parental preference. A parent might choose to renovate a child's body for the same reasons he would paint a car or renovate a functioning kitchen. The resulting product will be more aesthetically pleasing, a source of pride, and easier to operate. This process of manufacture may have been at play in each focus case. Despite his claims that it was for her own good, for example, it is quite possible that the adoptive father modified his daughter because he preferred the look of round-eyed girls; that the father injected HGH into his son's body to claim rights to a basketball-playing son; that Brooke Bates's parents had her fat removed because they did not want to see it or it brought them shame; and that Ashley's parents stunted her growth and removed her organs to improve their own lives by creating a child who was, in effect, easier to operate than the one to which they gave birth. To be sure, it is also possible, especially in Ashley's case, that the parents were motivated solely by a desire to do what they deemed best for their child.¹⁸⁰ Indeed, I would be surprised if the parents' motives in the cases were black or white. My point is simply that the possibility of self-dealing is present in each of these cases.

Self-dealing from a child's body is not acceptable. Although children may be part of a family unit in which they have little control, their bodies are not community property. Their right to bodily integrity is personal. Indeed, it is not clear that parents have any right to invade a child's body except to meet a child's demonstrated need. Children are not cars. They are not kitchens. They are not a parental possession to be crafted. Children are persons who should not be treated as objects of design or instruments of ambition. Objectifying children denies their personhood and subordinates their present and future interests. Parental overreaching is especially troubling in the health-care context because the impact on the child's bodily integrity is immediate and irrevocable.

Philosopher Michael Sandel explains the problem from a similar perspective. He argues that when parenting takes on the role of manufacture "[t]he problem lies in the hubris of the designing parents Even if this disposition did not make parents tyrants to their children, it would disfigure the relation between parent and child"¹⁸¹ Sandel reflects on the teaching of theologian William May that parenthood, more than any other human relationship, teaches an "openness to the unbidden."¹⁸² May's construct, says Sandel, "appreciates children as gifts as they come, not as objects of our design or products of our will or instruments of our ambition."¹⁸³ It recognizes that "[p]arental love is not contingent on the talents and attributes a child happens to

179. *Parham*, 442 U.S. at 600; see also *Washington v. Harper*, 494 U.S. 210, 221 (1990).

180. Even Brooke Bates's parents might have been trying to help her avoid social stigma.

181. Michael J. Sandel, *The Case Against Perfection: What's Wrong with Designer Children, Bionic Athletes, and Genetic Engineering*, in BONNIE STEINBOCK, ALEX JOHN LONDON, & JOHN ARRAS, *ETHICAL ISSUES IN MODERN MEDICINE: CONTEMPORARY READINGS IN BIOETHICS* 890, 894 (7th ed. 2009).

182. *Id.*

183. *Id.*

have,”¹⁸⁴ but on acceptance of the person the child is. Accepting the child as a gift, he says, does not “mean that parents must shrink from shaping and directing the development of their child” or “be passive in the face of illness or disease.”¹⁸⁵ To the contrary, Sandel says parents have an “obligation to cultivate their children,”¹⁸⁶ which includes healing and preventing sickness and injury. “Healing sickness or injury does not override a child’s natural capacities but permits them to flourish.”¹⁸⁷

Sandel, then, would differentiate the parent’s role in treating a broken leg from the father’s role in the eye shaping focus case by what the parental choices say about the relationship between parent and child. The parent who consents to surgery and casting on the broken leg is not rejecting the child as she came or overriding the child’s natural capacities. Instead, that parent is fulfilling an obligation to cultivate the child and to allow her to flourish. By contrast, the adoptive father who consented to surgery to modify the shape of his Asian daughter’s eyes has failed to appreciate the child as a gift and rejected the child’s natural capacity as a complete person. He changed her into a child with round eyes that better matched his Caucasian family. In so doing, he has denied her a physical marker of ethnicity that some people value as a critical component of identity.¹⁸⁸ He has turned her from a fully formed and healthy child into a patient, a person in need of treatment. His decision imposed his will on her in an exercise of hyperagency and hubris that distorted the parent-child relationship.

The fact that the father in the eye surgery focus case was a new adoptive parent makes Sandel’s gift analogy particularly apt, and makes the father’s determination to modify his daughter’s ethnic features feel particularly egregious. Perhaps because adoption already involves an exchange, the transfer of custody of a fully formed human being, an adoptive parent’s moral obligation to respect the child’s individuality is especially clear, especially in a cross-cultural or cross-racial adoption. But the fact of adoption changes nothing about the moral or legal status of the child. Every child deserves respect for his or her individual personhood separate from the interests of the parent. The nonsubordination principle helps ensure that this respect is afforded.

Application of the nonsubordination principle to define the limits of parental rights in the context of medical decision making in specific cases is complicated by the fact that parents have both a right and a “high duty to recognize symptoms of illness and to seek and follow medical advice.”¹⁸⁹ Unlike with adult relationships, the line that defines as unacceptable unilateral decisions by one person that interfere with bodily integrity of another person is not at all clear in the parent-child relationship. For example, a parental decision to consent to surgery to insert a pin into a child’s broken leg has an immediate impact on the child’s bodily integrity and liberty interests, but the decision is surely a parent’s to make. By contrast, a decision to cut the genitals of a female child to conform to cultural traditions of the parents is not. Distinguishing parental decisions designed to meet a child’s needs from those that subordinate the child’s interests for the sake of the parent is no easy task.

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. Kobrin, *supra* note 1.

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

Sandel relies on an apparent, but not express, distinction in the law between parental power to use medical interventions to restore and protect health and function and parental power to intervene for nontherapeutic purposes. In *Parham*, for example, the Court expressly held that “it is necessary that the [third-party] decisionmaker have the authority to refuse to admit any child who does not satisfy the medical standards for admission.”¹⁹⁰ In other words, at least in the context of mental health commitments, the Court limited the parents’ power to make health-care decisions for the child to decisions that are medically necessary or otherwise therapeutic. Similarly, in the research context, state and federal laws limit parental authority to enroll children in nontherapeutic research protocols.¹⁹¹ Limitations on parental authority to consent to nontherapeutic treatment on their children make sense if the parent’s right to control a child’s health care is understood as rooted in the parental obligation to meet the child’s needs, not in an ownership right over a child’s body. But even some nontherapeutic interventions—vaccines or cutting tendons in a child with severe contractures, for example—may meet a child’s needs. Thus, to some extent at least, application of the nonsubordination principle to medical decision making for children depends in part on parental motive, and that too is case dependent. A decision to use HGH or to attenuate the growth of child like Ashley, for example, may or may not be a matter of parental preference rather than care for the child. For these reasons, recognition and application of the nonsubordination principle is unlikely to yield bright-line rules for medical decision-making cases.

