

Lowering the Age of Consent for Vaccination to Promote Pediatric Vaccination: It's Worth a Shot

Margaret Irwin¹, Derek R. Soled², and Christy L. Cummings³

1. BOSTON COMBINED RESIDENCY PROGRAM, BOSTON, MASSACHUSETTS, USA. 2. HARVARD COMBINED INTERNAL MEDICINE/PEDIATRICS PROGRAM, BOSTON, MASSACHUSETTS, USA. 3. HARVARD MEDICAL SCHOOL, BOSTON, MASSACHUSETTS, USA.

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Abstract: This paper challenges historically preconceived notions surrounding a minor's ability to make medical decisions, arguing that federal health law should be reformed to allow minors with capacity as young as age 12 to consent to their own Centers for Disease Control and Prevention (CDC)-approved COVID-19 vaccinations. This proposal aligns with and expands upon current exceptions to limitations on adolescent decision-making. This analysis reviews the historic and current anti-vaccination sentiment, examines legal precedence and rationale, outlines supporting ethical arguments regarding adolescent decision-making, and offers rebuttals to anticipated ethical counterarguments.

Vaccines are safe, effective preventative tools against the risk of future illness, both for individuals and communities. They inherently involve a degree of uncertainty. For many considering vaccination for themselves or their children, questions may arise: Will I/they be exposed to the disease? Will I/they become sick? Will the vaccine work if I am/they

are exposed in the future? This uncertainty may lead some to think that vaccination is unethical "experimentation" given there is no definite certainty to vaccines' usefulness or effect, despite scientific evidence.¹ While all medical innovation is subject to some degree of uncertainty, the fear and controversy surrounding vaccination is complex and intensifying.²

Vaccines have dramatically decreased the incidence and subsequent morbidity and mortality of infectious diseases. For instance, vaccines have enabled the eradication of smallpox and near eradication of polio.³ However, even though many in the science community view vaccines among the greatest successes in modern medicine, rates of vaccination in the US are precipitously dropping.⁴ This drop is most apparent in adolescents. Adolescent rates of vaccination lag rates of all younger age groups, and about 35 million American adolescents fail to receive at least one recommended vaccine.⁵ A 2011 national immunization survey showed that in a cross-sectional sample of 13–17-year-old adolescents, only 78% got their Tdap booster dose and 71% got their meningococcal booster dose compared to over 90% of children aged 19–35 months who had received these respective vaccines.⁶ Only 53% of adolescent girls aged 13–17 received 1 dose of the Human Papilloma Virus (HPV) vaccine and a mere 35% had completed the 3-dose series, though these rates may be compounded by stigma.⁷

Margaret Irwin, M.D., is a pediatrics resident in the Boston Combined Residency Program (Boston Children's Hospital and Boston Medical Center). **Derek R. Soled, M.D., M.B.A., M.Sc.**, is a resident in the Harvard Combined Internal Medicine/Pediatrics Program (Brigham and Women's Hospital, Boston Children's Hospital, and Boston Medical Center). **Christy L. Cummings, M.D. HEC-C**, is an Assistant Professor in Pediatrics at Harvard Medical School and neonatologist at Boston Children's Hospital, where she is an Ethics Associate, member of the Ethics Advisory Committee and the IRB. She is a member of the HMS Center for Bioethics, Director of Medical Ethics & Humanities in Newborn Medicine, and Associate Director for the Harvard Neonatal-Perinatal Fellowship Program.

In a current lens, where the large burden of the COVID-19 pandemic seems behind us, the growing anti-vaccination sentiment is worrisome and threatens public health. Vaccinating against COVID-19 no longer seems important to many and moreover the hesitancy from the peak of the pandemic continues to find its way into all vaccination rates. In March of 2023, about 31% of American adults were still not fully vaccinated.⁸ Pediatric vaccination lags significantly behind: as of April 2023, 88% of children aged 6 months to 5 years, 68% of children aged 5-11 and 42% of children aged 12-17 were not fully vaccinated.⁹ Further, 30% of parents of American teenagers aged 13 to 17 said their child was “definitely not” going to get the COVID-19 vaccine.¹⁰

The solution to promote vaccination is multi-pronged. Communication with vaccine-hesitant parents is not always effective. Stricter federal vaccine mandates are wrought with ethical dilemmas

Academy of Pediatrics (AAP), the consensus is that these sensitive issues are important to address with the minor without parental involvement because otherwise the minor may not seek care.¹³ Similarly, vaccination could be regarded as a similar sensitive issue in the pediatric population and an acceptable extension of adolescent decision-making.

