The HPV Vaccine and a Minor’s Right to Consent to Medical Treatment

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Human papilloma virus (“HPV”) is a group of DNA viruses that infect the skin and mucous membranes. There are over one hundred different types of HPV, more than thirty of which are sexually transmitted. HPV is one of the most commonly transmitted sexual infections in the United States; approximately twenty million people are currently infected with the virus and approximately 6.2 million Americans acquire a new infection every year. Fifty percent of sexually active men and women are infected with the virus at some point in their lives and by the age of fifty at least eighty percent of women will have acquired the virus. HPV causes genital warts and virtually all cases of cervical cancer, the second leading cancer killer of women worldwide and in the United States. Each year, approximately 10,000 women are diagnosed with cervical cancer and over 3700 women die from the disease.

I. Introduction

The introduction of the new HPV vaccine has caused a great deal of controversy. In June 2006, the Advisory Committee on Immunization Practices unanimously voted to recommend that girls between the ages of eleven and twelve receive the Gardasil vaccination. Gardasil is the first vaccine developed to prevent cervical cancer, pre-cancerous genital lesions, and genital warts caused by certain strands of HPV. The Food and Drug Administration (“FDA”) has approved the vaccine for use in females ages nine through twenty-six. The vaccine is recombinant; it contains no live virus and is administered through three separate injections over a six-month period.

The vaccine has proven to be almost one-hundred percent effective in preventing infections and diseases associated with HPV, and it is expected to prevent most cases of cervical cancer caused by HPV strands 6, 11, 16, and 18. The vaccine is strongly supported by the medical field in large part because of its near perfect effectiveness in preventing precancerous cervical lesions linked to the indicated HPV strands. Strong medical support for the vaccine has been fostered by the view that HPV is an extremely serious women’s health issue. The severity of the health issue indicates the need for a strong and immediate effort to maximize the use of the vaccine by any means possible, including government mandates. New studies have also found Gardasil to be much more effective in a female if given before she becomes sexually active. These studies clearly support the movement to vaccinate girls as young as eleven years old.

However, significant debate still exists around the use of the HPV vaccine and the possibility and appropriateness of mandating the vaccine. This Article will explore various issues surrounding the HPV vaccine with a focus on minors’ rights to either consent to, or opt out of, this and other similar medical treatments. Part I will explore the status of HPV vaccine legislation around the country, with a focus on current Illinois legislation. Part II will examine the medical decisions a minor can make under Illinois statutory exceptions. Part III will explain the medical treatment implications of the common law Mature Minor doctrine. Part IV will look at the legal effect that pregnancy and “parenting” have on a minor’s right to consent to medical treatment in Illinois. Part V will explore the consent-related issues regarding vaccinations. Part VI will discuss the relationship between mandatory vaccinations and informed consent requirements. Finally, Part VII will examine the arguments for and against the HPV vaccine.

II. Status of HPV Vaccine Legislation

Vaccination requirements are decided primarily by state legislatures. Some states have given regulatory bodies, such as the state’s health department, the power to require vaccines, but these states still require the state legislature to provide funding to carry out these requirements. Illinois currently has three pieces of legislation pending and once piece of legislation that the Illinois legislature recently passed relating to HPV vaccination issues. Illinois House Bill 0115 would create an awareness campaign on HPV and cervical cancer, provide parents with information, and require the vaccine for girls entering sixth grade, unless parents choose to exempt their daughters. As of May 25, 2007, House Bill 0115 was being reviewed by the Rules Committee and had not been passed into law. Illinois Senate Bill 0010 would require the HPV vaccination for girls ages eleven to twelve, but allows parents to opt-out. This
legislation would also require each school to track the number of immunized children attending the school.\textsuperscript{23} As of December 3, 2007, Senate Bill 0010 was referred to the Rules committee.\textsuperscript{24} Illinois House Bill 2033 would require the Illinois Department of Health to provide and promote information on the HPV vaccine.\textsuperscript{25} House Bill 2033 passed in the House on April 3, 2003.\textsuperscript{26} As of May 16, 2007, House Bill 2033 was being reviewed by the Rules Committee in the Senate.\textsuperscript{27}

