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Note

The Mature Minor Doctrine and COVID Vaccination in Connecticut

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The mature minor doctrine is an exception to the common law rule of parental informed consent for a child's medical decisions. The mature minor doctrine is applicable as either doctrine or statute in some states, but not all. Connecticut currently upholds the common law view for a minor child's medical decision-making authority. Consequently, one prominent topic of discussion in recent years deals with the Covid-19 pandemic and the public policy discussions over nationwide vaccination efforts. Many minors, children legally under the age of eighteen, are looking to make their own medical decisions when dealing with vaccination for the Coronavirus. By expanding the parameters of the mature minor doctrine, and implementing it into Connecticut statute, mature minors can be given the autonomy to acquire, or resist, vaccination despite their parent's wishes. Although there has been a history of case law favoring parental authority over children, psychologists and legal scholars have brought to light new studies demonstrating adolescent development and capacity with understanding medical treatment. Furthermore, other northeastern U.S. states have gradually started to recognize mature minors in the context of vaccinations. As with any new introduction of a rule to a particular state, Connecticut legislation and courts must weigh the benefits, as well as the potential drawbacks that the mature minor doctrine may bring to light. Overall, the mature minor doctrine is a complicated doctrine, and it includes many different competing interests. However, if applied correctly, the doctrine can help competent and capable minors to make their own informed medical decisions in the state of Connecticut.

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INTRODUCTION

Victoria Ramirez was a lively, intelligent, and charismatic fifteen-year-old girl from Pensacola, Florida, who tested positive for Covid-19 back in August of 2021.¹ Her father, Hector, had refused the Covid-19 vaccine for both him and his daughter, resulting in a downturn of events.² After trying to fight off Covid pneumonia for close to two weeks, Victoria passed away in a bed at her local hospital.³ After Victoria's passing, Hector Ramirez came forward expressing his guilt for not letting his minor daughter get vaccinated, and hopes that other parents will learn from his mistake and take Covid-19 more seriously: "It's something that's going to be stuck with me for my whole life, thinking maybe I should have [gotten vaccinated] sooner . . . I don't want any other parent to go through what I did."⁴

The Covid-19 pandemic brought forward much uncertainty, chaos, and controversy over medical health decisions. During the height of the pandemic, more tragic stories, like Victoria's, arose dealing with unvaccinated children dying or experiencing permanent health complications from Covid-19, usually in part from parents' refusal to have their child vaccinated. As more of these cases caught nationwide coverage, minor adolescents all throughout the U.S. tried to get vaccinated despite their parent's wishes.⁵ This vaccination issue involves multiple parties: the minor

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¹ Cody Long, *Florida Dad Feels Regret After Unvaccinated Teen Daughter Dies of COVID-19*, CBS NEWS (Sep 9, 2021, 9:20 AM), <https://www.cbs17.com/community/health/coronavirus/florida-dad-feels-regret-after-unvaccinated-teen-daughter-dies-of-covid-19/>.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ Nicholas Montero is a sixteen-year-old from Pennsylvania who received the Covid-19 vaccine pursuant to Philadelphia's regulation, which allows minors of at least eleven years old to consent to vaccination without parental consent. He received the vaccination despite his parents' continued disdain for the shots. Nina Feldman, *This 16-Year-Old Wanted to Get the COVID Vaccine. He Had to Hide it From His Parents*, NPR (Feb. 16, 2022, 5:08 AM), <https://www.npr.org/sections/health-shots/2022/02/16/1074191656/this-16-year-old-wanted-to-get-the-covid-vaccine-he-had-to-hide-it-from-his-pare>. See the cases of Elizabeth and Isabella, two seventeen-year-old girls from different households, which also demonstrate the child-parent conflict about vaccination. Jan Hoffman, *As Parents Forbid Covid Shots, Defiant Teenagers Seek Ways to Get Them*, N.Y. TIMES (Sept. 30, 2021),

child, the parent, and even the state, each with differing interests in medical decision-making.

Throughout many aspects of our society, children's rights are automatically compromised and become deferred to parental consent. Clear explanations of children's rights and autonomy are also absent in the U.S. Constitution. The medical field is a prime example of the limitations on child autonomy. In the state of Connecticut, minors (individuals under the age of eighteen)⁶ are not legally capable of providing informed consent for medical treatment.⁷ Therefore, a parent or legal guardian makes this decision on a child's behalf. There are some exceptions to this rule, depending on the type of medical treatment offered. For example, adolescents under the age of eighteen can make their own decisions with pregnancies, abortions, and treatment dealing with sexual or mental health.⁸ But in terms of general practice, Connecticut requires parental consent in place of what the minor wants. The parents ultimately make the final medical decisions for their children. The mature minor doctrine is a rule implemented by some, but not all, states. Connecticut is one of the states that does not look to this doctrine as law. This Article looks at the mature minor doctrine's efficacy in states where it is implemented and demonstrates why the state of Connecticut should adopt this doctrine, or a variation of it, to expand greater autonomy to minors. Additionally, this doctrine should be expanded beyond life threatening situations and include more general health areas of controversy, like vaccination.

First, this Article will analyze the role of parental consent regarding a minor's health decisions. Parental consent is found in education, in making legal decisions, and in the medical field. In a constitutional context, child autonomy is basically absent from the U.S. Constitution.⁹ Part I of the Article delves into the common law reasoning behind parental consent and provides an overarching background of minors' autonomy in health care. Despite the limitation in child autonomy, there is an overarching rule that parents cannot "make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for

<https://www.nytimes.com/2021/06/26/health/covid-vaccine-teens-consent.html>; see also Fortesa Latifi, *Vaccine Rebels: The Teens Defying Their Parents to Get the COVID Vaccine*, TEENVOGUE (Apr. 7, 2021), <https://www.teenvogue.com/story/vaccine-rebels-the-teens-defying-their-parents-to-get-the-covid-vaccine> (portraying how Heather is eager to turn eighteen so she can get the Covid vaccine in California without parental consent).

⁶ CONN. GEN. STAT. §1-1d (2023).

⁷ CONN. GEN. STAT. §45a-604(5)(B) (2023) (explaining that parents are in charge of determining their child's "major medical, psychiatric or surgical treatment" until the child turns of adult legal age).

⁸ CONN. GEN. STAT. § 19a-582 (2021); Jessica Callahan, *Parental Control and Teenagers' Rights*, OFF. LEGIS. RSCH. (2022).

⁹ Homer H. Clark Jr., *Children and the Constitution*, 1992 U. ILL. L. REV. 1, 1-3 (1992) (explaining that the absence of children rights in the Bill of Rights may be due to the Framers' belief that children did not need constitutional status or the emphasis on state power to control the familial relationship).

themselves,”¹⁰ and these implications play a fundamental role in the field of medicine. Next, in Part II, this Article discusses the origins of the mature minor doctrine and explains why it has yet to be consistently used within Connecticut legislation. Child and adolescent psychological case studies are included to show the connection between one’s age and making informed medical decisions. Finally, Part III discusses the benefits, but also some possible drawbacks with incorporating the mature minor doctrine in Connecticut. More specifically, Connecticut legislatures should consider the use of the doctrine when dealing with less-serious illnesses and preventative measures, like vaccinations. This Part provides a comparative analysis of other U.S. states’ success rates to predict the doctrine’s efficacy in the state of Connecticut, concluding that the mature minor doctrine can be helpful with diffusing competing interests of parents, children, and even the state.