There is precedent for lowering the age of consent to improve vaccination rates. The District of Columbia (D.C.) Council passed a bill that became law on December 23, 2020, allowing patients in DC as young as 11 to obtain Center for Disease Control (CDC)-approved vaccinations without their parents’ consent.¹⁴ Responding to the recent US measles outbreaks, D.C. council members hope to improve adolescent vaccination rates. Under this law, if the minor in DC demonstrates capacity, they can consent to their own vaccinations, even if their parent(s) object for religious, personal, or philosophical reasons.

Therefore, it is argued that it is both ethically important and permissible to change federal law to allow minors with capacity, as young as age 12, to consent to their own CDC-approved COVID-19 vaccinations in the case of parent/guardian refusal. Part A of this analysis discusses the historic and current anti-vaccination sentiment, Part B outlines the current state of minor vaccination, Part C outlines supporting ethical arguments, and Part D concludes the discussion by addressing potential ethical counterarguments.

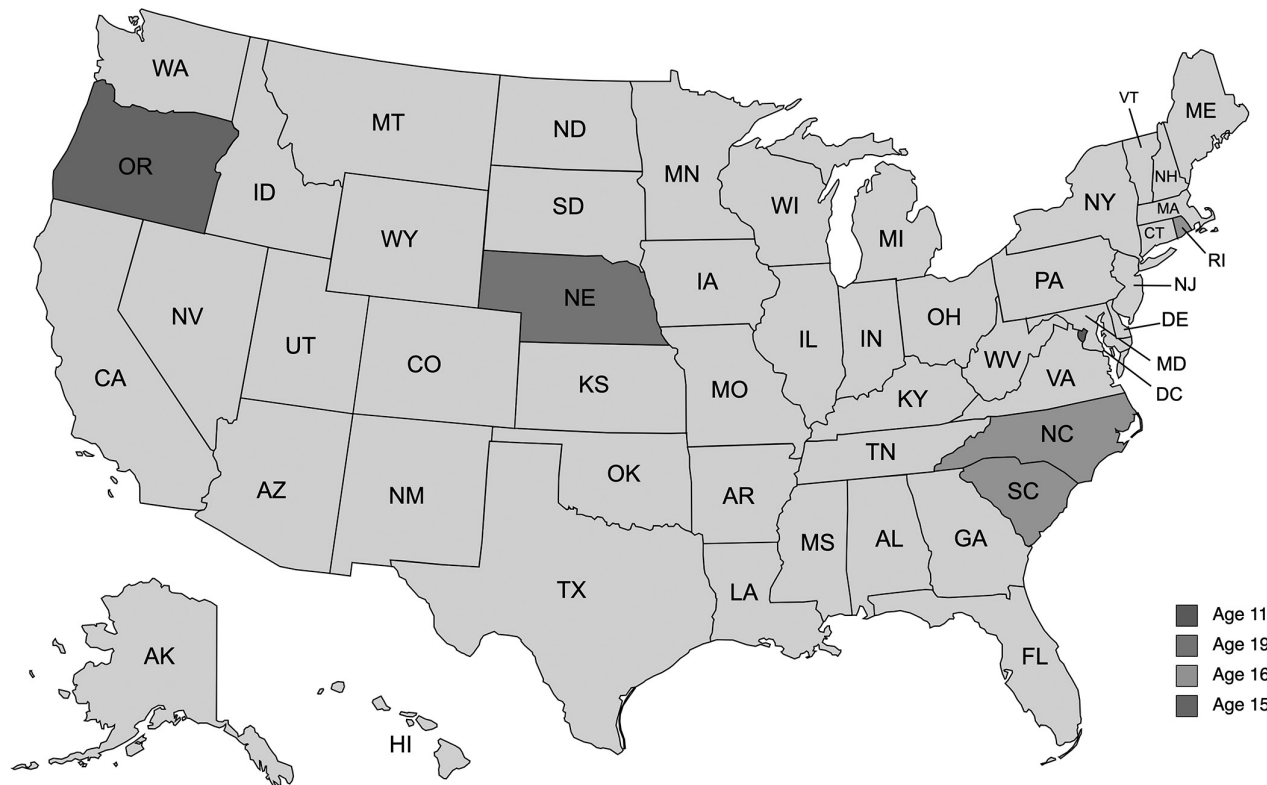
around patient autonomy and freedom to choose. One approach to improve vaccination rates in adolescents involves re-examining consent, namely the age at which one can consent to their own vaccination. Lowering the age of consent draws from and aligns with existing laws allowing minors to consent to mental and sexual health services and treatment without parental consent or involvement. It is an accepted ethical pillar in pediatrics that adolescents can provide consent for care related to sexual and mental health.¹¹ The law supports this tenet: in 1967 the Supreme Court emphasized that minors have constitutional rights, albeit limited ones. Moreover, the 1977 case of *Carey vs Population Services International* made it illegal to prohibit the sale of legal contraceptives to minors and supported a minor’s rights to privacy regarding decisions about reproduction.¹² As a result, minors can make decisions about their sexual and mental health to varying degrees in all states, although confidentiality is not always protected. Supported by the American

