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In re Cassandra C.: Why Won't You Believe Me?

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Obtaining valid and informed consent from patients before treatment is an essential responsibility for oncologists. They may rely on the decision-making ability of the competent adult or the substituted judgment from parents of young children to guide recommended treatment programs, but what about the adolescent? When can a physician be confident that an adolescent is acceptably mature to make his or her own medical treatment decisions? Consider the case of Cassandra C.

A few weeks shy of her 17th birthday, Cassandra C. was diagnosed with Hodgkin lymphoma. She was advised by her physicians to begin chemotherapy treatment immediately, but she and her mother were reluctant to “put poisons in her body.” They missed several medical appointments, were often difficult to reach, and had personality conflicts with providers, and thus Cassandra did not start therapy as had been prescribed. Her physicians contacted the Connecticut Department of Children and Families (“the Department”), which filed a neglect petition seeking an order of temporary custody of the minor, Cassandra. The trial court granted the order. Cassandra started treatment but then ran away, stating that she did not want to be treated for her lymphoma. The Department moved to reopen the case to determine whether Cassandra was competent to make medical decisions. The trial court judge determined that Cassandra was immature and not competent to make her own medical decisions, and ordered that she be removed from her home and have the Department make all her medical treatment decisions. Cassandra and her mother appealed to the Connecticut Supreme Court (SC) to recognize as a matter of the state’s common law the mature minor doctrine (MMD), which allows a “sufficiently mature” minor to consent to or refuse medical treatment.¹ The SC held that (1) the trial judge’s findings were not “clearly erroneous,” (2) this was not a proper case in which to decide whether to adopt the MMD, and (3) respondent’s due process rights were not violated.¹

The age of majority in Connecticut was 18 years, so the state (the Department), under its *parens patriae* authority (public policy authority of the state), sought to intervene against an allegedly negligent mother to protect a minor. The treating physician, Michael Isakoff, MD, testified as to his opinion of the unreasonableness of the mother and the immaturity of the minor. In his efforts to promote Cassandra’s best chances for a favorable treatment outcome, he influenced the court’s decision to remove the teenager from her home and enforce treatment. This case began, then, as a legal issue involving a state’s right to intervene to protect a minor who was by law incompetent to make medical decisions for herself. The SC reasoned that, because the trial court found Cassandra to be “immature” (based on the judge’s observations and Dr. Isakoff’s testimony), there was no need to adopt the MMD because it would not apply to Cassandra. The SC recognized that a number of other courts had found exceptions to the common law principle that minors are incompetent to make medical decisions for themselves. It referenced a 1989 Illinois case, *In re EG*, in which the Illinois Supreme Court held that if the evidence was clear and convincing that the minor was “mature enough to appreciate the consequences of her actions,” then the MMD afforded her the common law right to consent to or refuse medical treatment.² Last, because there was no factual predicate for a due process claim made in the trial court, the SC declined to

consider maturity testimony of any evidentiary standard and found, necessarily, no violation of Cassandra C.'s constitutional rights.

Despite these legally based footings of the issues represented by the Cassandra C. case and the case's popular notoriety, the ethical concerns arising from the case and their analyses involving the major stakeholders may be regarded as having had the greater influence in shaping subsequent judicial and ethical considerations. Is there a bright-line age (ie, clearly defined rule or standard age) at which adolescents are competent to make autonomous medical decisions? Is maturity purely a neuroscientific benchmark, or are other less definable qualities involved? What are the rights of children and parents, and how are they interrelated? How are physicians' duties to children, adolescents, and adults modified by age? What shall society define as the moral standing of its children to protect their autonomy and respect the integrity of their personhood?

In his review of adolescent brain development, psychologist Laurence Steinberg³ suggested that recent studies have not challenged the MMD and do not substantiate the need for a bright-line age marker for competency in medical decision-making. He cautions, however, that adolescent decision-making depends not only on intellectual capacity but also on the psychosocial circumstances under which decisions are made.³ He urges healthcare practitioners to enable adolescents to make mature medical decisions by being involved in the decision-making process and helping them consider the short- and long-term consequences of their decisions. In these settings, physicians may be able to rely on the adolescent's decisions to be as mature as the adult's decisions and so shape the physician-patient relationship and therapeutic assessments.

Bioethicist Erika Salter⁴ advised against conflating adolescent medical decision-making capacity with decision-making authority. She argued that parental authority is justified because parents are morally and legally responsible for their children. One could argue, however, that the exceptions to this guideline that are based on circumstances (rather than on age) might seem to belie her proposal of the absolute right of parents to decide for their children. For example, the emergency treatment of minors exception does not rely on parental permission, nor in some states is parental authorization required for adolescent family planning, abortions, treatment of sexually transmitted infections, or treatment of substance abuse. The emancipated minor exception does not rely on the maturity of the minor, but rather on the minor's life status (eg, bearing a child). Are the parents no longer morally responsible for their 13-year-old with her new baby?

Barina and Bishop⁵ might label the special category of reproductive and sexual exclusions to the parental authority role as "mission creep." They believe that in the tradition of Western political philosophy idealizing the autonomous state

(ie, emancipated) and the state's public health and financial interest in curbing the transmission of venereal diseases, the parents and family are further marginalized such that their functioning as a complete and nurturing unit is no longer supported.

In a law review article titled "Let's Get Real," Rosato⁶ pleaded for the "dismantling" of the presumption of incompetence in adolescent medical decision-making to recognize the distinctiveness of older adolescents compared with younger children. As remotely as 1979, the Supreme Court of the United States (SCOTUS) stated that "most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment."⁷ Rosato explained that this notion of incompetence is pervasive in the law governing healthcare decision-making and that reform in this jurisprudence is necessary, especially to have it correspond with "reality." In his commentary on mature minors and medical choice, Burk⁸ likewise highlighted concerns about the need for immediate legislative and judicial reform and used the *In re Cassandra C.* case to illustrate his argument. Although Cassandra's case was not based on religious grounds, Burk believed strongly that the case presents a more comprehensive representation of the legal and ethical quandaries underlying adolescent medical decision-making rights. He believed that SCOTUS is "primed to recognize a constitutionally derived mature minor exemption through the First Amendment."⁸

On the basis of neuroscientific evidence, Diekema⁹ argued that adolescents' brains are not developed enough for them to be competent in medical decision-making. When adults refuse medical treatment or lifesaving therapies, they are assumed to possess the capacity to make that decision, and out of respect for their autonomy, the refusal is honored. Diekema argued that although healthcare providers also have ethical duties toward adolescents, those duties are not based on the principle of autonomy, because the adolescent's decision is not competent or rational. Instead, practitioners have the duty of beneficence and nonmalevolence.

Only 14 states have some version of the MMD, and there is no federal law that allows mature minors the right to make autonomous medical decisions. Neuroscientists, psychologists, healthcare providers, and bioethicists have shown no consensus regarding how to appropriately conclude which minors are competent to direct their medical care. In Cassandra's case, the urgency in treating her lymphoma and the testimony of her treating physician may have significantly influenced the SC to find in favor of the Department and to disallow any consideration of the MMD. Oncologists must continue to exercise their best judgment in determining the validity of all of their patients' medical decision-making, especially when dealing with disorders that are potentially life-ending. Cassandra C.'s journey at best may have allowed the adolescent in the room to be seen.

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