Nonetheless, it is my position that the nonsubordination principle should be embedded in legal models for evaluating the scope of parental power. The current decision-making paradigm for medical decision making for children fails to recognize the possibility and importance of the subordination inherent in shaping cases. Instead, it structures the parent-child relationship as a hierarchical one in which a parent has a broad right to use medicine or surgery to physically invade a child’s body except in exceptional cases involving grievous harm, death, or obvious conflicts of interest. In this way, the hierarchical model of family allows a parent to impose his will on a child without regard for the child’s welfare or the child’s right to make autonomous decisions as an adult. The hierarchal model should be replaced with a more nuanced model that better respects the child as a vulnerable but complete person.

IV. CONCERNING THE CHILD: ANOTHER VIEW OF PARENTHOOD

Thus far, I have argued that although parents have constitutionally protected authority to make most medical decisions for their children, they have no *right* to use medicine or surgery to shape their children’s bodies. The traditional hierarchical model of the family at play in the health-care setting, which starts from an assumption of

190. *Id.* at 607.

191. 45 C.F.R. § 46.404–07 (2009) (restricting the use of healthy children in research to studies that involve no more than “minimal risk”); *see also* Grimes v. Kennedy Krieger Inst., Inc., 782 A.2d 807, 843–44 (Md. 2001) (declaring invalid parental consent given to the use of children in nontherapeutic research protocols involving more than minimal risk); T.D. v. N.Y. State Office of Mental Health, 650 N.Y.S.2d 173 (N.Y.App. Div. 1996) (invalidating state regulations that allowed more than minimal risk on children).

parental power, does not support such a distinction.¹⁹² The law is not wed to the hierarchical model, however.¹⁹³

In fact, there is a clear trend outside medicine toward increasing respect for children's rights and dignity that is incompatible with the understanding of children inherent in the hierarchical model of family.¹⁹⁴ Children's rights were strengthened in 1969 when the Supreme Court determined that the Fourteenth Amendment's Due Process Clause applied to children; that children are "'persons' under our Constitution,"¹⁹⁵ and that children have rights to freedom of expression.¹⁹⁶ By 1979, in abortion and contraception cases, the Supreme Court recognized that minors have a right to privacy, which is at least as important as parental rights.¹⁹⁷ Thus, the law recognizes that children are rights-possessing persons, not property or extensions of their parents.

But what it means for children to be individual persons with rights is far from clear because these rights-bearing people are needy and vulnerable, and their familial relationships directly affect their welfare.¹⁹⁸ Moreover, these rights-bearing but

192. The hierarchical model allows for state intervention only in cases in which the parental choice will cause the child grievous harm or death. See Ann MacLean Massie, *The Religion Clauses and Parental Health Care Decisionmaking for Children: Suggestions for a New Approach*, 21 HASTINGS CONST. L.Q. 725, 774 (1994) (explaining that parents have both "the freedom and the responsibility to make health-care decisions for [young children]"). And while the parents' perspectives and values, including their religious beliefs, will play a part in the choices they make, the State "has defined the parameters of parental freedom: failure to provide adequate medical care amounts to child abuse or neglect and entitles the state to step in and take over the supervision of a child's medical treatment or to punish parents whose violation of their statutory duty has resulted in harm to a child." *Id.* For reasons I've explained, it is unlikely that any court would deem being a few inches taller, having a little less fat, having rounded eyes, or even being smaller and more transportable, to be grievous harms constituting medical abuse.

193. Martha Minow identifies "five legal frameworks for thinking about children" that affect the legal construction of family: "child protection, child liberation, children as potential adults, children in need of traditional authority, and social resource redistribution." 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).

194. See *id.*; 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 (1993). The notion that children are persons not property is firmly rooted in modern family law. See, e.g., Coleman, *supra* note 122, at 526–27, 614–16.

195. *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503, 511 (1969).

196. See *id.* ("Students in school as well as out of school are 'persons' under our Constitution. They are possessed of fundamental rights which the State must respect, just as they themselves must respect their obligations to the State.").

197. See *Bellotti v. Baird*, 443 U.S. 622, 655–56 (1979) (Stevens, J., concurring) (comparing a minor's privacy interest in obtaining an abortion with the judicial exception to parental consent requirements); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 75 (1976) ("Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.").

198. See John A. Robertson, *Genetic Selection of Offspring Characteristics*, 76 B.U. L. REV. 421, 480–82 (1996).

vulnerable persons are part of a familial unit, which is itself afforded constitutional protections. As a result, the legal role of parents in relation to their children varies by context and is at times conflicting and paradoxical. John Robertson explains:

Children spring from their parents' loins and are dependent on them for many years, yet they are separate persons with interests and rights that on occasion conflict with the interests of parents. Parents control whether they come into existence, but cannot control their existence once they are here.

. . . The parental bundle of rights over children includes great latitude over where children will live, be educated, and the values they will be taught.

At the same time, the child's separate personhood strictly limits this bundle of rights. Parents have rearing rights in children, but they also have duties to provide children with food, shelter, and medical care, and to protect their welfare. They may choose their education within parameters set by the state, but they cannot deny them education altogether. If they neglect those duties or physically abuse children, they lose their rights to rear.¹⁹⁹

Whatever the nature of children's rights, young children cannot make their own health-care decisions. Young children are especially vulnerable when they are sick or injured. They need care, but they lack the capacity to chart their own course by making reasoned judgments about complex science, individual values, and long-term consequences. As children mature, they are increasingly able to participate in medical decision making, but young children need their parents to make medical decisions for them. Parents, more than anyone else, understand the child as an individual with individual needs, pain tolerance, capacity for confinement, values, and fears.²⁰⁰ As a matter of good policy (and constitutional law), parents are presumed to "possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions."²⁰¹

A. Alternative Models

In efforts to reconcile the competing needs and rights of children, the rights of parents, and interests of the state in protecting children, several prominent family law and moral theorists have suggested models of the family that appear well suited to medical decision making for children. These robust models respect the child as a

199. *Id.* (footnotes omitted).

200. See Jacqueline J. Glover, *Should Families Make Health Care Decisions?*, 53 MD. L. REV. 1158, 1160–62 (1994) (addressing how families are suited to make medical decisions for family members because of their capacity to serve as clinical helper, tape recorder, and assessor of patient best interest and because of their status as intimates of the patient).

201. *Parham v. J.R.*, 442 U.S. 584, 602 (1979). "The unique interdependence between the child and the family justifies the family's participation in treatment related decisions. Within the family unit, there is a strong presumption in favor of the parents as primary decision-makers for their children." Erin A. Nealy, *Medical Decision-Making for Children: A Struggle for Autonomy*, 49 SMU L. REV. 133, 153 (1995).

vulnerable, yet complete individual within an autonomous family unit in ways that the hierarchical model does not.