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Part A: Anti-Vaccination Sentiment Historically and Today

History can provide an invaluable lens to better understand the current anti-vaccine sentiment. Hesitancy surrounding modern vaccinations is largely attributed to Dr. Wakefield’s 1988 *Lancet* article, which linked the Measles-Mumps-Rubella (MMR) vaccine to autism in children.¹⁵ This study, deeply problematic and biased in design, has long been debunked and the

Figure 1a

Selected laws by US state regarding minors and consent.

lack of association between the measles vaccination and autism has been robustly demonstrated.¹⁶ Even after the study was retracted, its detrimental impact has since eroded public trust in pediatric vaccines. For example, the measles outbreaks in the early 2000s in the US, Canada and UK have been at least partially attributed to the non-vaccination of children.¹⁷ The anti-vaccine movement has since grown and spread through hundreds of websites, with an estimated 58 million followers on various social media platforms.¹⁸

Historic examples of unethical research have contributed to public mistrust and hesitancy. For many, especially minorities, the 1930s Tuskegee experiment still lingers as a painful memory. A horrific example of uninformed consent and abuse of power, Black men with syphilis were given placebo instead of penicillin, while researchers unethically studied the natural history of the disease.¹⁹ Another example of unethical research is the Willowbrook hepatitis study. Starting in 1956 and lasting for 14 years, mentally disabled children at the Willowbrook State School were intentionally given hepatitis to study the virus's development.²⁰ Understandably, the history of human experimentation in America has left many wary of medical treat-

