Douglas Opel and Benjamin Wilfond, discuss other real-life examples of cosmetic surgery in cognitively impaired children. They argue that it is all too easy—and wrong—to dismiss such procedures if the psychological benefit to the parents is clearer than the benefit to the child. "[E]xploring parental motivations and clarifying parental values may be precisely what is needed before performing cosmetic surgery on children with profound cognitive impairments," they write.

Erik Parens offers some advice to parents of children with profound cognitive impairments who are considering cosmetic surgery. The insights come from children with physical disabilities who have considered cosmetic surgery and their reasons for either going with it or refusing it. Parens, a senior research scholar at The Hastings Center, led a research project on surgeries to reduce physical deformities in children.

Gregory Kaebnick, editor of the *Hastings Center Report*, analyzes one of the objections to the Ashley intervention—that it was "against nature." Even if one believes that leaving nature alone can be valuable, does it follow, he asks, that messing with nature is *wrong*? Kaebnick, who recently completed a research project funded by the National Endowment for the Humanities that explored moral appeals to nature, concludes that the answer is no. Where possible, though, he believes that decisions about cosmetic surgery should be postponed until they can be made by the children themselves.

Queensland's new law is not aimed at medically necessary procedures. The law does not affect procedures to correct congenital abnormalities or to reduce the disfigurement caused by a trauma. It does outlaw breast augmentation and liposuction for children under eighteen. Asian eye surgery would probably be banned, too. But legal lines are brighter than ethical ones. What about medical and surgical treatment for gender identity disorder? Or a feeding tube implanted into the stomach of a profoundly disabled child to make feeding easier? Or the Ashley treatment? Between the extremes of medical necessity and enhancement, the border disputes continue. ■

Eyes Wide Open: *Surgery to Westernize the Eyes of an Asian Child*

BY ALICIA OUELLETTE

The speaker was a proud father.[1] To illustrate his comments about a piece of art that celebrated the wonders of modern medicine (and which he had just donated to a local hospital), he told a story about his adopted Asian daughter. He described her as a beautiful, happy child in whom he took much delight. Her life, he told the audience, had been improved dramatically by the miracle of modern medicine. When she joined her new Caucasian family, her eyes, like those of many people of Asian descent, lacked a fold in the upper eyelid, and that lack was problematic—in his view—because it made her eyes small and sleepy and caused them to shut completely when she smiled. A plastic surgeon himself, he knew she did not need to endure this hardship, so he arranged for her to have surgery to reshape her eyes. The procedure, he explained, was minimally invasive and maximally effective. His beautiful daughter now has big round eyes that stay open and shine even when she smiles.

The case may or may not be unusual in the United States. While surgery to widen the eyes of children, even newborns, is reportedly common in Taiwan, Japan, and Korea, no statistics are available on its use in children in the United States. The Web site of the American Academy of Facial Plastic and Reconstructive Surgery reports that "Asian eye surgery," or blepharoplasty, is the most common procedure elected by Asian Americans, and the American Society for Aesthetic Plastic Surgery reports that more than 230,000 such procedures were performed in 2005, but since no report breaks that number down by the patient's age and ethnicity or even mentions surgeries performed on children, blepharoplasty may be performed on children only rarely.

On the other hand, no specific legal barriers block the use of plastic surgery on children, and 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." A nonscientific but reasonably thorough survey of Web sites advertising Asian eye surgery revealed just one group of physicians that expressly sets a minimum age of eighteen for the surgery,[2] and a search of chat rooms indicates that some families in the United States have obtained the surgery for their

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daughters. In an article in *Salon* in 2000, Christina Valhouli wrote of families traveling from the United States to Taiwan or Korea to obtain the surgery, but no hard data are available on how often that occurs.

Even if such cases are relatively rare, however, they merit consideration. The intervention is distinctive because its purpose is to shape the child solely for the sake of shaping the child, not to provide a medical or functional benefit. Because the surgery is triggered by a cosmetic preference, it raises stark questions about the limits of parental choice and the failure of the current model of medical decision-making to take into account the rights of the child. In the law's existing paradigm for parental decision-making, eye-shaping is a run-of-the-mill decision requiring deference to parental choice. The case stands as a clear example of the need to reconceptualize the legal role of parents in medical decision-making to better protect children from well-meaning but misguided parents.