For example, Barbara Bennett Woodhouse proposed a “generist perspective [that] views nurturing of the next generation as the touchstone of the family.”²⁰² The generist perspective does not simply substitute children for adults as autonomous rights bearers in an adversarial system. This perspective recognizes “that most children’s law involves adults acting on behalf of children”²⁰³ and that “[c]hildren do not start out as autonomous beings; they grow into autonomy.”²⁰⁴ The Woodhouse model views an adult’s relationship with children as one more like a trustee to a beneficiary rather than owner to chattel:

Adult “rights” of control and custody yield to the less adversarial notions of obligation to provide nurturing, authority to act on the child’s behalf, and standing to participate in collaborative planning to meet the child’s needs. A generist perspective involves taming the expression of adult power known as “rights talk” in order to redirect the discussion in terms of meeting children’s needs.²⁰⁵

Legal philosopher Joel Feinberg also incorporates a conception of parent as trustee in his work defining a child’s right to an open future.²⁰⁶ His model essentially envisions parents as holders in trust of certain future interests that belong to the child. He explains that rights ordinarily can be divided into four categories. First, there are rights that adults and children have in common,²⁰⁷ such as a right not to be killed. Second, there are rights that are generally possessed only by children and “childlike” adults that derive from the child’s dependence on others for such basics as food, shelter, and protection.²⁰⁸ Feinberg calls these “dependency rights,” and they include the child’s right to be fed, nourished, and protected.²⁰⁹ Third, there are rights that can be exercised only by adults, such as the free exercise of religion.²¹⁰ Finally, Feinberg identifies a

202. Woodhouse, *supra* note 194, at 321.

203. Barbara Bennett Woodhouse, *Hatching the Egg: A Child-Centered Perspective on Parents’ Rights*, 14 CARDOZO L. REV. 1747, 1756 (1993).

204. *Id.*

205. Woodhouse, *supra* note 194, at 321; *see also* Woodhouse, *supra* note 203 (considering parents not as holding rights in their children but as fiduciaries entrusted with their children’s care and empowered to care for them). “[P]olicy-makers and judges need to see children not as abstract constructions of innocence detached from their surroundings, but as real people embedded in families and communities. These children have their own deep attachments, experiences, and individual needs that may not conform to the child saver’s own values or experience.” Woodhouse, *supra* note 194, at 330.

206. Joel Feinberg, *The Child’s Right to an Open Future*, in WHOSE CHILD? CHILDREN’S RIGHTS, PARENTAL AUTHORITY, AND STATE POWER 124 (William Aiken & Hugh LaFollette eds., 1980).

207. *Id.* at 125; *cf.* Philip Fetzer & Laurence Houlgate, *Are Juveniles Still “Persons” Under the United States Constitution?: A New Theory of Children’s Constitutional Rights*, 5 INT’L J. CHILD. RTS. 319, 335–36 (1997) (emphasizing the difference between having a right and enjoying it).

208. Feinberg, *supra* note 206, at 125.

209. *See id.*

210. *Id.*

category of “rights-in-trust,” rights that are to be “saved for the child until he is an adult.”²¹¹

Rights-in-trust, Feinberg argues, include “anticipatory autonomy rights,”²¹² which will eventually belong to the child when she becomes a “fully formed self-determining adult.”²¹³

An example is the right to choose one’s spouse. Children and teenagers lack the legal and social grounds on which to assert such a right, but clearly the child, when he or she attains adulthood, will have that right. Therefore, the child *now* has the right not to be irrevocably betrothed to someone.²¹⁴

According to Feinberg, rights-in-trust can be violated before the child is in a position to exercise them:

The violating conduct guarantees *now* that when the child is an autonomous adult, certain key options will already be closed to him. His right while he is still a child is to have these future options kept open until he is a fully formed self-determining adult capable of deciding among them.²¹⁵

Houlgate continues on this point:

For example, an infant of two months has the right to walk freely down the public sidewalk, even though she is not yet capable of enjoying this right. What then could it mean to say that she has the right to freedom of movement? The answer is that it is a right-in-trust. It is a right to be saved for the child until she gains the ability to walk. One would violate this right now by cutting off her legs, making it physically impossible for her to ever be capable of self-locomotion at some future time.²¹⁶

Parents are morally obligated to protect a child’s rights-in-trust now so that the child can exercise them as an adult. When a parent seeks to violate a right held in trust, Feinberg argues, the state should step in: “[c]hildren are not legally capable of defending their own future interests against present infringement by their parents, so that task must be performed for them.”²¹⁷

211. *Id.* at 125–26. Laurence D. Houlgate makes a similar argument in Laurence D. Houlgate, *Three Concepts of Children’s Constitutional Rights: Reflections in Moral Theory*, 2 U. PA. J. CONST. L. 77 (1999).

212. Feinberg, *supra* note 206, at 126; *cf.* 1 JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO OTHERS* 38 (1984) (explaining that a person has an interest in something when he “stands to gain or lose” depending upon the outcome).

213. Feinberg, *supra* note 206, at 126.

214. Dena S. Davis, *The Child’s Right to an Open Future: Yoder and Beyond*, 26 CAP. U. L. REV. 93, 94 (1997) (emphasis in original).

215. Feinberg, *supra* note 206, at 126 (emphasis in original).

216. Houlgate, *supra* note 211, at 87.

217. Feinberg, *supra* note 206, at 128.

Elizabeth Scott and Robert Scott take the conception of parent as fiduciary farther and more literally than Woodhouse or Feinberg.²¹⁸ Scott and Scott propose a model of the family “premised on a fiduciary framework [that] would entrust parents with the duty to raise their children to adulthood, to provide for their physical and psychological needs, and to perform the services of parenthood with reasonable diligence and ‘undivided loyalty’ toward their children’s interests.”²¹⁹ Scott and Scott acknowledge the difficulties of applying fiduciary law to the parent-child relationship,²²⁰ but they contend that defining parental power by the imposition of duties of care and loyalty analogous to those of other fiduciaries will “encourage parents to approach the tasks of child-rearing with an elevated sense of duty and [will] detect when parents fail to perform those tasks adequately.”²²¹ In addition, they argue the fiduciary model rewards the fiduciary role. “The role of trustee, for example, invokes respect in the community, signaling that the individual has assumed an important responsibility, and is trustworthy and morally upright. Community recognition of these attributes carries its own reward, enhancing the nonpecuniary value of the fiduciary role.”²²²

Scott and Scott would apply a “parental judgment rule” to afford parent-fiduciaries considerable deference and relax the blanket rule against self-dealing, which normally applies to trustees.²²³ As a result, their relational model would limit

legally-imposed restrictions to only those that reflect a normative consensus about the welfare of children, [leaving parents] with broad discretion to rear their children according to their own values. Thus, a limited domain for legal regulation

218. See Elizabeth S. Scott & Robert E. Scott, *Parents as Fiduciaries*, 81 VA. L. REV. 2401 (1995).

219. *Id.* at 2419.