On August 24, 2007 Illinois Senate Bill 0937 passed.\textsuperscript{28} It was signed into law, creating Public Act 095-0422.\textsuperscript{29} Public Act 095-0422 requires insurance companies to provide coverage for the HPV vaccine.\textsuperscript{30} It also requires the Illinois Department of Health to cover vaccination costs for girls under age eighteen that are not covered by an insurance provider.\textsuperscript{31}

Nationally, as of December 2007, at least forty-one states and the District of Columbia had introduced some form of legislation relating to the HPV vaccination.\textsuperscript{32} Virginia passed legislation to mandate the HPV Vaccine for school aged girls.\textsuperscript{33} In March 2007, Virginia passed a law that requires girls entering sixth grade to receive the HPV vaccine.\textsuperscript{34} Virginia’s governor returned the bill to the legislature with an amendment that allows parents certain exemption rights.\textsuperscript{35} The Virginia legislature approved this amendment and the governor signed the amended bill.\textsuperscript{36} Virginia became the first state to enact a school requirement for the HPV vaccine.\textsuperscript{37} In February 2007, Texas Governor Rick Perry bypassed the state legislature and instituted an executive order requiring the vaccine for all girls ages eleven through twelve entering the sixth grade.\textsuperscript{38} However, there was strong opposition to the order both from the public and other state officials.\textsuperscript{39} Two months later, the Texas House of Representatives, in a 135-2 vote, passed a senate bill barring mandatory HPV vaccinations until at least 2011.\textsuperscript{40} Many state officials and Texas residents believed Governor Perry had abused his executive authority in ordering a vaccination supported by relatively inconclusive research.\textsuperscript{41}

As states began to introduce HPV vaccination legislation, various groups voiced concerns about mandating the vaccination.\textsuperscript{42} The vaccine is supported by arguably limited efficacy and safety data since trials have involved small patient populations and a limited follow-up period.\textsuperscript{43} Many people believe that, before mandating the use of the vaccine, the long term effectiveness and safety of the vaccine should be tested among a larger population of younger girls, especially since the efficacy of the vaccine has not been thoroughly evaluated for girls between the ages of nine through fifteen.\textsuperscript{44} To date, most studies of the HPV vaccine have been limited to a five-year follow-up period.\textsuperscript{45} There are also concerns that early immunization may not be particularly effective because the vaccine may wear off before the person becomes sexually active and more susceptible to the virus.\textsuperscript{46} A final concern relates to the cost of the vaccine. At $360 for the three-part injection series, the HPV vaccination is one of the most expensive vaccinations on the market.\textsuperscript{47} Multiple cost-effectiveness studies have had variable results.\textsuperscript{48} However, even those persons who currently oppose mandating the vaccine appear to support a systematic approach to HPV prevention utilizing voluntary measures, with state compulsion being viewed as a last resort.\textsuperscript{49}

In accordance with this approach, many states have passed legislation aimed at increasing awareness of HPV and the benefits of vaccination. For example, Indiana requires that parents of girls entering sixth grade receive information about the link between HPV and cervical cancer, and the availability of the vaccine.\textsuperscript{50} Parents must then sign a statement notifying the school of their decision on whether or not to vaccinate their child.\textsuperscript{51} New York recently passed a bill allocating five million dollars to promote the HPV vaccine.\textsuperscript{52} The state of Washington will provide every parent of sixth grade girls with information on HPV, as well as locations where the vaccine is available.\textsuperscript{53}

### III. Medical Decisions a Minor Can Make Under Illinois Statutory Exceptions

The HPV vaccine is recommended for girls ages nine through twenty-six.\textsuperscript{54} As a result, an important issue related to the HPV vaccination is what rights a minor has to receive the vaccine without the consent of her parents. A minor’s right to opt out of HPV vaccination is also relevant if more states begin to mandate the vaccine. This Part explores what rights a minor has under Illinois law to either receive or opt out of other medical treatments.