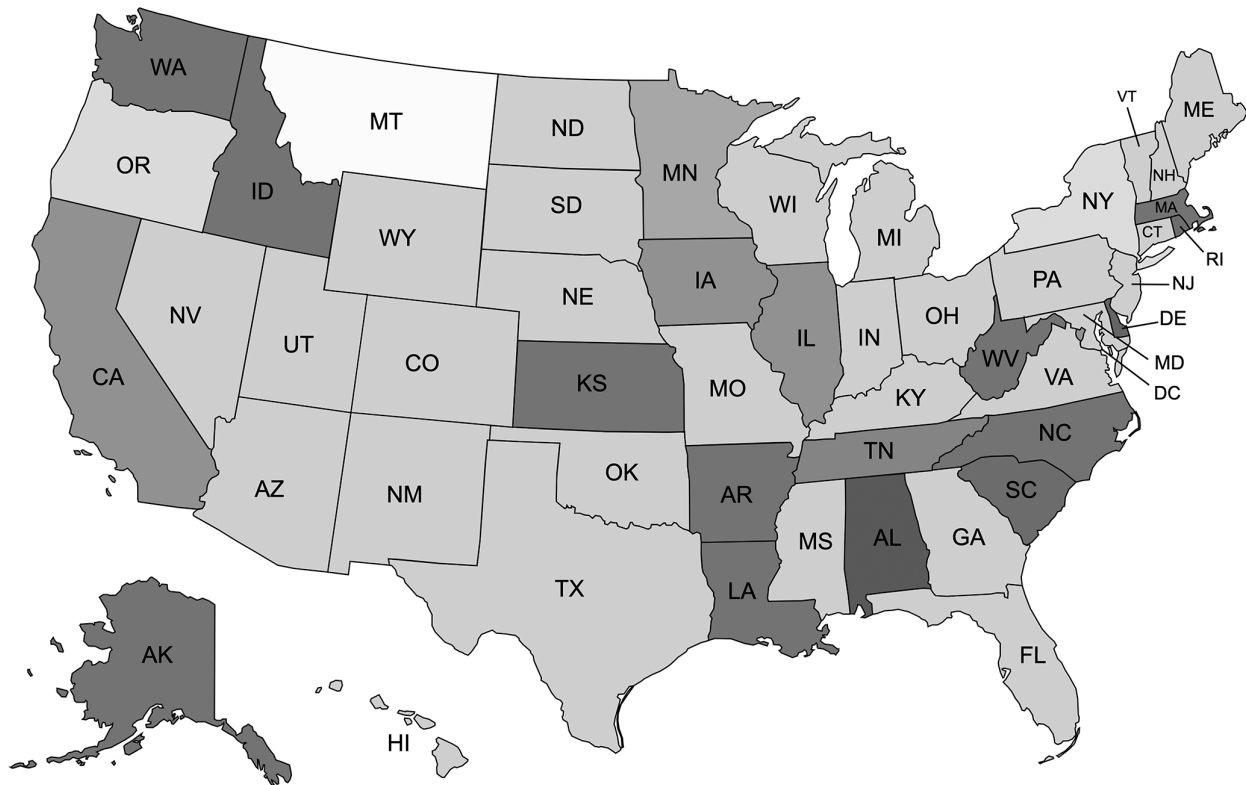
ment, such as vaccinations, especially those mandated by the government.

Unfortunately, this mistrust has continued into the COVID-19 pandemic and post-pandemic eras. Exaggerated conspiracy theories surrounding COVID-19 vaccination have emerged, such as the use of the COVID-19 vaccine to implant a tracking device into billions of people or that the vaccines turn people into monkeys.²¹ Beyond these theories, others more metered, yet nonetheless false, ideas have circulated, such as that COVID-19 vaccines irreversibly change people's DNA or that the vaccine's development was unsafely rushed.²²

To understand why some have chosen to decline the COVID-19 vaccine, Derek Thompson, a staff writer for the *Atlantic*, took to Twitter inviting those not planning to get the COVID-19 vaccine to explain their reasoning. Recognizing selection bias here, many of the anti-COVID vaccine respondents were not opposed to *all* vaccines. Many regarded this vaccine as rushed, did not want to risk "being a guinea pig," and feared a slippery slope regarding civil rights.²³ The dangers and consequences of the anti-vaccination movement have grown; in 2020 alone, anti-vaxxers have increased their following by 7-8 million.²⁴

Figure 1b

Selected laws by US state regarding minors and vaccine consent.



- Minors over age 14 can consent to all vaccinations
- “Mature Minor” doctrine: Minors of any age can consent to receive all health care services, theoretically including vaccination
- Minors over age 12 can consent to HPV + Hep B vaccination, but no other vaccinations
- Minors over age 12 can consent to all vaccinations
- Minors over age 11 can consent to all vaccinations
- Minors of any age can consent to Hep B vaccination, but no other vaccinations
- Minors of any age can consent to all vaccinations, except HPV vaccination; once the minor graduates from high school they can also consent to HPV vaccination
- Minors of any age can consent to HPV vaccination, but no other vaccinations
- Minors over age 15 can consent to all vaccinations
- Minors over age 16 can consent to all vaccinations
- Minors over age 14 can consent to all vaccinations

Part B: Legal Precedence & Rationale

As previously discussed, the recently passed D.C. Council bill set the precedent for minor consent to vaccinations. The bill allows patients in D.C. as young as 11 years old to obtain vaccinations without parental/guardian consent, or even over their objection for religious or other reasons. The bill was initially proposed in early 2019 during the US measles outbreak that swept across 31 states, causing 1,282 cases nation-

wide.²⁵ The bill, which was approved 12 to 1, was strongly supported by the D.C. chapter of the AAP and passed into law December of 2020.