220. *Id.* at 2430.

It is apparent at the outset, however, that applying a fiduciary framework to the parent-child relationship requires accommodation of some peculiar features that distinguish this relationship from many others in the fiduciary category. Given the extensive scope of the relationship, a prescription that parents must systematically subordinate their personal interest to that of the child when the two are in conflict seems unduly burdensome, and ultimately likely to deter prospective parents from taking on the role. Furthermore, enforcement of such an obligation, although theoretically feasible, would require costly and intrusive state supervision of intact families. This effect seems particularly troublesome given the intimacy of the relationship and the presumed importance of privacy to optimal family functioning. Moreover, the substantial costs to children of replacing parents and of severing the filial bond inhibits the imposition of a sanction that is used to discipline fiduciaries in other contexts.

Thus, a model scheme for regulating the parent-child relationship must attend to the unique features of this familial bond, and some adaptation of the conventional regulatory mechanisms is required. The usefulness of this approach is not diminished by these constraints, however, so long as policymakers appreciate the goals of regulation and evaluate legal rules as means to the prescribed ends.

Id. (footnote omitted).

221. *Id.* at 2452.

222. *Id.* at 2429.

223. See *id.* at 2438.

promotes the shared objective of encouraging investment in the parental role. At the same time, the law reinforces broadly shared social norms in ways that induce parents to internalize an obligation to attend to their children's welfare.²²⁴

The models proposed by Woodhouse, Feinberg, and Scott and Scott differ in their specifics, and those specifics are subject to criticisms beyond the scope of this Article.²²⁵ Nonetheless, the three models reflect various applications of a core set of common values that frame an understanding of family that respects children as vulnerable, yet independent, human beings.

B. Common Principles

The Woodhouse, Feinberg, and Scott and Scott models all have the normative goal of promoting child welfare, not parental autonomy. They each position the parent as a fiduciary holding a child's welfare in a kind of trust, not as an owner of the child's person. This construct—parent as trustee—reflects an understanding that children are not chattel. They are persons who hold rights but lack an immediate capacity to enjoy or exercise some of those rights. The trustee construct also recognizes that children have unique needs as developing persons and that those needs give rise to parental responsibilities. Thus, according to Woodhouse, Feinberg, and Scott and Scott, parents have the responsibility for meeting children's basic needs for food, education, health care, culture, and nurture, and they must speak for their children when those children are not able to speak for themselves. In meeting these obligations, parents must have room to exercise discretion and make judgment calls. But because parental authority is defined in terms of meeting children's needs, and because children have full moral status as persons, it is not appropriate for parents to subordinate a child's life, liberty, or property for their own purposes. Thus, parents must protect the child's developing autonomy interests so that the child can exercise those interests as an adult. For that reason, parental action should not foreclose the child's ability to make choices for herself as an adult except when necessary to meet an immediate need of the child.

It is my position that the same principles should guide medical decision making for children to ensure that children's needs are met with the dignity and respect due to all persons. I propose, then, to consider application of a trust-based construct of family in that context. The first task is to delineate a parent's specific rights and duties in a framework positing the parent as trustee of the child's welfare and developing rights.

V. RECONSTRUCTING THE ROLE OF THE PARENT IN MEDICAL DECISION MAKING FOR CHILDREN

This Part develops an explicit analogy between parents and trustees by considering the application of the laws governing trustees and other fiduciaries in the family context. The trust-based construct I propose borrows from Woodhouse the notion that

224. *Id.* at 2439.

225. For example, I've criticized Feinberg's framework for its portrayal of people with disabilities as cheated of lives worth living. See Alicia R. Ouellette, *Insult to Injury: A Disability-Sensitive Response to Smolensky's Call for Parental Tort Liability for Preimplantation Genetic Interventions*, 60 HASTINGS L.J. 397, 402–03 (2008).

parents are best regarded as trustees or stewards of their child's welfare,²²⁶ from Feinberg the notion that what parents hold in trust is not the child him- or herself, but the child's welfare and developing rights,²²⁷ and from Scott and Scott the notion that parents owe their children specific fiduciary-type responsibilities.²²⁸ The goal is to use an understanding of the trust relationship to define the scope of parental power in medical decision making for children.

Before setting forth the specifics of the synthesized model I wish to explore, I should explain why I am not advocating wholesale application of the Woodhouse, Feinberg, or Scott and Scott models. The short answer is that they are not detailed enough to address the very narrow and complex problem of defining the limits of parental power in medical decision making for children, which is, of course, necessary to achieve this Article's goal. Trustee analogies, such as those drawn by Woodhouse and Feinberg, are typically "only casually drawn, without any systematic attention to the implications of treating parents as fiduciaries."²²⁹ Like Scott and Scott, I wish to "push the analogy beyond rhetoric"²³⁰ and use the trustee analogy to define roles in a complex part of a complex relationship. The Scott and Scott model is more helpful than Woodhouse's or Feinberg's in its development both of fiduciary duties appropriate to the family context and of a corollary to the business-judgment rule, which they call the "parental judgment rule."²³¹ But their model is so broad and sweeping—Scott and Scott would regulate all aspects of the parent-child relationship with monitoring, bonding, and sanctioning devices²³²—its usefulness for resolving any particular dilemma is limited.²³³ As Scott and Scott acknowledge, application of conflict-of-interest and duty-of-loyalty rules varies depending on the nature of the fiduciary relationship, which in the family context may be that of agent, corporate director, guardian, or trustee depending on context.²³⁴ "Predicting the precise domain of these rules *ex ante* is a problematic exercise,"²³⁵ and Scott and Scott offer little guidance about how to resolve the issue. In this respect, Woodhouse and Feinberg are more helpful. Both make strong arguments about the source of parental power and children's vulnerability, which help define the terms of the "trust" at play in the health-care domain.

226. See Woodhouse, *supra* note 194, at 321.

227. See Feinberg, *supra* note 206, at 125–26.

228. See Scott & Scott, *supra* note 218.

229. *Id.* at 2419. Feinberg's rhetoric is especially casual because his goal is to define children's rights, not the relational interest of parents and children.

230. *Id.*

231. *Id.* at 2438. The parental judgment rule establishes a presumption of reasonable diligence and good faith in the exercise of parental duties. *Id.* at 2437–38.

232. Their framework would regulate everything from the formation of families to the termination of parental rights. They apply their framework to regulate intact families and what they call "broken families." See *id.* at 2442–43; see also *id.* at 2457–60 (discussing the regulation of unmarried fathers' claims).

233. I am also not persuaded by their application of their model to argue for stringent regulation of what they term "broken families." See *id.* at 2442.