The Law of Shaping

Current law affords parents broad, well-recognized rights to shape their children, whether the shaping is figurative (such as cultivating a love of music or reading through early exposure) or literal (such as cultivating a lean body through limited diet and enforced exercise). Indeed, the right of parents to shape their children's lives by deciding where they will live, how they will be educated, and what values they will be taught is so fundamental that it receives constitutional protection.[3] To the extent that the law gives parents the right to shape their children, it treats children "like a special kind of 'property'"[4] over which parents have exclusive control.[5]

Of course, the right of parents to shape their children is not unlimited. Parents cannot use excessive physical violence to teach a lesson. They must feed, clothe, and protect their children. If they neglect those duties or physically abuse their children, they can lose the right to raise them. In such cases, the law recognizes that "the parents are trustees of their children's separate welfare, not owners of their personhood."[6]

When it comes to health care decisions, the law supports a parental prerogative to make choices for children. In virtually all cases, parents are free to choose for their children among reasonable medical alternatives.[7] Indeed, the law presumes that a parent's medical decision for a child is in the child's best interests, and the presumption is difficult to overcome if a provider deems the choice medically reasonable. The parent is thought to be the person best situated to determine the child's best interests, and in making that determination, the parent is free to consider personal and familial values as well as the needs of the individual child.

To be sure, parental power over medical decisions is not unlimited.[8] Theoretically, abuse laws are available to prevent a parent from exposing a child to unnecessary procedures. Child protection laws prohibit parents from acting intentionally to cause or to risk causing physical harm to their children unless the risk is offset by a direct benefit. Cases of medical neglect for failure to treat are not uncommon, but cases in which a parent is found to be abusive for choosing to provide medical care for a child are few and far between. They involve repeated misuse of medical interventions, such as in Munchhausen's by proxy.

The more important limitations on parental choice are procedure- or intervention-specific. In some states, children must be vaccinated regardless of parental choice. In others, parents may not deny children life-sustaining treatment or sterilize a minor without express court approval. Federal law criminalizes female genital cutting, and federal and state laws strictly limit the ability of parents to enroll their children in research protocols. To the extent that the law limits parental choices for children in specific situations, it acknowledges that parents are only trustees of their children's welfare, not owners of their personhoods. Owners may freely destroy their property; trustees are legally bound to protect what they hold in trust. But because the laws limiting parental choice are procedure-specific, not based on a broader conception of the child as person or on a categorical view of parent as trustee, the rule giving priority to parental choice remains the default.

Elective shaping procedures almost always fall within the broad default rule of parental choice. Parents may elect surgery to pin back a child's ears, circumcise a newborn son's penis, repair a cleft palate, or remove a mole from a child's face. The exceptions to the rule are the procedure-specific rules mentioned above: female genital cutting and surgical sterilization of a minor. None applies to eye-shaping surgery.

Thus, unless it could be characterized as an abuse case—which would be difficult given the utter lack of supporting precedent—current law would treat the case of the father who chose to reshape his daughter's eyes no differently from those of a mother who opts to pin back her child's ears, the couple that chooses to circumcise a newborn son, or the father who agrees to hormone treatment to add height to his child. It is a matter of parental choice, limited only by finances and the availability of a willing provider. The question the case raises, then, is whether the existing paradigm is adequate.

In the Eye of the Beholder: What Is at Stake?

It is hard to say that the father was not acting in his child's best interest, as he defined it, when he opted for surgery. Nonetheless, the case is troubling. Not only was his child exposed to the actual harm of surgery for purely cosmetic reasons, but she may have been damaged in less tangible but no less important ways.

The literature describes blepharoplasty on the Asian eye as a straightforward and fairly simple procedure. After the patient is sedated and anesthetized, the surgeon makes an incision above the eyelid and removes skin, tissue under the skin, and fat pads. 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. Recovery may be uncomfortable.

Although some women see the surgery as a rite of passage, it is controversial even for adults. Christina Valhouli quoted a twenty-nine-year-old Korean American as saying that she "had the eyelid surgery done her junior year of high school, largely because of nudging from her mother, who had it done as a child in Korea." A young woman on *The Oprah Winfrey Show* explained that eye-shaping surgery "wasn't a vanity thing. It really was this belief that if you looked a little more Western and a little less Asian, it's like having a great degree from a better school. . . . It was something to put in your portfolio." Others condemn the surgery as an attack on ethnic identity. Another woman quoted by Valhouli describes the surgery as "trying to get rid of something that is so distinctly ethnic." Eugenia Kaw argues that "The desire to create more 'open' eyes or 'sharpen' noses is a product of racial ideologies that associate Asian features with negative behavioral or intellectual characteristics like dullness, passivity, or lack of emotion (the proverbial Oriental bookworm)."[9] Surgeons have become increasingly conscious of the criticism of the surgery and have developed techniques to duplicate naturally occurring Asian double-eyelids, theoretically allowing them to open the eyes without "Westernizing" them.[10]

Despite the controversy, hundreds of thousands of Asian American adults have elected to have eye-shaping surgery for the same reasons the surgeon-father chose it for his daughter. If the father was the decision-maker for the child—the person best situated to decide what is in his child's best interest—and he determined that surgery was in her best interest, then his election of surgery for his daughter was quite appropriate.