In Illinois, a minor is defined as a person who is under eighteen years of age.\textsuperscript{55} Generally, a minor child may not receive medical treatment without the consent of a parent. However, Illinois law allows adolescents under the age of eighteen to make independent medical decisions in certain situations.\textsuperscript{56} If a minor wants to make a medical decision that falls into a statutorily defined exception, the minor may do so without parental knowledge or consent.\textsuperscript{57} If there is no statutory exception, an adolescent may still be able to make a medical decision under the Mature Minor doctrine.\textsuperscript{58}
Illinois statutory exceptions to parental consent rules revolve around nine different situations: (1) emergency treatment; (2) emancipation; (3) birth control; (4) pregnancy or marriage; (5) abortion; (6) treatment for venereal diseases or substance abuse; (7) treatment for a victim of sexual abuse or assault; (8) mental health treatment; and (9) blood donation.\(^{59}\)

1. Emergency Treatment
A minor of any age may receive emergency medical treatment without parental consent.\(^{60}\) The Illinois Consent by Minors to Medical Procedures Act provides that a minor may receive treatment without parental consent if, in the opinion of the treating physician, dentist, or hospital, it would not be reasonably feasible to obtain consent.\(^{61}\) In making this decision, the health care provider must consider the circumstances and determine whether trying to obtain consent would adversely affect the minor’s health.\(^{62}\)

2. Emancipation
If a minor is determined to be emancipated under the common law Mature Minor doctrine, he or she may make all medical decisions independent of his or her parents.\(^{63}\) A minor may gain the same medical independence under the Illinois Emancipation of Minors Act.\(^{64}\)

3. Birth Control
Under the Illinois Birth Control to Minors Act, a physician may provide a minor with birth control and information on contraceptives if: (1) the minor is married; (2) the minor is a parent; (3) the minor is pregnant; (4) the minor has the consent of a parent or guardian; (5) the failure to provide these services would create a serious health hazard; or (6) the minor is referred by a physician, a member of the clergy, or a Planned Parenthood agency.\(^{65}\)

4. Pregnancy or Marriage
According to the Consent by Minors to Medical Procedures Act, a minor who is married, pregnant, or a parent may consent to her own medical treatment.\(^{66}\) A minor parent may also consent to, or refuse, medical treatment for his or her own child.\(^{67}\)

5. Abortion
The pregnant minor exception to medical treatment, governed by the Consent by Minors to Medical Procedures Act, also applies to a minor seeking an abortion, since there are no special prohibitions on abortion for minors in Illinois.\(^{68}\) At one time there were parental consent, notice, and waiting period requirements enacted by the Illinois legislature but, except for the notice requirement, these requirements were either repealed, or determined to be unconstitutional.\(^{69}\) Applying the Minors Consent to Medical Treatment Act, a minor can consent to any medical treatment while pregnant, including an abortion, without consent of a parent or guardian.\(^{70}\)

6. Treatment for Venereal Diseases and Substance Abuse
A minor who is twelve years of age or older and may have come into contact with a venereal disease may consent to the treatment and counseling related to this diagnosis.\(^{71}\) In addition, this exception applies to a minor who is an addict, an alcoholic, or an intoxicated person.\(^{72}\) Minors age twelve and over may also receive counseling related to the drug or alcohol abuse of a family member without consent.\(^{73}\) While parental consent is not necessary in these situations, a professional health care provider must nonetheless attempt to involve the family of the minor in his or her treatment if the provider believes that the involvement of the family would not be detrimental to the care and progress of the minor.\(^{74}\)

7. Treatment for Victim of Sexual Assault or Abuse
Under Illinois law, a health care provider may provide medical care or counseling related to the diagnosis or treatment of any disease or injury resulting from sexual assault or abuse, without the consent of a parent or legal guardian.\(^{75}\) This statute applies to minors who are victims of the following crimes: (1) aggravated criminal sexual assault; (2) criminal sexual assault; (3) aggravated criminal sexual abuse; or (4) criminal sexual abuse. In the above contexts affected minors may consent to treatment, including counseling, as if they have already reached the age of majority.\(^{76}\)