Furthermore, there are also already multiple states that allow minors of varying ages access to certain vaccines. **Figures 1a and 1b** depict by state the various eligibilities for consent (**1a**) and vaccine consent (**1b**) by minors.²⁶ **Figure 2** depicts by state the more specific eligibility for COVID-19 vaccine consent by minors.²⁷

Part C: Ethical Arguments for Lowering the Age of Consent for Vaccination

This proposal would fundamentally change pediatric healthcare policy, yet aligns with and expands upon current exceptions to limitations on adolescent decision-making. While there exists legal precedent for this proposal, law should not inform ethics. As such, it is integral that the ethical arguments first be examined. The ethical arguments can be distilled to two major ethical principles: the principle of autonomy and the principle of utilitarianism.

The concept of consent is derived from the principle of autonomy, a core tenet in medical ethics. Autonomy requires two elements: liberty, or freedom from controlling influence, and agency, or capacity for self-rule.³³ In pediatrics, where children do not yet possess capacity, parents (or guardians) have authority and responsibility as surrogate decision-makers for providing informed parental permission or consent for their child.³⁴ Decisions are made in the child's best interest, attempting to maximize benefit and minimize harm, and are generally accepted if they do not fall below the harm threshold. With developmental maturation during childhood and adolescence, shared decision-making and the provision of assent is the cornerstone of optimal pediatric care until decisions can be made autonomously at the arbitrary age of majority. The criteria for capacity, particularly in adolescent medicine, have moved away from age and more towards individual experience and understanding. Accepted exceptions to limitations placed on adolescent decision making include 1) specific categories, such as sexual and mental health, 2) 'mature minor' exception, and 3) emancipated minors.³⁵ This acknowledges an adolescent's developing autonomy, fundamentally empowers minors to act independently in this context, and aligns with and expands upon existing exceptions to limitations on adolescent decision-making. Importantly, this proposal only allows individuals to consent to CDC-approved vaccinations if they have capacity for informed consent on a case-by-case basis, determined by a clinician familiar with the patient.³⁶ Ultimately, allowing minors to consent to their own vaccinations promotes individual and public health, and further aids in the transition from child to responsible, autonomous adult when making medical decisions.

Moreover, consent to vaccination is a relatively low risk decision and thus more appropriate for the tenant of autonomy to be applied. CDC- and AAP-recommended vaccines have been rigorously studied in large clinical trials, found to be safe and efficacious in children and adolescents. Allowing a child to receive a vaccination is very unlikely to result in death or any

long-term morbidity.³⁷ By comparison, medical decisions involving a higher level of risk or complexity, for instance decisions around life-sustaining treatment, require adolescents to demonstrate a higher level of capacity or decision-making maturity.³⁸ While minors should not have free reign over all medical decisions, allowing minors to consent to their own vaccinations appropriately balances medical autonomy and responsibility.

A second ethical argument central to this proposal is the utilitarian argument surrounding public health good. Allowing minors to consent to their own vaccination should help increase vaccination rates, which is inherently beneficial to the health of society. Public health measures, such as vaccination, are supported by the central moral justification to prevent poor health outcomes and advance good health outcomes.³⁹ Given the minimal scientific safety concerns around the vaccinations for which adolescents are eligible, allowing more individuals to consent and thus receive vaccinations promotes a "good outcome" of increasing both individual and public immunity of potentially morbid diseases. While the magnitude of the potential increase in vaccination rates resulting from this policy remains unknown, allowing minors to consent to vaccination supports patient autonomy and promotes the greater health of society.

Another angle through which the utilitarian argument can be applied is protecting the vulnerable. Increasing vaccination rates is especially important in protecting others who do not have the choice to vaccinate for medically valid reasons. For instance, infants who are too young, pregnant persons, or immunocompromised patients cannot receive live vaccines. If enough of the population is immunized however, these individuals may still be protected by proxy due to herd immunity. The immunization rates needed to confer herd immunity depend on how contagious the illness is: For a more contagious disease, like pertussis or measles, vaccination of 95% of the population is necessary, while a less contagious disease, like mumps or rubella, only need 85%.⁴⁰ Therefore, when parents refuse vaccines for children who are medically able to receive the vaccine, they are not only potentially harming their child, but also those unable to vaccinate because of medical conditions or circumstances.