I. CONTROVERSY OVER CHILDREN’S RIGHTS IN HISTORY

A. Parental Consent in Common Law

Parents typically possess a duty to protect and take care of their children until the children have the proper capacity to take care of themselves. But when is it the right time to let minors make these health decisions? The common law tries to address this question by creating a bright-line standard with an age eligibility requirement. Under the common law, generally, “minors may not engage in medical treatment for themselves without the permission of a parent or guardian.”¹¹ Furthermore, minors are “incapable of making informed decisions about health and welfare that require understanding and weighing risks and benefits.”¹² Therefore, “[s]tate law[] shifts that responsibility to the parental figure.”¹³ Parents ultimately have the final say over their child’s or adolescent’s medical treatment and diagnoses,¹⁴ even if it is at odds with what the child wants. Parents hold this legal responsibility until their child turns eighteen, whereby the child can have full autonomy to make his or her own medical decisions.¹⁵ Until the age of eighteen, children are generally not allowed to “seek a vaccination,

¹⁰ See *Prince v. Mass.*, 321 U.S. 158, 170 (1944) (holding as constitutional a Massachusetts statute that forbade minors from selling merchandise in public places, including religious literature furnished upon a child by their guardian or custodian).

¹¹ See *State v. William B.*, 822 A.2d 265, 276 (2003) (noting that parents or guardians seek out medical care for minors).

¹² Jason Potter Burda, *PrEP and Our Youth: Implications in Law and Policy*, 30 COLUM. J. GENDER & L. 295, 320 (2015).

¹³ *Id.*

¹⁴ 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, 262 (2005).

¹⁵ See, e.g., CONN. GEN. STAT. § 1–1d (2023) (explaining that “[A]ny person eighteen years of age or over shall be an adult for all purposes whatsoever and have the same legal capacity, rights, powers, privileges, duties, liabilities, and responsibilities as persons heretofore had at twenty-one years of age, and ‘age of majority’ shall be deemed to be eighteen years.”).

attend an annual physical, have a cavity filled, or ask for an eye exam” without prior parental consultation and consent.¹⁶ There are few exceptions under the common law for a minor to consent to his or her own medical decisions absent parental input. These exceptions, which are determined on a state-by-state basis, are usually found within health areas of pregnancy, substance abuse, sexually transmitted diseases, and mental health concerns.¹⁷ Minors have more autonomy here due to the gravity, along with the personal and sensitive nature, of the health concern in these areas. The state of Connecticut upholds some of these exceptions, and a few more concerning emancipated minors or minors with minor children, which is expressed in more detail in Section C of this Part.¹⁸

This common law rule of parental consent has been supported by years of psychological findings determining that child and even adolescent brains are not fully developed to consider and understand medical terms and recommended forms of treatment.¹⁹ However, what the common law does not consider is the effect on how different cultures, religions, levels of education, and upbringing can alter a minor’s brain development to cognize, process, and understand new and complex ideas.²⁰ Furthermore, the common law rule has failed to take into account the fairly new and recent psychological studies performed on adolescents, with new findings that adolescent brains are more similar to adult brains than what we previously had thought.²¹

B. *Constitutional Law – Lack of Child Autonomy*

The U.S. Constitution, along with current public policy, supports the parental duty to make decisions on behalf of the child “for the good of the family.”²² By looking at Supreme Court precedent, we can see that parental rights are protected under the Due Process Clause of the Fourteenth Amendment.²³ For example, *Meyer v. Nebraska* is a significant U.S. Supreme Court case that promotes parental rights to control children’s education.²⁴ Furthermore, this case brought to light that the state has some limited authority over children because of the strong arguments in favor of

¹⁶ Mutcherson, *supra* note 14, at 263.

¹⁷ Kathryn Hickey, *Minors’ Rights in Medical Decision Making*, 9 JONA’S HEALTHCARE L., ETHICS, & REGUL. 100, 102 (2007).

¹⁸ See *infra* Section I.C.

¹⁹ Hickey, *supra* note 17, at 101.

²⁰ Mutcherson, *supra* note 14, at 275–76.

²¹ Mary Irene Slonina, Note, *State v. Physicians et al.: Legal Standards Guiding the Mature Minor Doctrine and the Bioethical Judgment of Pediatricians in Life-Sustaining Medical Treatment*, 17 HEALTH MATRIX: J. L.-MED. 181, 196–97 (2007).

²² Michael Hayes, *The Mature Minor Doctrine: Can Minors Unilaterally Refuse Medical Treatment*, 66 U. KAN. L. REV. 685, 687 (2018).

²³ *Parental Rights Cases to Know*, AM. BAR ASS’N (Feb. 1, 2016), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol-35/february-2016/parental-rights-cases-to-know/.

²⁴ See generally *Meyer v. Nebraska*, 262 U.S. 390 (1923).

the rights of parents.²⁵ *Pierce v. Society of Sisters* was decided two years after *Meyers*²⁶ and holds similar opinions to the earlier-decided case. In *Pierce*, the Court held that the Act in question (the Compulsory Education Act) was unlawful because it interfered “with the liberty of parents and guardians to direct the upbringing . . . of [their] children.”²⁷

Prince v. Massachusetts is another insightful case because the Court ruled that the state can, in fact, override parental decisions if certain elements are met.²⁸ The state has power over parents only if the statute in question is necessary to the child’s protection against a clear and present danger.²⁹ In summation, parent’s rights may be limited by a compelling state interest if the parents expose their children to serious and impending harm.³⁰ *Prince* recognizes a tension between the state’s rights and parents’ rights in the context of religion, but fails to recognize the rights of a child. Consider the following vaccination hypothetical within the context of *Prince*. The State of A is authorizing child autonomy when it comes to vaccination. A child may choose to take a vaccine or not. However, the parents of the child are saying no to the vaccination. This poses a conflict between the competing interests of the state, the child, and the parents. The state can try to override parental control by arguing for a compelling state interest (child health and safety) and applying strict scrutiny. However, the parents will most likely have the superior argument because of the longstanding common law belief that they control the medical decisions over their children. The state may not have a sufficient compelling interest in a child’s health regarding vaccination if the “best interests” standard is applied.³¹ Parents typically have a stronger “best interests” argument since they tend to live with their children under one household roof; it is safe to say that the state does not have this same familial relationship with the child. From this hypothetical, one can see that the child was given a glimpse of autonomy from State A in having a choice over vaccination, but ultimately, the decision defaulted to the parents.

The issue of parental control comes into question in other aspects of the medical field as well. One very common issue deals with blood transfusions and opposition from Jehovah’s Witnesses.³² Jehovah’s Witness parents can

²⁵ *Id.* at 401, 403.