8. Mental Health Treatment
The Illinois Mental Health Code allows minors to receive mental health treatment without the consent of a parent or guardian in two different contexts.\(^{77}\) The first context is outpatient counseling or psychotherapy.\(^{78}\) Minors over the age of twelve may consent to and receive these services on an outpatient basis without the consent of a parent or guardian.\(^{79}\) The parent or guardian will not be informed of this treatment without consent by the minor, unless the facility director feels it necessary to notify the parent or guardian, and then the minor will be informed of
such disclosure. There is no limit on how much treatment a minor seventeen years of age or older may receive. Children ages twelve to sixteen may receive up to five forty-five minute sessions without parental consent or knowledge.

The second context in which a minor may be treated without parental consent is when he or she wishes to be admitted to a mental health facility as an inpatient. A minor sixteen years and older may consent to admission. However, upon admission, the minor’s parent or guardian must immediately be informed of the situation. If a minor is admitted under these conditions, he or she will be treated the same as an adult under the admission, transfer, and discharge procedures described in the Mental Health Code. Alternatively, a minor may be admitted to a mental health facility if his or her parent or guardian consents, and if the facility director determines that the minor may benefit from inpatient treatment.

9. Blood Donation

Under Illinois law, a minor who is seventeen years of age or older may donate blood without the consent of a parent or guardian. A minor sixteen years of age may donate blood, but only if his or her parent or guardian provides written consent.

III. A Minor’s Eligibility to Make His or Her Own Medical Decisions

If a minor demonstrates the same level of competency as an adult then it logically follows that the minor should be able to make medical decisions as if he or she were an adult. A minor may be able to get permission from a court to make medical decisions if the minor is considered mature enough to act independently in this area. In Illinois there are two approaches that allow for independent and responsible minors to make their own medical decisions: (1) the common law Mature Minor doctrine, and (2) the Emancipation of a Mature Minor Act.

1. Common Law Mature Minor Doctrine

The Mature Minor doctrine originated under common law. At common law, minors who understood the nature and consequences of medical decisions were deemed competent enough to make these decisions on their own. Therefore, while a minor’s situation may not fall into one of a state’s statutorily defined exceptions, the Mature Minor doctrine may apply.

2. Factors Courts Consider in Deciding Whether an Adolescent is a Mature Minor

While the Mature Minor doctrine is part of common law, its application varies from state to state. However, there are typically four factors that courts will look at to determine if a minor falls under this doctrine. These factors are: (A) age; (B) degree of maturity; (C) the quality or nature of the medical intervention; and (D) whether or not the parent or guardian agrees with the minor’s decision.

A. Age of the Minor

Typically a court will not find an adolescent to be a mature minor unless he or she has reached the age of fourteen. Some courts have recognized the “Rule of Sevens.” The Rule of Sevens is a guideline for predicting a minor’s capacity for decision-making. This child development theory says that children under the age of seven have no capacity, minors between the ages of seven and fourteen have a rebuttable presumption of no capacity, and minors between fourteen and twenty-one have a rebuttable presumption of capacity. While there is no single theory of competence, modern developmental psychologists have found that children over the age of fourteen often develop a competency level similar to that of an adult. Courts may use these findings or the Rule of Sevens to support a presumption that a teenager over the age of fourteen has the capacity to give informed consent for medical treatment.

B. Minor’s Maturity Level

Even if a court employs the Rule of Sevens, it will still look to other factors to determine whether the adolescent is a mature minor. One factor the court will look to is the degree of maturity possessed by the child. Courts across the country have different perspectives on what constitutes ‘maturity.’ In this regard, a court may require that the minor has his or her own convictions, that he or she is able to understand the possible benefits of the medical treatment versus the risks, or that generally the minor is old enough to appreciate the consequences of his or her own actions. The current standard in Illinois is that there must be clear and convincing evidence that the minor has the decision-making abilities of an adult before a minor is allowed to consent to medical treatment.
C. Type of Medical Treatment