Lastly, this proposal is extremely relevant to COVID-19, and potentially others in the future. While in the US and globally, fewer cases of COVID-19 have been reported in children aged 0-17 compared with adults, there is evidence that children and adolescents have acted as vectors promoting spread.⁴¹ A recent systemic review estimated that 16% of children with COVID-19

are asymptomatic, but evidence suggests that asymptomatic pediatric infections may be as high as 50%.⁴² Thus, COVID-19 incidence is likely underestimated among children and adolescents. Moreover, the testing volume in age groups under 18 is lower than adults, but the rate of positive tests is generally higher among these groups, particularly those aged 11-17.⁴³ Another misconceived notion is that children are not getting as sick as adults. Even though children are hospitalized at lower rates, about 1 in 3 children hospitalized with COVID-19 in the US are admitted to the ICU, which is comparable to adult ICU admissions.⁴⁴ While the global priority remains vaccinating adults against COVID-19, those at highest risk for death and serious

gatherings because of their unvaccinated status.⁴⁶ Thus, parental refusal may not only risk infection, but also preclude a child's participation, potentially compromising academic and social development.

Another possible counterargument against this proposal is that it potentially exposes minors to coercion to be vaccinated. Some may argue that a clinician could rely on the power dynamic in the relationship to convince a minor to vaccinate. This argument holds less weight because the persuasion is not with malicious intent but instead reflects the clinician's larger obligation to promote health. In medicine, generally improving vaccination rates is objectively positive. Acknowledging the "slippery slope" argument,

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Part D: Potential Ethical Counterarguments & Rebuttals

Counterarguments to expanding vaccine consent to minors include whether public health goals should supersede individual autonomy, in this case parental authority.⁴⁵ Providing more individuals the choice to be vaccinated is in the best interest of the general public but may cause individuals' rights, namely those of the parent and minor, to clash with one another.

To start, some may argue that the minors who disagree with their parents' refusal of their vaccinations can simply wait until they are 18 to be vaccinated without parental consent. While waiting does solve the narrow problem, the COVID-19 vaccination should not wait. Waiting years may pose significant individual and community risk and perpetuate disease. Furthermore, COVID-19 vaccination is explicitly required to attend school or certain extracurricular activities (or even an informal requirement that peers/families create among themselves). In a poignant *New Yorker* interview, an anonymous 16-year-old, who wanted to be vaccinated against COVID-19 and whose parents forbid it, describes how they were left out of social

encouraging vaccination to the point of coercion may be in the best interest of the population's health in the eyes of some healthcare professionals.⁴⁷ Those that would support this claim cite the stringent scientific testing and objective benefits of these vaccinations. Moreover, clinicians are likely already trying to convince hesitant parents to vaccinate their child, so persuasion already exists. Again, minors will only be able to decide to vaccinate themselves against parental objection if they demonstrate appropriate capacity to understand and weigh the options being presented. It would also be necessary to include safeguards, such as specifying what licensed clinicians (i.e., pediatricians, school nurses, etc.) will be able to receive this consent from the minor, to ensure that these individuals are well trained in capacity evaluations and appropriate informed consent.

Another ethical qualm with the proposal might be that opting out of vaccination is not permissible if parental permission has been obtained. Although dissent must be acknowledged and carry appropriate weight depending on the proposed treatment, minors in general cannot refuse treatments to which their parents have consented (parental permission), such as vaccination. Thus, the adolescent right to consent to vaccination is really the right to agree with parents, clinicians and the government, which is ethically

charged. From an ethical standpoint, the principle of respect for individual rights and developing autonomy should theoretically allow adolescents to express both viewpoints. If a minor is judged competent to accept, then they should also be competent to refuse. However, as Wood points out in his discussion about HPV vaccination minor consent, immaturity is more likely to play a role in adolescent vaccine refusal.⁴⁸ Immaturity could manifest as needle phobias, attention seeking behavior, and other emotionally driven behavior and could result in a competent minor refusing vaccination. Because immaturity does not mean that a minor does not have capacity, it is important to protect against immature behaviors and thus only enable a minor to opt-in to vaccination and not opt-out. Furthermore, given anticipated benefits outweigh potential risks in the case of vaccination, parents and clinicians may choose to pursue a treatment over a minor's objection or dissent.