²⁶ See generally *Pierce v. Soc’y of Sisters*, 268 U.S. 510 (1925).

²⁷ *Id.* at 534–35. See also *DeShaney v. Winnebago Cty. Dep’t Soc. Servs.*, 489 U.S. 189, 195–97 (1989) (emphasizing the importance of a parent’s right to privacy against the intrusion of the state).

²⁸ *Prince v. Mass.*, 321 U.S. 158, 167–68 (1944).

²⁹ *Id.* at 167.

³⁰ *Id.* at 167–68.

³¹ See generally Lynne Marie Kohm, *Tracing the Foundations of the Best Interests of the Child Standard in American Jurisprudence*, 10 J.L. & FAM. STUD. 337 (2008). Regarding Connecticut state law, the best interest standard is applied to a child’s welfare, typically used in cases dealing with child custody. CONN. GEN. STAT. § 46(b)–56 (2023) (as amended by 2022 Supplement).

³² Competent adults who identify as Jehovah’s Witnesses have been recognized by courts to be able to properly deny blood transfusions based on their religious beliefs. See generally Application of

deny receiving life-saving blood for themselves as part of their religious beliefs, but they do not have the authority to deny life-saving blood transfusions to their children—the hospital will administer blood to children regardless of their religious beliefs, because the minor child has no rights in this situation.³³ One noteworthy constitutional case dealing with vaccination and citizen’s rights is *Jacobson v. Commonwealth of Massachusetts*.³⁴ The court held that the Commonwealth of Massachusetts was legally allowed to require and enforce *all* of its residents to receive free vaccination from smallpox—including minor children.³⁵ The city’s compelling interest consisted of maintaining the public health and safety of its residents by minimizing the spread of the disease.³⁶ The court in *Jacobson* also shows deference to physicians, allowing doctors to be the ultimate decision-makers if certain children are “unfit subjects for vaccination,” and thus exempting these children from the vaccination mandate.³⁷

All of these cases have one thing in common: children’s rights are often pushed aside, whereas the main controversy presented is the state’s policing power versus the parents’ autonomy. Historically, courts have failed to acknowledge the rights of children in many different areas dealing with health and safety, education, and privacy. However, little by little, courts have shown a greater deference to young adults’ and minors’ autonomy over the years. For example, the passage of the Twenty-Sixth Amendment of the Constitution granted eighteen-year-olds the right to vote (lowering the previous age requirement from twenty-one), giving these young adults the freedom of choice.³⁸ In addition, the U.S. Supreme Court has shown deference to minors in health care by extending a minor’s right to privacy to obtain contraceptives or terminate a pregnancy.³⁹ However, in light of the global state of emergency triggered by the onset of the Covid-19 pandemic, authoritarian political behavior took effect, even in well-established liberal democracies (i.e., the United States).⁴⁰ Authoritarianism, although with hopes to centralize power and mobilize the masses, produced negative socio-

President & Dirs. of Geo. Coll., Inc., 331 F.2d 1000 (D.C. Cir. Feb. 3, 1964); *Pub. Health Tr. v. Wons*, 541 So. 2d 96, (Fla. Mar. 16, 1989).

³³ See generally Application of President & Dirs. of Geo. Coll., Inc., 331 F.2d 1000 (D.C. Cir. Feb. 3, 1964).

³⁴ See generally *Jacobson v. of Mass.*, 197 U.S. 11 (1905).

³⁵ *Id.* at 38–39.

³⁶ *Id.* at 35.

³⁷ *Id.* at 12.

³⁸ U.S. CONST. amend. XXVI, § 1.

³⁹ *Carey v. Population Servs. Int’l*, 431 U.S. 678, 678, 694, 696 (1977); *Planned Parenthood v. Danforth*, 428 U.S. 52, 75 (1976) (ruling that parents do not have an absolute veto over a minor’s decision to have an abortion). See also, Heather Boonstra & Elizabeth Nash, *Minors and the Right to Consent to Health Care*, THE GUTTMACHER REP. ON PUB. POL’Y 4, 5 (2000) (explaining that the U.S. Supreme Court helped expand minor’s authority over health care by extending the constitutional right to privacy to include a minor’s decision to obtain contraceptives or end a pregnancy).

⁴⁰ Stephen Thomson & Eric C. Ip, *COVID-19 Emergency Measures and the Impending Authoritarian Pandemic*, 7 J. L. & THE BIOSCIENCES 1, 5 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7543595/>.

political effects: specifically, the “overrid[ing] of civil liberties and fundamental freedoms, [and the] failure to engage in properly deliberative and transparent decision-making.”⁴¹ The Covid-19 pandemic led to the establishment of travel bans, business interruptions, social distancing, and national lockdowns.⁴² Once again, the main conflict of state versus parental authority comes into play when dealing with these disruptions of day-to-day life, with a very limited focus on the constrained power of minor children during this time of chaos. If a minor’s rights to medical decision-making were not already constrained as is, the Covid-19 pandemic further limited child and adolescent autonomy. Overall, this state of emergency prompted federal governments around the world to impose many restrictions and harsh guidelines in response to fear of the unknown—limiting individuals, and further constricting minors, from medical decision-making.

C. Connecticut Legislation Upholds Common Law View

Despite some advances in minor autonomy across the nation, the state of Connecticut upholds the common law doctrine that minors, under the age of eighteen, must defer medical consent to their parents.⁴³ Connecticut’s medical legislation presents a few exceptions where parental consent is not required. For example, in the health areas of “abortion, HIV [or] AIDS, STD testing and treatment, treatment of drug or alcohol abuse, hospitalization for mental disorder, and outpatient mental health treatment,”⁴⁴ minors have the capacity to make informed decisions regarding their own sexual lives and dealing with substance abuse or mental health treatment.⁴⁵ This is because these particular aspects of health are seen as more personal and sensitive topics in comparison to that of an annual health check-up, for example. Additionally, if a minor is emancipated (usually around sixteen or seventeen years of age⁴⁶), the minor has the capacity to make her own informed medical decisions⁴⁷ since she is acting independently of her parents in all aspects of life. A minor who has given birth to a child has the autonomy to provide medical consent for that child.⁴⁸ Finally, if an emergency presents undue delay of obtaining parental consent that endangers the minor’s life, this too is an exception to the common law rule, because such parental

⁴¹ *Id.* at 4.

⁴² *Id.*

⁴³ CENTER FOR CHILDREN’S ADVOCACY: MEDICAL-LEGAL PARTNERSHIP PROJECT, ADOLESCENT HEALTH CARE: LEGAL RIGHTS OF TEENS, 8 (5th ed., 2016) [hereinafter ADOLESCENT HEALTH CARE].

⁴⁴ *Id.*

⁴⁵ CONN. GEN. STAT. § 19a–582 (2021).

⁴⁶ *Minors and Consent to Treatment*, WOMEN’S HEALTH CONN. 1, 3 <https://www.womenshealthct.com/media/5afpkm1n/whtr-rights-of-minors.pdf>.