234. Their model would impose relaxed rules against self-dealing in some cases but not in others. See *id.* at 2438.

235. *Id.*

I should also explain why I develop a trust-based model for medical decision making, instead of working with another fiduciary relationship, such as a guardianship or conservatorship. First, a trust is the most flexible fiduciary relationship. It affords trustees wide discretion without imposing categorical rules. Also, the trust's terms can be defined to change over time to best serve the beneficiary's needs. Such flexibility is necessary to accommodate children's developing ability to participate in their own decision making. Although this Article does not explore how a trust-based construct would apply to a mature minor—the Article's goal is to introduce the model, not flesh out every aspect of its application—one could easily develop the trust-based model to give children increasing rights as they mature. Second, in a trust relationship, the duty of loyalty is strictly enforced to prohibit self-dealing and conflicts of interest. In some parenting contexts, it would be inappropriate to prevent a parent from making decisions for a child that are for her own or a sibling's benefit. For example, it would be unrealistic to say that a parent could not choose a school based on proximity to her work or the presence of a special program for a sibling. With respect to medical interventions, however, I think it appropriate to require a parent to make decisions solely in the child's interest in light of the decision's immediate impact on the child's bodily integrity.

Thus, I follow Scott and Scott's lead in looking to the law governing trustees and other fiduciaries as a tool for understanding the parents' role with respect to their child's welfare and developing rights. I am not arguing that the trust law should be directly incorporated into health law, however. Trust law relies on significant court oversight, which is not appropriate in medical or family decision making.²³⁶ Moreover, deeming parents to be trustees in a technical sense is incompatible with the vast scope of parental obligations²³⁷ and the nebulous nature of the "property" held by parents for children.²³⁸ Of course, I also recognize the irony of using property law to prevent children from being treated like chattel. The trust relationship is, nonetheless, a relationship between two people, and consideration of the well-studied power dynamics between trustees and trust beneficiaries provides a robust framework for defining the power dynamics between parents and their children in the medical context.

236. *Parham v. J.R.*, 442 U.S. 584, 607 (1979). The Court found that "[t]he mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgment of the physician in each case." *Id.* at 608. The Court also rejected the "notion that shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing office after a judicial-type hearing." *Id.* at 609; *see also id.* at 607 (stating that in addition to either a law-trained judicial or administrative officer, a staff physician would suffice so long as they are free to evaluate the child's well-being and need for treatment).

237. "Given the extensive scope of the relationship, a prescription that parents must systematically subordinate their personal interest to that of the child when the two are in conflict seems unduly burdensome." Scott & Scott, *supra* note 218, at 2430.

238. A trust is recognized at law only when there is a clearly defined trust property. *See* RESTATEMENT (THIRD) OF TRUSTS § 2 (2001). It would be impossible to define a child's welfare and developing rights as a property.

A. Powers and Responsibilities of Trustees Generally

A trust is a fiduciary relationship with respect to property that subjects the person who holds legal title to the property, the trustee, to duties to manage the trust property for the benefit of another person or persons, the beneficiary or beneficiaries of the trust. A trustee occupies a position of particular responsibility with a primary duty to administer the trust solely in the interest or for the benefit of the beneficiary.²³⁹ The beneficiary's interest in the trust property may be present, future, or contingent, but a valid trust requires a clearly defined trust property.²⁴⁰

All trustees have "comprehensive powers . . . to manage the trust property and to carry out the terms and purposes of the trust,"²⁴¹ but those powers "must be exercised, or not exercised, in accordance with the trustee's fiduciary obligations."²⁴² A trustee has the broad discretionary powers to make ordinary decisions in managing, protecting, and improving the property held in trust,²⁴³ but the trustee cannot exercise that power in a manner prohibited by the terms of the trust. In managing real property held in trust, for example, the trustee can properly incur expenses to keep, maintain, and even improve the trust property "if, and as the property's retention and improvement are prudent and suitable to the purposes of the trust,"²⁴⁴ but "[w]here the terms of a trust direct retention of certain property or forbid the making of improvements or certain types of repairs," the trustee lacks authority to make such improvements absent permission of the court.²⁴⁵

With respect to acts within the discretion of the trustee, "judicial intervention is not warranted merely because the court would have differently exercised the discretion."²⁴⁶ "When a trustee has discretion with respect to exercise of a power, its exercise is subject to supervision by a court only to prevent abuse of discretion."²⁴⁷ A trustee may abuse discretionary power by acting in bad faith or in a manner otherwise inconsistent with the trustee's fiduciary duties; by misinterpreting the terms of the trust; or by acting "beyond the bounds of reasonable judgment."²⁴⁸

All the trustee's powers are subject to fundamental duties of prudence, loyalty, and impartiality.²⁴⁹ The trustee's primary duty is one of loyalty to the beneficiary, which requires the trustee to administer the trust solely in the interest of the beneficiary.²⁵⁰ The trustee violates his duty of loyalty when he uses the trust property for his own or a third party's purposes. Accordingly, the trustee must not engage in transactions that

239. RESTATEMENT (THIRD) OF TRUSTS §§ 77–79 (2007).

240. See UNIF. TRUST CODE §§ 103(3)(A), 103(12), 401 (2005).

241. RESTATEMENT (THIRD) OF TRUSTS § 70(a) (2007).

242. *Id.* cmt. a.

243. *Id.* § 76 ("The trustee has a duty to administer the trust, diligently and in good faith, in accordance with the terms of the trust and applicable law.").

244. *Id.* § 88 cmt. b.

245. *Id.*

246. *Id.* § 87 cmt. b.

247. *Id.* § 87.

248. *Id.* cmt. d.

249. *Id.* §§ 77–79.

250. *Id.* § 78.

involve the trust property or create a conflict between his duty to the beneficiary and his personal interests.²⁵¹ Self-dealing occurs

when the trustee personally has a financial interest in the transaction of such a nature that it might affect the trustee's judgment. Illustrative would be a sale to or purchase from a firm of which the trustee is a member or a corporation in which the trustee has a controlling or substantial interest.²⁵²

In exceptional circumstances, a court may approve a transaction that would be prohibited as self-dealing or as involving a conflict of interest if the court determines that "[the transaction] is in the interest of the beneficiaries,"²⁵³ but the general rule against self-dealing is normally strictly enforced. In some cases, appointment of a trustee *ad litem* is appropriate for resolving issues about which the trustee may have a conflict.²⁵⁴

The trustee's "duty of prudence requires the exercise of reasonable care, skill, and caution" in the administration of the trust.²⁵⁵

The duty to act with caution does not, of course, mean the avoidance of all risk, but refers to a degree of caution that is reasonably appropriate or suitable to the particular trust, its purposes and circumstances, the beneficiaries' interests, and the trustee's plan for administering the trust and achieving its objectives.²⁵⁶

When investing assets of the trust, the duty of prudence requires the trustee to act "in the context of the trust portfolio and as a part of an overall investment strategy, which should incorporate risk and return objectives reasonably suitable to the trust."²⁵⁷

A trustee commits a breach of trust by violating a duty as a result of negligence, misconduct, or "mistake concerning the nature or extent of the trustee's powers and duties under the terms of the trust or applicable law."²⁵⁸ For this reason, when there is reasonable doubt about the scope of a trustee's powers, a trustee or beneficiary may

251. *Id.*; *id.* cmt. d.