Some may find fault with this proposal because it de-emphasizes parental or guardian authority over minors. Parental/guardian authority and the age of consent exist as a means of protection because historically it is thought that an adult parental perspective will have foresight to make decisions in the best interest of their child, both in the short-term and long-term. However, there already exist many court-supported medical decisions that minors can make without parental input, such as those surrounding sexual and mental health. Further, minor consent laws aim not to prevent parental involvement in health decisions, but instead to protect children who cannot have productive dialogue with their parents.⁴⁹ Some clinicians may worry that going against parental wishes could erode trust between clinicians and parents. The clinician's primary patient remains the minor, and care should be taken to maintain open and respectful communication with families for their benefit.

Connected to the prior counterargument, others may argue that children cannot make medical decisions because they cannot understand decisions in the wider context of their lives. There are arguments that minors cannot evaluate information with lasting personal values.⁵⁰ This proposal does not disregard this need to respect a minor's vulnerability. To start, minors will only be able to consent to vaccination if they are deemed to have capacity. By evaluating one's capacity, the clinician is in essence trying to determine if a minor's values are *mature* enough to evaluate the decision of vaccination as it pertains to their life both currently and in the long-term. Additionally, it is important to highlight that the decision of vaccination is not a health-restricting decision or a decision with

immense ramifications. Thus, even if a minor's values are not completely *mature*, this decision does not result in pronounced or lasting consequences, such as refusing treatment that results in significant harm or death. Therefore, minors with capacity — especially adolescents — should have the right to consent to highly beneficial, low-risk treatments.⁵¹

There is potential concern that vaccination may lead to riskier behavior when enabled minors make their own decisions. This has been directly refuted in studies on the HPV vaccination. Historically, it was believed that HPV vaccination would increase promiscuous activity, especially since it is recommended to be given to an age group that typically is not yet sexually active.⁵² In a large study comparing HPV vaccinated and unvaccinated girls, there was no difference in rates of other sexually transmitted infections, and that HPV vaccine does not promote unsafe sexual behavior, such as decreased condom use.⁵³ Moreover, the HPV vaccine may be associated with increased protective health behaviors, such as higher Pap smear screening and condom use.⁵⁴ Those motivated enough to get the HPV vaccine are more likely to be health conscious and thus display other protective behaviors, although this may be association and not causation. While there are no studies evaluating COVID-19 vaccination and behavioral changes, it is possible that increased protective behavior seen with the HPV vaccine may extend to the COVID-19 vaccine.

Finally, there is also concern that changing the landscape of vaccination consent could potentially lead to a reactionary increase in anti-vaccination dialogue. Amidst vaccine hesitancy and conspiracy, lowering the age of consent for all vaccinations could result in significant anti-vaccination lobbying efforts. However, decisions should not be driven by the fear of irrational disagreement, especially if they have the potential for good. Policy and medical decisions should be made with public health in mind, rather than charting a path of least resistance to avoid criticism.

Conclusion

Respect for parental authority and developing patient autonomy in the pediatric context is complex. Maturity and foresight develop with age and experience, along a continuum; capacity does not simply appear at 18 years, the arbitrary age of majority. This proposal challenges historically preconceived notions surrounding a minor's ability to make medical decisions about vaccinations yet aligns with and expands upon current exceptions to limitations on adolescent decision making. Minors from age 12 onwards should be allowed to consent to their own COVID-19 vaccinations if there

is parental or guardian refusal. Although this paper limited this ethical discussion to the COVID-19 vaccine, the ethical and public health concerns addressed here are not restricted to these vaccines. By taking the step to allow minor consent for the COVID-19 vaccines, this could be an important step forward in promoting individual and public health while recognizing developing adolescent autonomy and fostering change in this current post-pandemic and in the future. While acknowledging potential counterarguments, it is ethically important and beneficial to give this right to minors. At the end of the day, it's worth a shot.

Note

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