⁴⁷ CONN. GEN. STAT. § 46b–150d (2019).

⁴⁸ Notice here how the minor has the authority to provide consent for his or her minor child, but the Connecticut statute is quiet regarding giving these minors the autonomy to make their own medical decisions. CONN. GEN. STAT. § 19a–285 (2023).

permission is implied by law.⁴⁹ This handful of exceptions creates a patchwork of Connecticut's health regulations.

Putting Connecticut's practice in context, in the year 2000, a health report demonstrated that all fifty states and the District of Columbia agreed that minors may explicitly consent to any STD or HIV services.⁵⁰ However, that report found that only sixteen states allowed adolescents to consent to "general medical care"—including vaccination—without parental consent.⁵¹ Connecticut—along with the majority of other states—does not allow "general medical care" consent for minors.⁵² Today, not much has changed. According to the Centers for Disease Control and Prevention ("CDC"), only twelve states have upheld provisions that give adolescents the right to consent to "general health care services or procedures, not specific to a disease or condition."⁵³ Connecticut law currently allows an individual to consent to STD treatment, HIV testing and treatment, and HIV prophylaxis.⁵⁴ However, it is clear that the "age of majority," or the age of legal decision-making, is eighteen in Connecticut.⁵⁵ Furthermore, there is no authorization for a minor in Connecticut to consent to general health care treatment, like a vaccination, that is not specific to a disease.⁵⁶ In conclusion, minors in Connecticut can partake in their own medical decisions for certain high-stakes health issues, like substance abuse and mental health. However, all other lower stakes medical decisions, like annual physician appointments, treatments, and vaccinations, require parental consent.

II. MATURE MINOR DOCTRINE

A. Background Information

Applicable and recognized throughout most of the United States, the mature minor doctrine is another exception to the common law rule of

⁴⁹ ADOLESCENT HEALTH CARE, *supra* note 43, at 8.

⁵⁰ Boonstra & Nash, *supra* note 39, at 6.

⁵¹ Brian Dean Abramson, *Do U.S. Teens Have the Right to Be Vaccinated Against Their Parents' Will? It Depends on Where They Live*, THE CONVERSATION (Aug. 31, 2021), <https://theconversation.com/do-us-teens-have-the-right-to-be-vaccinated-against-their-parents-will-it-depends-on-where-they-live-166147>.

⁵² *Id.*

⁵³ *State Laws That Enable a Minor to Provide Informed Consent to Receive HIV and STD Services*, CENTERS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/hiv/policies/law/states/minors.html> (last updated Oct. 25, 2022) (demonstrating how all fifty states enforce laws that allow a minor to consent for STD treatment, and about eighteen states allowing a minor's consent to HIV testing, but fewer states allow for minor consent to general healthcare treatment).

⁵⁴ *Id.*

⁵⁵ *Id.* Connecticut law is very stringent with the age of majority for medical decisions, whereas states like California, Delaware, New Jersey, and New York allow minors as young as twelve years old to make certain medical decisions.

⁵⁶ *Id.* The twelve states that currently allow for a minor's consent to general health care treatment, irrespective of a particular disease or condition, are Alabama, Alaska, Arkansas, Idaho, Kansas, Louisiana, Mississippi, Nevada, Oregon, Pennsylvania, Rhode Island, and South Carolina.

parental consent for a minor’s medical decisions. By definition, the mature minor doctrine allows a minor “who is sufficiently intelligent and mature to understand the nature and consequences of a proposed treatment to consent to medical treatment without consulting his or her parents or obtaining their permission.”⁵⁷ Only a few states, like Arkansas and Oregon, have enacted the mature minor doctrine into statute.⁵⁸ Some other states, like Massachusetts, Maine, Pennsylvania, Tennessee, and Illinois, have implemented the doctrine as law.⁵⁹ Throughout the United States, the mature minor doctrine has been consistently applied to minors of sixteen years of age and older, concerning non-life threatening medical procedures.⁶⁰ Despite its common application across the nation, the mature minor doctrine has yet to establish firm roots in Connecticut legislation with its vaccination efforts.

B. *Factors to Consider*

One of the main controversies when dealing with the mature minor doctrine is figuring out the threshold level for “maturity” and which actors are best suited to make this judgment call. Ultimately, a series of factors, such as the minor’s age, medical situation, and level of intelligence and understanding helps demonstrate maturity levels.⁶¹ Furthermore, a trial judge’s discretion, along with the ruling from a jury, will determine a minor’s appropriate maturity level.⁶² There is an assumption that many adolescents, regardless of gender or upbringing, will not have a fully-developed adult brain until the age of eighteen.⁶³ However, in recent years, studies have been performed showing a close resemblance of adolescent cognitive abilities to that of adult abilities.⁶⁴ One psychologist of developmental research even noted that “adolescents and adults are equally able to identify possible consequences of risky behavior,” such as “substance use, alcohol use, unprotected sexual activity . . . [and can] assess the consequences similarly.”⁶⁵ Additionally, the Piagetian Cognitive Development Theory has also explored adolescent capacity in light of

⁵⁷ Boonstra & Nash, *supra* note 39, at 4.

⁵⁸ See, e.g., ARK. CODE ANN. § 20-9-602(7) (2019); OR. REV. STAT. ANN. § 109.640 (West 2023).

⁵⁹ See, e.g., MASS. GEN. LAW ANN. ch. 112, § 12F (West 2022); ME. REV. STAT. ANN. tit. 22, § 1503 (West 2019); 35 PA. STAT. AND CONS. STAT. § 10104 (West 2023); 410 ILL. COMP. STAT. 210 / 1.5 (2023).

⁶⁰ *The Mature Minor Doctrine*, U.S. LEGAL <https://healthcare.uslegal.com/treatment-of-minors/the-mature-minor-doctrine/> (last visited Mar. 12, 2023).

⁶¹ *Id.*

⁶² Slonina, *supra* note 21, at 184.

⁶³ *Id.* at 183 (demonstrating how most laws will allow eighteen-year-olds to fight in war, but prohibit them from drinking alcohol, implying that these individuals are not fully developed according to societal standards).

⁶⁴ A test group of ninety-six subjects, divided by age, revealed that fourteen-year-old adolescents were “fairly competent” with choosing medical treatment options, alongside eighteen and twenty-one-year-olds. *Id.* at 196–97.

⁶⁵ *Id.* at 197.

medical decisions.⁶⁶ Under this theory, articulated by researcher Jean Piaget, there are four levels of cognitive development that an individual experiences.⁶⁷ The final stage of development occurs between the ages of eleven and fifteen where a child can envision, predict, and hypothesize consequences from a situation or assess alternative results.⁶⁸ According to the Piagetian Theory, children by the age of fifteen possess a mature state of thinking, in which “adult thought exists within the child’s repertoire of mental functions” (internal citations omitted).⁶⁹ Such case studies and theories illustrate that adolescents as early as fourteen years of age have a capacity to make mature medical decisions.⁷⁰ Therefore, Connecticut courts should utilize these studies to help create an objective standard of maturity when analyzing the mature minor doctrine.