The problem with this reasoning, of course, is that the child is, well, a child. She is an individual with full personhood rights, but an incomplete capacity to exercise all those rights. Unlike an adult who chooses to expose herself to the physical risks of surgery, she exercised no choice and was unable to reach and express her own view on the value of the controversial surgery. Her father made choices and imposed them on her.

The same can be said about all medical choices made by parents for children, but two things separate this case from the run-of-the-mill medical case. First, no medical, psychological, or physical impairment triggered the need for a parental decision; the father chose the surgery based on his aesthetic preference. Second, the intervention itself permanently altered a feature that is to some people an integral aspect of identity. These points make a moral difference. Most parental decisions to treat a child medically or surgically are a response to a physical or psychological impairment, illness, or injury in the child. In those cases, some need of the child triggers the decision to intervene, and the parent is the best person to sort through the medically appropriate choices for the child. But when a parent modifies features of a child that have nothing to do with physical impairment but can be integral to identity, and bases that decision on his own needs or aesthetic preferences, he asserts physical control over the child's body in the same way that he might assert control over a piece of property that he can modify to his specifications.

Viewing parents as trustees of their children's welfare would better protect children from harmful medical decisions than the current emphasis on parental choice does.

The point can also be put in terms of the child's autonomy. A child has autonomy interests even if she currently lacks the power or capacity to exercise them. While a parent must sometimes act as the child's agent to exercise those autonomy interests, this power is not unbounded. The parent holds the child's right to autonomy in trust.[11] As trustee, the parent must sometimes make choices for the child, but he must also preserve certain choices for the adult the child will become. For example, he cannot choose whom his child will marry, as this choice rightly belongs to her alone when she is grown. The same principle applies to medical decisions. The parent has a duty to preserve for the child the right to make her own decisions about controversial, unnecessary surgery until that child is an adult unless some medical or other necessity triggers the need for an immediate decision. When needs arise, meeting them through an immediate parental decision is more important than preserving the child's ability to make her own decisions in the future. But when intervention is sought to "improve" a child through surgery or medicine for cultural or aesthetic reasons, the impairment to the child's autonomy is hard to justify.

The nature of the surgery makes the case especially troubling. For some people, the shape of the eye is an integral part of ethnicity, a component of identity. A change to it may, therefore, go deeper than the removal of a mole or the pinning of a child's ears. In choosing the surgery, the father took from his daughter the ability to make her own choice about her identity. His exercise of parental autonomy thus limited his daughter's potential autonomy in a critical way; it took away her right to make a decision central to her identity as an adult, a right that is, like others, central to an open future.[12]

In this way, the case is similar to those involving surgical "correction" of ambiguous genitalia, and even female genital cutting. Scholarship about the long-term effects of genital as-

signment surgery makes a strong case that surgically assigning a gender to a child born with ambiguous genitals may have horrific consequences as the child matures.[13] And female genital cutting—a culture-bound, medically unnecessary ritual—is so harmful to a child's future sexuality that it is banned in all cases, even in those in which physical trauma is minimal.[14] Gender and sexuality are integral components of identity. So, too, is ethnicity. Just as genital surgery and female genital cutting may cause long-term psychological trauma through an insult to identity, so the permanent modification of a child's eye may cause trauma through its insult on identity. At the very least, the long-term consequences of eye-shaping surgery on children are unknown.

The fact that the father was a new adoptive parent makes his decision feel particularly egregious. Perhaps because adoption already involves an exchange, worries about ownership seem closer to the surface. As a result, the adoptive parent seems to have a stronger obligation to accept the child's individuality, especially if the adoption is cross-cultural or cross-racial. But this is a matter of appearances. All parents have the same obligation to accept the child as an individual with separate interests from the parent.

Toward a New Paradigm

The case of eye-opening surgery for an adoptive Asian daughter should open our eyes to the need to reexamine the paradigm that defers to parental choices concerning health care for children when the medical intervention sought addresses the social, cultural, or aesthetic preferences of the parent rather than a medical condition in the child. A paradigm built around the conceptual framework of parent as trustee of the child's welfare would better protect a child from well-meaning but harmful parental decisions than does the current paradigm, with its emphasis on parental choice. The specifics of such a paradigm are beyond the scope of this essay, but certain guiding principles should apply.