252. *Id.* cmt. d.

253. *Id.* cmt. c(1). The Restatement offers the following illustration:

S devised her estate to her brother B and T Co., as cotrustees, for the benefit of her three minor children. B and T Co. have petitioned the appropriate court for authority to sell certain property of the trust to B for a particular price. The court approved the proposed sale to B based on its finding (i) that the evidence, including testimony by T Co. and others, showed that the trustees' decision to sell the property was sound for reasons of diversification and overall investment strategy, and (ii) that, after qualified appraisals and prudent efforts over a reasonable period of time, the trustees justifiably concluded that it was not reasonably foreseeable that another buyer could be found who would match B's offer. On this basis, the trustees may proceed with the proposed sale to B.

Id. cmt.c(1) illus. 1.

254. *Id.* cmt. c(1).

255. *Id.* § 77(2).

256. *Id.* cmt. b.

257. *Id.* § 90(a).

258. *Id.* § 71 cmt. a.

apply to an appropriate court for instructions regarding the trust's administration or distribution.²⁵⁹ Resort to the courts is not always appropriate, however. "If a matter rests within the sound discretion of the trustee, or is a matter of business judgment, the court ordinarily will not instruct the trustee how to exercise that discretion or judgment."²⁶⁰ Thus, a trustee's power to exercise his discretion over the trusteeship is afforded presumptive deference and remains beyond review except to the extent that its exercise is inconsistent with his duties to the beneficiary or deemed an abuse of discretion. Those trustee decisions that may constitute an abuse of trust—such as those that suggest self-dealing or involve a conflict of interest—should not be implemented unless reviewed and deemed appropriate by the court or a trustee *ad litem*.

B. Powers and Responsibilities of Parents Concerning Children's Health

In a trust-based construction of the parent-child relationship, a parent's powers and responsibilities should roughly parallel those of other trustees as outlined above. This Part begins the task of sorting out parental rights and responsibilities in tandem with trust law in an effort to clarify what positioning the parent as a trustee means in the context of health-care decision making for children. This discussion does not purport, or even attempt, to resolve every medical case involving children. Nor does it advocate literal application of trust law to the parent-child context. Rather, it uses trust law as a tool for identifying those parental decisions to which health-care providers need not, or should not, acquiesce.

The first task in extending the parent-as-trustee analogy is to clarify what constitutes the trust "property" held by the parent-trustee and the terms of the trust under which parents operate. In explaining what it means for a parent to serve as trustee of the child's welfare, Woodhouse defines parental power in terms of the child's needs because parental authority is justified not by some ownership right, but by the "limitations childhood imposes on personhood."²⁶¹ Because of his uniquely vulnerable state the child needs nurturing, safety, health, food, education, culture, and shelter from his parent. Feinberg calls these the child's dependency rights.²⁶² These basic needs comprise the child's welfare, which is among the "property" held in trust. Also among the property held in trust are the child's developing autonomy rights—such as the right to self-determination, privacy, and reproductive choice—which are the child's to exercise once she becomes an adult. Feinberg calls these the child's "anticipatory autonomy rights" or "rights in trust."²⁶³ The child's developing rights are personal to the child; the parent-trustee must preserve them for the child to exercise as an adult.

Thus, the trust implicit in Woodhouse's and Feinberg's models provides parents express power to protect, nourish, and preserve the child's welfare, but denies them authority to limit a child's future ability to make her own autonomous choices as an adult unless the limitation on the child's developing rights to autonomy is necessary to

259. *Id.* § 71.

260. *Id.* cmt. d.

261. Dolgin, *supra* note 90, at 392 (explaining that the Supreme Court in *Parham* "justified the scope of parental authority through reference to the limitations childhood imposes on personhood"); *see also* Woodhouse, *supra* note 194, at 321.

262. *See* Feinberg, *supra* note 206, at 125.

263. *Id.* at 125–26.

preserve the child's welfare now. In other words, the trust limits the parent's power to foreclose opportunities and choices for the child by imposing an express duty on parents to preserve for the child the ability to make his or her own choices in the future.

As trustees, parents would have comprehensive powers to manage the trust property. As such, they could make ordinary decisions to protect and preserve the child's health, which is a component of the child's welfare. In fact, most decisions to protect and preserve a child's health would fall to the sound discretion of the parent trustee and be entitled presumptive deference. Where, for example, a specific physical or psychological need in a child triggers the need for a decision to prevent deterioration of the trust asset (the child's health or a function necessary to becoming an autonomous adult), the parent-trustee's decision about how to preserve and protect the child's welfare would be the parent's prerogative so long as it does not violate a fiduciary duty owed the child or otherwise constitute an abuse of discretion. The parent-trustee's discretionary powers would also include the power to "improve" the child's health through the administration of vaccines, despite the cost injections incur to the child's body, because "retention and improvement [of the child's health, a component of the trust property,] are prudent and suitable to the purposes of the trust."²⁶⁴

On the other hand, the terms of the trust and the duty of prudence would limit parental power to make major "improvements" to the child's health.²⁶⁵ The trust requires parents to preserve for the child the future ability to make his or her own autonomous choices about use and treatment of his or her body. Thus, improving the child at the expense of the child's ability to make future choices or exercise liberty interests as an adult would likely be prohibited absent court permission.²⁶⁶ The exact scope of this limitation is subject to debate and would need further development if a trustee-based model were implemented. But I would suggest that a parental decision to elect a preventive mastectomy or hysterectomy for a child carrying genes predictive of breast or uterine cancer would be considered an "improvement" beyond the parent-trustee's ordinary power in most cases. Such an improvement would prevent the child from exercising choices about reproduction and bodily integrity as an adult, and, as such, would likely fall outside the parent-trustee's discretionary authority absent an immediate health crisis. It should be noted, however, that parents of children with severe developmental disabilities who will never be able to make decisions for themselves might well have the power to elect a preventive mastectomy or hysterectomy for a child with disease-predicting genes. In such cases, "anticipatory autonomy rights" are not part of the "property" of the trust. For that reason, the trustee need not preserve decisions for the child to make in the future but could act now to make discretionary decisions to preserve the child's health.