C. *In Re Cassandra*

One of the very few times a Connecticut court mentions the mature minor doctrine is in a Connecticut Supreme Court case, *In re Cassandra*.⁷¹ Cassandra was a sixteen-year-old girl diagnosed with Hodgkin’s lymphoma, a cancer that is treatable but can be fatal if left untreated.⁷² Cassandra’s mother continually refused to have her daughter undergo chemotherapy treatment, despite doctors’ recommendations.⁷³ Doctors were obligated to abide by the mother’s wishes because Connecticut upholds the common law rule of parental consent over minor children. Ultimately, the court analyzed the mature minor doctrine, but found the doctrine inapplicable because Cassandra had not proven the maturity and competence required to make her own medical decisions.⁷⁴

In re Cassandra is the main example demonstrating how Connecticut courts have dabbled with the mature minor doctrine, but it has yet to work itself into a form of precedent. The *In re Cassandra* case is unique to the medical field: Cassandra was dealing with a progressive form of cancer, making her situation one of life or death. The current issue with the mature minor doctrine, especially in Connecticut, is that its application is inconsistent. This doctrine has been interpreted in different ways “when applied to life-threatening illnesses, as opposed to illnesses that are not serious.”⁷⁵ The mature minor doctrine should not be confined solely to these

⁶⁶ *Id.* at 194.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *See id.* at 197 (noting that adolescents over age fourteen identify more benefits and risks of medical treatments and can better understand treatment outcomes).

⁷¹ *See generally, In re Cassandra C.*, 316 Conn. 476 (2015).

⁷² *Id.* at 482.

⁷³ *Id.*

⁷⁴ *Id.* at 500–02.

⁷⁵ Slonina, *supra* note 21, at 190.

heightened health situations. In fact, high-stress situations, like having cancer, may affect a minor's ability (let alone an adult's ability) to make competent decisions, therefore making the mature minor doctrine difficult to rule on. Mature minors should be able to have some sort of opinion regarding their own high-stakes medical situations, but since the emotional stakes are so high, other opinions should also be factored in as well—opinions from medical experts, parents and other family members, or even the court itself. Additionally, the mature minor doctrine should be expanded to include more routine procedures, like vaccinations, for example. The application of the mature minor doctrine to routine procedures is more realistic and practical for minors to make effective decisions; no high-stake illnesses or risky medical procedures will be clouding a minor's judgment. The choice to receive the Covid-19 vaccine does not typically fall into a category of life-saving medical care, which may be better for minors to decide on. This expansion of the mature minor doctrine to include routine procedures and vaccinations can help minors achieve some form of personal autonomy, without completely discarding the boundaries of medical decision-making.

III. AMENDING CURRENT LEGISLATION

A. *Expanding the Mature Minor Doctrine to Vaccination*

Vaccination is one form of medical treatment that should fall within the mature minor doctrine for several reasons. First, it is a scientifically supported and often generally administered procedure that will prevent individuals from facing potentially adverse symptoms of illness. Second, schools and employers may require adolescents to get vaccinated to participate in social activities. Overall, minors (if deemed mature and competent under the mature minor doctrine) should have the final say on whether they would like to get vaccinated from certain illnesses, especially Covid-19, which can affect daily living.

Vaccinations are known to be a preventative measure. Generally, vaccination is not a life-or-death issue for minors, however it can be depending on the strain of a virus or the underlying health of the child. Accordingly, minors' competence and maturity levels will not waver as much since it is not in response to a high-stress medical condition. Psychologists and other medical scholars have also sided with an adolescent's choice to be vaccinated, despite legal setbacks.⁷⁶ One psychologist, Gregory D. Zimet, explains that adolescents (around 14 years old and even younger) are developmentally capable at balancing the risks of a vaccine in comparison to adults.⁷⁷ By expanding the applicability of the

⁷⁶ Hoffman, *supra* note 5.

⁷⁷ *Id.*

doctrine to cover more non-serious illnesses, courts can apply a clear standard based on reasonable expectations, and therefore, decide on difficult cases in a more consistent manner.

B. *Covid-19 and Vaccine Hesitancy*

Following the emotional stir of the Covid-19 pandemic, vaccination continues to be a big topic of discussion across the news and media. The CDC recommends that children as young as six months old receive either the Pfizer or Moderna Covid-19 vaccine.⁷⁸ Not only is the Covid-19 vaccine recommended for adolescents, but the CDC also encourages teenagers to receive routine immunization from other potential illnesses, like Hepatitis A and B, Rubella, Poliovirus, Influenza, Meningococcal disease, and HPV.⁷⁹ Adolescent vaccination is important to mitigate the spread of contagious diseases and to create “herd immunity” in society.⁸⁰

Despite the push from health care providers and agencies to get vaccinated, adolescents in the U.S. present a very low vaccination rate compared to other age groups.⁸¹ Furthermore, a survey from 2021 disclosed that three in ten parents would choose to get their adolescent child vaccinated from Covid-19 immediately, while twenty-six percent of adults showed hesitancy, “eighteen percent said they would do so only if a child’s school required it,” and twenty-three percent opposed the vaccination for their children entirely.⁸²

In a staggering number of cases, adolescents across the U.S. are looking to get the Covid-19 vaccine, but vaccination becomes difficult when their legal guardians, and sometimes even the law, are not on their side.⁸³ “Vaccine hesitancy” is a term that is often used throughout Covid-19 surveys, but this phenomenon had existed prior to the Covid pandemic,

⁷⁸ *CDC Recommends COVID-19 Vaccines for Young Children*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/media/releases/2022/s0618-children-vaccine.html> (last visited Oct. 11, 2023).

⁷⁹ Noel T. Brewer et al., *Increasing Vaccination: Putting Psychological Science into Action*, 18 *ASS’N FOR PSYCH. SCI.*, 149, 153 (2017); see also, *Vaccines in the Child and Adolescent Immunization Schedule*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-indications.html#addendum-child> (last visited Oct. 11, 2023); *Addendum – Child and Adolescent Recommended Immunization Schedule for Ages 18 Years or Younger, United States, 2023*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-indications.html#addendum-child> (last visited Oct. 11, 2023).

⁸⁰ Fengming Pan et al., *Parents’ Decisions to Vaccinate Children Against COVID-19: A Scoping Review*, 9 *VACCINES* 1, 2 (2021).

⁸¹ Susanna McGrew & Holly A. Taylor, *Adolescents, Parents, and Covid-19 Vaccination — Who Should Decide?*, 386 *NEW ENG. J. MED.*, art. no. e2(1) (2022).

⁸² The Soc’y for Adolescent Health and Med., *Adolescent Consent for Vaccination: A Position Paper of the Society for Adolescent Health and Medicine*, 53 *J. ADOLESCENT HEALTH* 550, 551 (2013).