First—as with any trustee—a parent's primary duty must be to protect and preserve what is held in trust. Second, the trustee parent must avoid self-dealing—that is, taking advantage of his position as trustee to serve his own interests. Third, the trustee parent may not engage in transactions that involve or create a conflict between his duty to protect the child and his personal interests. As with any trust situation, the trustee's power to exercise his discretion over the trusteeship should be afforded presumptive deference and remain beyond review except to the extent that its exercise is inconsistent with his duties to the child. Those trustee decisions that may constitute an abuse of trust—such as those that suggest self-dealing or that involve a conflict of interest—should be implemented only when reviewed and deemed appropriate by someone other than the trustee.

Applying these principles to medical decisions made by parents for children would maintain the deference given to decisions that are triggered by a physical or psychological need in a child. Decisions to use medicine or surgery to shape a child based on a parent's social, cultural, or aesthetic preferences—especially those that limit the child's ability to make significant choices central to his or her identity—would be treated differently. In such cases, a parent should have the burden of proving that his or her choice for the child will benefit the child in the long run.[15] The responsibility for evaluating such decisions might fall to a neutral third party, the physician, an ethics committee, or a court; but unless someone other than the parent finds convincing evidence that the proposed intervention will address an immediate need of the child's, the intervention should be put off until the child can make her own decision.

1. My description of the case is based on my best recollection of the doctor's remarks, but my memory of the details is spotty.

2. Meronk Eyelid Plastic Surgery, "Eyelid Surgery—Blepharoplasty," http://www.drmeronk.com/asian/asian-overview.html.

3. *Troxel v. Granville*, 530 U.S. 57, 66 (2000); *Wisconsin v. Yoder*, 406 U.S. 205 (1972).

4. J.A. Robertson, "Genetic Selection of Offspring Characteristics," *Boston University Law Review* 76 (1996): 426-482, at 481.

5. For a more detailed discussion, see J.L. Dolgin, "The Fate of Childhood: Legal Models of Children and the Parent-Child Relationship," *Albany Law Review* 61 (1997): 345-431.

6. Robertson, "Genetic Selection Of Offspring Characteristics."

7. See *In re Hofbauer*, 47 N.Y.2d 648 (1979); *Tenenbaum v. Williams*, 193 F.3d 581 (2d Cir. 1999); and *In re Hudson*, 126 P.2d 756 (Wash. 1942).

8. *In re Custody of a Minor*, 379 N.E.2d 1053 (Mass. 1978); *Jehovah's Witnesses v. King County Hosp. Unit No. 1*, 390 U.S. 598 (1968) (per curiam), aff'g 278 F. Supp. 488 (W.D. Wash. 1967).

9. K. Davis, *Dubious Equalities and Embodied Differences: Cultural Studies on Cosmetic Surgery* (Totowa, N.J.: Rowman and Littlefield, 2003), 93, quoting E. Kaw, "Medicalization of Racial Features: Asian American Women and Cosmetic Surgery," *Medical Anthropology Quarterly* 7, no. 1 (March 1993): 74-89.

10. C.S. Lee, "Blepharoplasty, Asian," at http://www.emedicine.com/plastic/topic425.htm. Lee advises practitioners that "In current American society, Asian patients almost never seek to westernize their appearance, and surgeons should be wary of modifying a patient's ethnic appearance, even in the rare case when it is requested."

11. Joel Feinberg characterized as "rights held in trust" those "rights that are to be saved for the child until he is an adult," such as the right to reproduce and the right to make life or death decisions. See J. Feinberg, "The Child's Right to an Open Future," in *Whose Child? Children's Rights, Parental Authority, and State Power*, ed. W. Aiken (Totowa, N.J.: Rowman and Littlefield, 1980), 124-53. Others have argued that the parent-child relationship is best viewed as one shaped by fiduciary responsibilities; see E.S. Scott and R.E. Scott, "Parents as Fiduciaries," *Virginia Law Review* 81 (1995): 2401-2476.

12. This way of expanding the scope of the open future framework is developed by Dena Davis; see "Genetic Dilemmas and the Child's Right to an Open Future," *Rutgers Law Journal* 28 (1997): 549-92.

13. For example, J. Bird, "Outside the Law: Intersex, Medicine and the Discourse of Rights," *Cardozo Journal of Law and Gender* 12 (2005): 65-80, at 74.

14. N. Ehrenreich, "Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of 'Cultural Practices,'" *Harvard Civil Rights-Civil Liberties Law Review* 40 (2005): 71-140.

15. The compromise agreement reached between Washington Children's Hospital and Washington Protection and Advocacy System in the Ashley X case implements this paradigm for growth attenuation cases.

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