Fundamental duties of prudence, loyalty, and impartiality would also limit the power of the parent-trustee.²⁶⁷ In managing the child's welfare and protecting her developing autonomy rights, the parent-trustee's primary duty would be one of loyalty to the child.²⁶⁸ The parent-trustee would violate her duty by trading on the trust

264. RESTATEMENT (THIRD) OF TRUSTS § 88 cmt. b.

265. *See id.*

266. *See id.*

267. *See id.* §§ 77–79.

268. *See id.* § 78.

property—the child’s welfare and ability to make her own choices in the future—for her own purposes. Accordingly, the parent would lack the power to make transactions compromising a child’s health, bodily integrity, or future autonomy to satisfy the parent-trustee’s own aesthetic, cultural, or social preferences.²⁶⁹ In exceptional circumstances, a court (or other third party) could approve a transaction that would be otherwise prohibited as self-dealing or involving a conflict of interest, but only after the reviewing body determined that the transaction is in the child’s interest. For example, a parent-trustee would not have discretionary authority to use one child as an organ or tissue donor for another. In such a case, the parent would have a clear conflict of interest. But a court (or other third party) could determine that serving as a donor for a sibling would in fact serve the donor child’s interests and therefore approve the transaction.

The duty of prudence would require the parent to exercise reasonable skill, care, and caution in managing the child’s welfare.²⁷⁰ The parent could make some decisions that put the child’s health at risk, but would be expected to exercise a “degree of caution that is reasonably appropriate or suitable”²⁷¹ to preserving, protecting, and enhancing the child’s welfare and future interests. When investing trust assets, that is, when risking the child’s health or safety or limiting the child’s ability to make future choices, the duty of prudence would require that parent-trustees act “in the context of the trust portfolio and as a part of an overall investment strategy, which should incorporate risk and return objectives reasonably suitable to the trust.”²⁷² In other words, a parent-trustee’s decisions to risk a child’s health or safety would be measured in terms of its overall benefit to the child’s welfare and the maintenance of future options.

If treated as a formal trustee, a parent could turn to a court (or other third party) when in doubt about the scope of his or her powers, but reviewing bodies would not be available to instruct parents as to how to act on matters within their discretion or parental judgment.²⁷³ Even a formal trustee’s power to exercise his discretion over the trusteeship is afforded presumptive deference and remains beyond review except to the extent that its exercise is inconsistent with duties to the beneficiary. Only those decisions that constitute an abuse of trust—such as those that suggest self-dealing or involve a potential conflict of interest—would require review before implementation.

As Scott and Scott recognized, “the unique features of th[e] familial bond” require adaptation of agency theory and trust law.²⁷⁴ In applying trust law to the parent-child relationship, I would suggest that it is necessary to appoint a third-party decision maker, other than a court, to resolve conflicts with respect to medical decision making. As the Court recognized in *Parham*, medical professionals are far better equipped than untrained judges to make medical judgments.²⁷⁵ The emergence of institutional review boards as bodies with authority to oversee the protection of human research subjects suggests the possibility for an expert body for resolving disputes.

269. *See id.*

270. *See id.* § 77(2).

271. *See id.* cmt b.

272. *Id.* § 90(a).

273. *See id.* § 71 cmts. c–d.

274. Scott & Scott, *supra* note 218, at 2430.

275. *Parham v. J.R.*, 442 U.S. 584, 607–08 (1979).

Also, I would urge adoption of Scott and Scott's "parental judgment rule," a corollary to the business-judgment rule applicable to corporate directors, which would afford parents a "presumption of good faith and reasonable diligence in assessing parental performance."²⁷⁶ Although the business judgment rule does not normally apply to trustees, who are held to the highest duty of loyalty among all fiduciaries, such a rule would help ensure minimal intrusion in matters that are properly handled in the private realm of family.²⁷⁷

Regardless of these specifics, reference to trust law to define the parent-child relationship illuminates a framework for restraining parental power to make medical choices for children consistent with the nonsubordination principle. In a trust-based construct, parents would have vast discretion over ordinary decisions concerning the management of their children's health—power that is necessary and appropriate given children's vulnerabilities and need for care. Parental decisions about how to address a particular child's health and functional needs would be entitled to presumptive deference and shielded from review except when there is an abuse of discretion or violation of the trust. Respect for family privacy could be further protected by adoption of a parental-judgment rule, which would afford parents a presumption of good faith. Like that of other trustees, however, parental power would be limited by duties of loyalty and prudence, which call into question parental choices to medically or surgically shape a child's body that might serve the parent's interest at a cost to the child. In such cases, a neutral third party would review the proposed procedure and decide whether it is one that can be reserved for the child once she reaches maturity. If the decision can be reserved, it would be reserved. If not, then the third party would approve the intervention only if convinced that it will advance the child's interests. If a proposed intervention was found to advance only the parent's interests or to unduly foreclose options for the child in the future, it would be denied. In this way, trust-based medical decision making for children would limit the parent's power to use medicine or surgery on a child's body to serve the parent's social, cultural, or aesthetic preferences, but would allow interventions that, in fact, serve the child's interests. Responsibility for evaluating cases that raise the specter of self-dealing or the possibility of conflict between the parent's duty to the child and the parent's personal interests would fall to a neutral third party—a guardian ad litem, an ethics committee, an institutional-review-board-like body, or a court—and unless someone other than the parent finds convincing evidence that the proposed intervention will address the individual child's immediate need, the intervention would be put off until the child is able to make her own decision.

VI. SHAPING RECONSTRUCTED

Having thus defined the scope of parents' duties and responsibilities by incorporating principles from trust law, it becomes possible to identify a principled approach to medical decision making for children—both in general and particularly in shaping cases—that respects children as human beings. As a practical matter, the application of a trust-based construct to medical decision making for children would

276. Scott & Scott, *supra* note 218, at 2437–38.

277. See *Troxel v. Granville*, 530 U.S. 57, 60–63 (2000); *Parham*, 442 U.S. at 601–02.

change little about children's health care. Parental choice would still govern most cases. The framework shift would call into question only the rare case in which the parental choice conflicts, or could conflict, with the parent's trustee-like obligations to the child. In those cases, the law would not allow on-demand modification of a child's body. Instead, parental choice for modification would be subject to third-party review before the modification could be implemented.

Under the trust-based construct, all of the focus shaping cases would trigger third-party review, but the outcome of that review would not necessarily be uniform. The outcome would depend on assessment of how the sought-after interventions would affect the child's welfare and developing rights. Let us consider each case in turn.

Under a trust-based construct, the adoptive father's decision to elect eye-shaping surgery for his daughter would trigger the need for third-party review because the decision raises the specter of self-dealing and creates a conflict between the parent's duty to child and the parent's personal interests. It is unlikely that a young child's parent could show that the sought-after surgery—which is quite controversial, even for adults—would advance the child's present interests to such an extent that it could justify curtailing the child's ability to make her own decision about modifying her eye shape as an adult. For that reason, it is unlikely that a parent would be allowed to elect ethnic eye-shaping surgery under a trust-based construct.