⁸³ Jan Hoffman, *Poll Shows Parents Are Reluctant to Get Their Children Vaccinated for Covid-19*, *N.Y. TIMES* (July 13, 2021), <https://www.nytimes.com/2021/05/06/health/vaccine-children.html>.

applying to other illness outbreaks.⁸⁴ Many underlying factors play into vaccine hesitancy, including: level of education, annual household income, race and ethnicity, political affiliation, insurance, and overall access to resources based on demographics.⁸⁵ Studies have revealed that minority groups have had more adverse and devastating health effects from the Covid-19 pandemic due to their socio-economic status and difficulty escaping such economic hardship.⁸⁶ Lower socio-economic status is correlated with a greater concern to get the Covid-19 vaccine.⁸⁷ Furthermore, studies confirm that there is a “strong correlation between parental hesitation to get a Covid-19 vaccine for themselves and for their child.”⁸⁸ From one sample size of 1,425 Americans, lower-income Black parents were reported to have one of highest vaccine hesitancy rates for themselves and for their children, due to the pandemic’s “disproportionate negative impact . . . on Black communities . . . throughout the United States.”⁸⁹

Another very common reason explaining vaccine hesitancy among Americans is that the Covid-19 vaccines were developed and administered within a short time frame, thus proffering safety concerns and possible side effects.⁹⁰ Camille, a Connecticut registered nurse, and mother of three boys, refuses vaccinations for herself and her children because of this safety concern.⁹¹ Despite seeing rising mortality rates among Covid patients, as

⁸⁴ A Connecticut-based survey from 2011 showed parental vaccine hesitancy towards “influenza, measles-mumps-rubella, rotavirus, and varicella” vaccines for their children. Susan Leib et al., *Pediatricians’ Experience with and Response to Parental Vaccine Safety Concerns and Vaccine Refusals: A Survey of Connecticut Pediatricians*, 126 PUB. HEALTH REPS. 13, 16 (2011).

⁸⁵ See Peter G. Szilagyi et al., *Parents’ Intentions and Perceptions About COVID-19 Vaccination for Their Children: Results From a National Survey*, 148 PEDIATRICS 1, 3 (2021) (demonstrating how Democratic parents were more supportive of children vaccination efforts, compared to other political affiliations); Nina L. Alfieri et al., *Parental COVID-19 Vaccine Hesitancy for Children: Vulnerability in an Urban Hotspot*, 21 BMC PUB. HEALTH 1, 2 (2021) (indicating that vaccine hesitancy has been observed in racial/ethnic minorities and those with lower socioeconomic status). See also Fengming Pan et al., *supra* note 80, at 9 (“Participants with more children, USA republican party voters, Black, Asian and minority ethnic [groups], uninsured families, parents with abnormal mental states, and living with high-risk family members were negative factors influencing parents’ decision to vaccinate their children.”) (footnotes omitted).

⁸⁶ Vaccine hesitancy studies reveal that “Black and Hispanic communities experienc[ed] an increased burden of hospitalizations and deaths compared to White counterparts.” Additionally, lower-income urban cities suffered greater detriment than suburban households from the onset of the pandemic. Alfieri et al., *supra* note 85, at 1.

⁸⁷ *Id.* at 7.

⁸⁸ Jeanette B. Ruiz & Robert A. Bell, *Parental COVID-19 Vaccine Hesitancy in the United States*, 137 PUB. HEALTH REPS. 1162, 1167 (2022).

⁸⁹ Alfieri et al., *supra* note 85, at 6.

⁹⁰ See Ruiz & Bell, *supra* note 88, at 1167 (“[P]articipants who identified as Black [or] Asian . . . were almost 3 times more likely than non-Hispanic White parents to reject a COVID-19 vaccine for themselves and their children, citing safety and efficacy concerns about the seemingly quick vaccine development.”). See also Peter G. Szilagyi et al., *supra* note 85, at 4 (parents expressing concern over their children’s well-being from possible vaccine side effects and lasting symptoms). See generally, Susan Leib et al., *supra* note 84, at 14 (arguing pediatricians increasingly find themselves at odds with parents who challenge the safety of vaccines).

⁹¹ Darren Kramer, *Faces of the Unvaccinated: Local Nurse Explains Her Reasoning for Not Getting*

well as her sixteen-year-old son wanting to be Covid-vaccinated, Camille is still adamant in her belief: “I [just feel] everything was rushed. I don’t feel there is enough evidence to make an educated decision on if the vaccine is safe and effective.”⁹²

Parents, as well as children, easily fall into the trap of relying on conspiracy theories, common health myths, or social media to protect themselves from the dangers of vaccination.⁹³ Such sources may seem compelling, but they often lack in medical expertise and can even be misleading. For example, Lee Stonum lost his seventeen-year-old daughter, Kennedy, to Covid-19.⁹⁴ Kennedy had no underlying health issues, but still refused the Covid-19 vaccine despite her parents being strong advocates for it.⁹⁵ As a result of his daughter’s tragic death, Lee Stonum hopes that people rely on proven scientific studies rather than social media platforms and posts, like YouTube and TikTok,⁹⁶ which are “not always the most accurate sources.”⁹⁷ Even though Kennedy Stonum made a decision to deny the vaccine, she was not properly informed by a health care provider, thus skewing her decision. If the mature minor doctrine had applied to this situation, Kennedy may have been deemed competent by a court to make her own medical decision, since the general standard evaluates an adolescent’s *capability* of understanding the procedure. Kennedy would have likely been able to deny the vaccine because she could convince the court that she was mature enough for her own vaccination decision. However, in this instance, there was an issue of *misinformation*, not capability; “[s]he didn’t know enough about the vaccine.”⁹⁸ This is one downside to the mature minor doctrine (as will be elaborated more in *infra* Part III Section C): the doctrine only evaluates the *ability* to understand, and not *actual* understanding. It would be useful if Connecticut uses a mature minor standard evaluating actual understanding of vaccination procedures and risks because it would help combat this misinformation problem.

Vaccinated, Not Letting Children Get COVID-19 Vaccine, WTNH NEWS (Nov. 16, 2021, 1:29 PM), <https://www.wtnh.com/news/faces-of-the-unvaccinated/faces-of-the-unvaccinated-local-nurse-explains-her-reasoning-for-not-getting-vaccinated-not-letting-children-get-covid-19-vaccine/>.

⁹² *Id.*

⁹³ See *COVID-19 Vaccines: Myth Versus Fact*, JOHN HOPKINS MED. (Mar. 10, 2022), <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/covid-19-vaccines-myth-versus-fact> (explaining popular myths involving the Covid-19 vaccine).

⁹⁴ *Father Of Local 17-Year-Old Who Died from COVID Warns Others About Risks of Not Getting Vaccinated*, KCAL NEWS (Feb. 11, 2022, 6:25 PM), <https://www.cbsnews.com/losangeles/news/father-of-local-17-year-old-who-died-from-covid-warns-parents-about-risks-of-not-getting-vaccinated/>.

⁹⁵ This is an interesting case because it shows the less common situation of when a parent advocates for the vaccine, but the minor child opposes. *Id.*; see also Bernard J. Wolfson, *Parents Mourn Teens Who Refused to Get COVID Vaccine*, TAMPA BAY TIMES (Mar. 13, 2022), <https://www.tampabay.com/news/health/2022/03/09/parents-mourn-teens-who-refused-to-get-covid-vaccine/> (contrasting Kennedy Stonum with another young adult who refused to get the Covid-19 vaccinations despite their parent’s wishes).

⁹⁶ KCAL NEWS, *supra* note 94.

⁹⁷ Wolfson, *supra* note 95.

⁹⁸ KCAL NEWS, *supra* note 94.

Misinformation with COVID-19 (as mentioned earlier) is very common among all ages. Adults may be misinformed about vaccination, yet they are nonetheless afforded the autonomy to decide whether to get COVID vaccinated. However, minors are different than adults in this respect. Minors may not have the same access to resources as adults may have with researching and being properly informed. Also, minors can be more easily influenced than adults can be (due to their developing brains), so that is why it is important to have a standard that will protect their best interests and prevent misinformation. Therefore, in Connecticut, the mature minor standard should apply to an adolescent with actual understanding. Kennedy lacked actual understanding, so if this new mature minor standard was applied, she would have likely been ordered to get the Covid-19 vaccine pursuant to common law parental consent, possibly giving her better immunity against the virus. If Kennedy was properly informed by a physician and she understood the risks and benefits of the vaccine in connection to her underlying illness, (showing actual understanding), and still denied the vaccination, under this new mature minor standard, the court would need to comply.

Accordingly, an informed understanding is necessary for minors to properly accept or reject vaccination, absent parental consent. There is an array of easily accessible resources to help educate parents and children about Covid-19 and its vaccination procedures. First and foremost, primary care doctors have expertise and proper knowledge about the Covid-19 vaccines and will be more than willing to weigh the vaccine's benefits and risks, all tailored to that patient's health history. Informed consent and recommendations by primary care providers have statistically been shown to have a "substantial impact on vaccine receipt."⁹⁹ Physicians can reduce vaccine hesitancy several different ways, while still being engaging and informative, like with storytelling, or offering positive stories through personal experience.¹⁰⁰ Medical agencies and organizations, like Health and Human Services (HHS), World Health Organization (WHO), U.S. Food and Drug Administration, the Advisory Committee on Immunization Practice, and the Center for Disease Control and Prevention (CDC), all provide educational resources to emphasize transparency during the pandemic.¹⁰¹ The CDC is currently developing a "Vaccinate with Confidence" strategy, which provides healthcare workers with tips on educating the public about general vaccination efforts.¹⁰² A recently trending website has drawn the attention of teenagers who are more curious about Covid vaccination. "VaxTeen" is a popular website where adolescents can ask for advice on

⁹⁹ See Jeanette B. Ruiz & Robert A. Bell, *Parental COVID-19 Vaccine Hesitancy in the United States*, 137 PUB. HEALTH REPS. 1162, 1168 (2022) (discussing the influence of primary care physicians' opinions on patient's vaccination decision-making); see also Peter G. Szilagyi, *supra* note 85, at 9.

¹⁰⁰ Szilagyi, *supra* note 85, at 9.

¹⁰¹ *Id.*

¹⁰² Alfieri et al., *supra* note 85, at 5–6.

how to deal with parental opposition, while also providing helpful information on state consent laws, information about the Covid-19 pandemic, and information about clinics administering the vaccine.¹⁰³ A second website, “Teens for Vaccines,” provides teenagers with answers to frequently asked questions about the Covid-19 vaccine, as well as a section addressing parental opposition and how to relieve this tension.¹⁰⁴ Overall, physician expertise and medically-certified internet sources are good tools for teenagers and their parents to use so they can be better informed about national vaccination efforts.

C. Drawbacks to the Mature Minor Doctrine in Connecticut

Although the mature minor doctrine, if applied in Connecticut, will give minors more medical autonomy, one must also acknowledge its drawbacks to see if it truly will be a good fit for the state. One possible drawback is that even if Connecticut adopts the doctrine as statute or law, many minors may not be properly informed enough to make their own medical decisions. To counter this problem, Connecticut should apply a different requirement to the mature minor doctrine: the state’s courts should evaluate an adolescent’s actual understanding of the medical procedure at issue, instead of merely looking at capability of the individual to understand. Capacity is important if it includes both the mental ability to use the brain, but also the ability to understand information to make an informed decision. Additionally, one must also acknowledge the risks that maybe the dynamic is flipped where a parent wants his or her child to be vaccinated, but the child may not want to become vaccinated.¹⁰⁵ If a minor can properly demonstrate his or her understanding of a vaccine’s purpose, and provides adequate reasoning weighing risks and benefits of the vaccine, the court should allow the minor to deny a vaccine based on the legitimate reason offered, pursuant to using the mature minor doctrine. This may not sit entirely well with parents, despite their child being properly informed of the possible results of non-vaccination. Another conflict is that even if minors have the right to exercise their own medical judgment, they may be unable to make their own decisions due to financial constraints.¹⁰⁶ Certain forms of medical treatment require out-of-pocket payments, or even insurance coverage¹⁰⁷—such payments require children to turn to their parents to cover, thereby

¹⁰³ Hoffman, *supra* note 5; see also Lois M. Collins, *What Happens When Teens Want the COVID-19 Vaccine and Parents Say No?*, DESERET NEWS (Sept. 9, 2021, 4:22 PM) <https://www.deseret.com/2021/9/9/22664684/what-happens-when-teens-want-the-covid-19-vaccine-and-parents-say-no-mature-minor-health-decisions> (discussing the resources provided on VaxTeen.org and its founding).

¹⁰⁴ Collins, *supra* note 103.

¹⁰⁵ The conflict between Kennedy and her father is a prime example of the associated risks when such roles are flipped. KCAL NEWS, *supra* note 94.

¹⁰⁶ ROGER J.R. LEVESQUE, *Mature Minor Doctrine*, in ENCYCLOPEDIA OF ADOLESCENCE 1660 (2014).

¹⁰⁷ *Id.*

demonstrating the fact that children still depend on their parents in the medical field. However, currently, the Covid-19 vaccine and subsequent boosters are administered free of charge in Connecticut—an individual does not need to pay out-of-pocket, and insurance coverage is not required.¹⁰⁸ This free vaccine administration in Connecticut thus lessens the burden minors have to face with dependence on parents for medical treatment.

Another possible drawback would be the need to re-evaluate the physician's role in considering this doctrine. By evaluating whether a child properly understands the risks associated with vaccination, and is properly informed, a family physician can step in the shoes of the parent, and can determine what is best for the child, based on the child's understanding. Critics may say that the current tension between balancing the interests of the parent, child, and the state is now further complicated by introducing a new interest of the physician. Again, Connecticut parents may not be too thrilled if a family doctor presents an opinion that is directly averse to the parents' wishes.