By contrast, a parent's decision to use HGH on a child might well be approved by a neutral third party depending on the particular case. Like the eye-shaping case, the parental decision would raise the specter of self-dealing and a conflict of interest and therefore trigger the need for someone other than a parent to review the decision before it was implemented. Unlike a decision about eye shaping, however, which could be preserved for the child to make as an adult, a decision to use HGH for height must be made when the child is still too young to make a decision for him or herself. A third party reviewing a request to use HGH would need to determine whether such decision was one that would benefit the child—a hard case to make given the evidence of physical harm and psychological injury generally associated with the treatment. Nonetheless, in rare cases, a particular child's expected adult height might cause the child lost opportunities, such as reaching the gas pedal on a car or the ability to reach counters. It might also be shown that a particular child is already suffering from stigma associated with small stature and that the particular child's psychological needs would be served by the treatment. A trust-based construct makes room for intervention under those circumstances.

Brooke Bates's parents appear to have violated their duty of prudence when they chose to use liposuction to remove thirty-five pounds of fat from her twelve-year-old body. The surgery put the child's health and life at risk for a short-lived aesthetic gain. The risks were not offset by any long-term physical or psychological gain, suggesting an absence of caution reasonably appropriate or suitable to preserving, protecting, and enhancing the child's welfare and developing rights.²⁷⁸ To be sure, a reviewing body could consider Brooke's specific situation, psychological makeup, and her position on the desired liposuction. But unless some strong evidence supporting the procedure came to light, it is difficult to envision its approval under a trust-based construct.

278. See RESTATEMENT (THIRD) OF TRUSTS § 77, cmt. b (2007).

As trustees of her welfare and future interests, Ashley's parents would not have had discretionary authority to modify her body in the way they did. The modifications would clearly fall under the category of major "improvements," which were outside the trust's terms and required third-party approval.²⁷⁹ The request for the interventions would also have raised the specter of self-dealing, as the parents may have been trading Ashley's bodily integrity for their own gain. Having said that, however, the reality of caring for a person with profound disabilities in a society that fails to support caregivers and to modify itself to accommodate the needs of persons with disabilities and their families is complex. It is quite possible that a neutral third party could reach the same conclusion reached by Ashley's physicians and the ethics committee that reviewed her case—that her interests would be best served by the high-dose estrogen and hysterectomy despite their costs. Arguably, the estrogen that stunted Ashley's growth served Ashley's interests for the reasons stated by the parents: as a person in a small body, Ashley can be cared for at home by her aging parents, participate in family outings, and avoid bedsores. Because estrogen would be effective in attenuating growth only when Ashley was small, waiting to make the decision was not an option. Likewise, a neutral third party could decide that the hysterectomy served Ashley's interests because it reduced the risks of thrombosis and the discomfort of menstruation. As Ashley is a person who will never be able to make her own medical decisions, the neutral third party need not try to preserve future autonomy rights when balancing the potential health and comfort benefits against the intrusion of the hysterectomy on Ashley's bodily integrity. The decision about whether the hysterectomy would in fact serve Ashley's interest would not change whether Ashley was six or twenty-six. By contrast, it seems unlikely that a third party employing a trust-based framework would permit a mastectomy on a six-year-old to prevent the possibility that she will develop large, uncomfortable breasts, or because her wheelchair strap would cross over her breasts when they develop. Although Ashley's trust did not include anticipatory autonomy rights, it did include a right to bodily integrity. Under a framework designed, in part, to protect a child's bodily integrity except when necessary to serve the child's needs, a decision to cut off a part of a child's body would need to be justified by something more than a vague fear of the future or a poorly constructed wheelchair.

VII. PRACTICAL MATTERS, LIMITATIONS, AND FINAL THOUGHTS

Allowing parents on-demand access to shaping interventions grants parents a degree of control over their children's bodies that is inconsistent with an understanding of the child as a complete person in an autonomous family. A trust-based construct for medical decision making for children has several benefits over the current paradigm. Most importantly, the trust-based construct centers on the child's welfare and needs. It recognizes children's vulnerability and need for someone to make decisions for them but also preserves autonomy rights for the child to exercise as an adult. At the same time, a trust-based construct, especially one that incorporates a "parental-judgment rule," respects the autonomy of the family unit by giving parents vast discretion over decisions concerning the management of their children's health. The trust-based construct is, in this way, entirely consistent with the nonsubordination principle

279. *See id.* § 88 cmt. b.

because the construct respects parental authority when children are limited in their abilities while limiting parental rights when their exercise would deny a child's personhood and corresponding rights.

By incorporating mechanisms for review of individual cases, a trust-based framework allows for a specific review of individual needs that is more appropriate for medical decision making than the procedure- or intervention-specific bans that tend to be advocated by those using a harm-based analysis. A trust-based construct is also flexible enough to accommodate a child's developing ability to participate in his or her own medical decision making and can be adapted to recognize the particular features of the family bond.

The argument for incorporating a trust-based construct in medicine does little to address the practical question of implementation, however. A trust-based construct could support direct regulation of medical providers or parents. It could be implemented through legislatures, regulatory bodies, or courts. Even better, it could be used as the starting point for self-regulation in medicine. Convincing the medical profession to change its ethos is not an easy job, however. Implementation on the ground level will take some work and further analysis.

The trust-based construct is also limited by the way it draws the line to separate discretionary parental decisions from decisions that merit scrutiny. The construct distinguishes decisions that meet children's health or medical needs from those that do not. "Health" and "medical need" are social constructs that shift over time.²⁸⁰ For example, so-called genital correction surgery was considered necessary for the health of intersexual children until quite recently when various providers and advocates called that view into question. Under a trust-based construct, parental decisions for such surgeries could be considered a matter of parental discretion or could be subject to scrutiny depending on one's point of view on the medical question. In other words, the trust-based construct perpetuates whatever dilemmas are created by current understandings of health and is of little use in drawing lines to define health.

Despite its limitations, the trust-based construct speaks to relational interests between parents and children in a way that makes room for nuanced discourse by physicians, ethicists, and lawmakers about the limitations on parental power over children's bodies. Its adoption as a conceptual framework would change medicine for the better by limiting the ability of parents and doctors to shape children's bodies for the parents' own purposes. It would also recognize and help doctors understand that not every decision about a child's body is a parent's to make.

280. See ROBERT A. ARONOWITZ, *MAKING SENSE OF ILLNESS: SCIENCE, SOCIETY, AND DISEASE* (1998), for a historical account of the understanding and construction of such conditions as coronary heart disease and chronic fatigue syndrome. *See also* *THE SOCIOLOGY AND POLITICS OF HEALTH: A READER* (Michael Purdy & David Banks eds., 2001) (chronicling constructions of health, illness, and health care).