Finally, there would be a lot of unaddressed answers regarding the efficiency of Connecticut courts if the mature minor doctrine is implicated into statute. Procedurally, the courts will need to assess whether the family physician can be given the first legal right in a court proceeding over these types of cases. This should be acceptable, as long as the aggrieved party can still make their case to the judge. But then the court will need some sort of mechanism to determine whether injunctions will be allowed, and what the parents' follow-up rights are after this initial claim. Also, there could be concerns that mature minor cases can be very burdensome on Connecticut courts. The courts can easily become filled with frivolous and redundant cases whenever a child is in disagreements with a parent over a vaccination or other medical decision. Some mechanism, here too, needs to be put in place to ensure court efficiency and expediency, while also deterring frivolous cases from backing up court proceedings. The Connecticut legislature and the courts must consider these possible drawbacks before making a final decision on whether the mature minor doctrine would be best utilized as state law or statute. To counter some of these added tensions and possible backlash from parents, counselling and social work can be beneficial for the family. Additionally, proper education and access to resources can help parents and children be on the same page with medical decision-making. Finally, experts in the medical field can also be used to weigh competing interests and provide objective medical advice to ease tension. Overall, there are some drawbacks to the mature minor doctrine, like the possible stressors relating to family disagreement. However, with proper educational tools and access to resources, parents and children can

¹⁰⁸ *COVID-19 2023 Update – Ending of the Public Health Emergency*, CT.GOV, (June 30, 2023) <https://portal.ct.gov/DPH/Communications/Health-Topics/COVID-19-2023-Update---Ending-of-the-Public-Health-Emergency>.

work through their disagreements and be on the same page with medical decision-making, thereby maintaining the importance of the nuclear family.

D. *Current and Pending Legislation of Covid-19 Vaccination of Minors*

Currently, there are a few states that allow the mature minor doctrine to apply to vaccination. The Society for Adolescent Health and Medicine urges states to develop legal strategies for “allowing minor adolescents with capacity for informed consent to give their own consent for vaccinations.”¹⁰⁹ As mentioned earlier in the Article, most states give adolescents the autonomy to make medical decisions regarding contraception and sexually transmitted infections.¹¹⁰ It can be argued that these medical concerns are “more complex and fraught than getting a vaccine.”¹¹¹ Yet forty states require a parent to consent to a child’s vaccination under eighteen years of age,¹¹² Connecticut being one of these states, but hopefully not for much longer. Because of the large national stir from the Covid-19 pandemic, some places, like the District of Columbia, Minnesota, New Jersey, New York, and Connecticut, have current or pending legislation allowing minors to consent to vaccines without parental consent.¹¹³ New York is currently reviewing Senate Bill S4244C, which would allow minor children at least fourteen years old to receive certain vaccinations required by the state, regardless of parental consent.¹¹⁴ A bill is also pending in the state of New Jersey, mirroring the language of New York’s proposal, and setting a similar age requirement of fourteen years of age.¹¹⁵ The New Jersey bill is applicable to the following vaccinations: “poliomyelitis, mumps, measles, diphtheria, rubella, varicella, Haemophilus influenza type b (Hib), pertussis, tetanus, pneumococcal disease, meningococcal disease, human papillomavirus (HPV), or hepatitis B”—this bill does not cover vaccination for Covid-19.¹¹⁶ While some of these states seem to be going in the right direction, other state legislation, like in South Carolina, Oregon, Tennessee, and Alabama, raises a series of ethical issues regarding parental consent and minor autonomy.¹¹⁷

The State of Connecticut is currently reviewing a bill that, if passed, would give minors of at least twelve years of age the authority to consent to vaccinations without parental consent.¹¹⁸ This bill, although it is a step in the right direction of increasing a minor’s autonomy in medical decision-

¹⁰⁹ The Society for Adolescent Health and Medicine, *Adolescent Consent for Vaccination: A Position Paper of the Society for Adolescent Health and Medicine*, 53 J. ADOLESCENT HEALTH 550, 552 (2013).

¹¹⁰ See *supra* Section I.A. See also Hoffman, *supra* note 5.

¹¹¹ Hoffman, *supra* note 5; see also *supra* Section III.A.

¹¹² Hoffman, *supra* note 5.

¹¹³ *Id.*

¹¹⁴ S. 4244C, 2019–2020 Leg., Reg. Sess. (N.Y. 2019).

¹¹⁵ S. A5144, 5144 219th Gen Assemb., 2020–2021 Reg. Sess. (N.J. 2020).

¹¹⁶ *Id.*

¹¹⁷ Hoffman, *supra* note 5.

¹¹⁸ H.B. 5480, Gen. Assemb., 2023 Reg. Sess. (Conn. 2023).

making, may bring up concerns as well. Many Connecticut parents are worried that twelve-year-old children will not have sufficient “mental capacity” for making immunization decisions.¹¹⁹ If Connecticut was to amend this proposal to include the mature minor doctrine, then parents’ concerns may be relieved to some extent. The mature minor doctrine is a way to give children more autonomy in their medical decisions, but courts would evaluate the adolescent and make the final determination. Physicians understand how truly complicated health regulations can be, and they are aware of many of the symptoms and side effects of a vaccine in pre-teens and young adults. Thus, under the mature minor doctrine, a physician can evaluate a minor’s maturity to consent, and the court will ultimately be the deciding factor to either allow a minor to consent or defer to parental wishes. Currently, the Connecticut bill does not place any restrictions on pre-teens when dealing with informed medical consent, but it would be useful to include an extra precaution of meeting the mature minor doctrine. This way, the child’s well-being will be protected, while simultaneously giving the child the freedom to choose, without conceding one value over the other.

CONCLUSION

The mature minor doctrine is largely absent from Connecticut law, but it would be beneficial for the state to adopt it into statute and directly apply it to vaccinations. Adolescents, if they have the capacity to be informed and understand vaccinations, should be able to make the determinations for themselves whether they want to accept a vaccine or not. The vaccine directly affects the child’s body, not the parent’s, so the child should at least have some say in the medical decision. Medical autonomy for minors is an important concept, but also a difficult one to balance considering competing interests from parents and the state. These tensions between different interests resurface and become more conflicting than ever when looking at medical decision-making today in light of the Covid-19 pandemic. By looking at the success rates of other states, future Connecticut legislation can use these implications from the doctrine to help frame their own medical standards for minors. However, the mature minor doctrine also poses some possible drawbacks: threatening the parent-child relationship and affecting the efficiency of courts. Overall, Connecticut should consider the mature minor doctrine to help combat vaccination hesitancy among parents, provide greater medical autonomy to minors, and help increase vaccination efforts nationwide, but still proceed with caution, and try to tailor the mature minor doctrine in a way that will best be suited for the state and its Connecticut residents.

¹¹⁹ Rob Polansky et al., *Bill Proposes Allowing 12-Year-Olds to Get Vaccines Without Parental Consent*, WFSB NEWS (Jan. 17, 2023, 12:58 PM), <https://www.wfsb.com/2023/01/17/bill-proposes-allowing-12-year-olds-get-vaccines-without-parental-consent/>.