Another factor courts may consider in deciding if a minor is capable of making a medical decision is the level of complexity involved in the medical procedure or treatment. For instance, courts outside of Illinois have determined that minors may consent to cosmetic surgery, tonsillectomy, and treatment for back pain. A Mississippi case decided in 1928 determined that minors seventeen years of age or older had the ability to consent to vaccinations. While none of these cases are controlling in Illinois, they demonstrate the principle that courts will be more open to allowing minors to make medical decisions in noncomplex cases. Because the complexity of the treatment may be taken into consideration, it is possible that a minor may be deemed competent to make some medical decisions and incompetent to make others. For example, Illinois is one state that allows for a limited guardian to be appointed if an adult is competent to make some, but not all, decisions independently. This same idea may be applied to the Mature Minor doctrine, although there is currently little case law available on this comparison. In addition, judges may take into account the nature of the treatment or vaccine and consider this as a factor when deciding whether a minor’s consent for medical treatment should be legally recognized. For instance, because the HPV vaccine is a three part vaccine, consideration should be given to the fact that a minor may turn eighteen before the treatment is completed. The minor would then have the right to refuse the completion of the vaccine, thereby reducing its effectiveness. Therefore, this factor may weigh in when deciding if the minor’s consent should be required prior to administering the vaccine.

D. Agreement with the Parent or Guardian for Major Medical Decisions

Although the Mature Minor doctrine allows a minor to consent to or refuse treatment, a court will still examine the wishes of the minor’s parent or guardian. Typically, the more important a decision, the more the court will weigh the interest of third parties, such as family members, against the interest of the minor in making that decision. For instance, the Illinois Supreme Court commented that its decision in In re E.G., which is discussed in detail immediately below, may have been different if the parents had disagreed with E.G.’s decision.

3. What is Illinois’ Approach to the Mature Minor Doctrine?

Illinois adopted the common law mature minor approach in In re E.G. In this case, the minor, seventeen-year-old E.G., was diagnosed with leukemia. The only treatment available was blood transfusions. E.G. was a devout Jehovah’s Witness and this treatment constituted a violation of her faith. Several witnesses testified regarding E.G.’s high maturity level and the authenticity of her religious beliefs. The Illinois Supreme Court considered all of the other statutory exceptions that allow minors to make medical decisions. Based on this examination, the Illinois Supreme Court found that the legislature did not intend to create a complete bar to adolescent independent decision-making. The Illinois Supreme Court stated, “If the evidence is clear and convincing that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent to or refuse treatment.”

However, this right is not absolute. As the court noted in an earlier case, In re Estate of Longeway, the right to consent to or refuse treatment must be balanced against four important state interests. These state interests are: (1) the preservation of life; (2) protecting the interests of third parties; (3) prevention of suicide; and (4) maintaining the ethical integrity of the medical profession. The Illinois Supreme Court recognized that the most important interest in the E.G. case was that of third parties—including E.G.’s parents, siblings, and other family members. In this case, E.G.’s mother agreed with her decision. However, in cases where a parent or guardian opposes a minor’s medical decisions, this opposition will weigh heavily against the minor’s right to make that decision.

4. Emancipation Requirements under the Illinois Emancipation of a Mature Minor Act

Under the Illinois Emancipation of Minors Act, a person who is sixteen years or older may be emancipated. A court may emancipate a minor if three factors are present. First, the minor must be of sound mind. Second, the minor must have the capacity and maturity to manage his or her own affairs, including finances. Finally, emancipation must be in the best interest of the minor and the minor’s family. A court may decide to emancipate a minor to give him or her all the rights of an adult, or it may ‘partially emancipate’ a minor, restricting his or her rights and responsibilities.
emancipation statute allows for minors to specifically seek a court’s permission to consent to, or refuse, medical treatment when his or her parent or legal guardian objects.  

IV. Effect of Pregnancy on a Minor’s Right to Consent to Medical Treatment

A minor parent’s right to consent to medical treatment after pregnancy, including the use of the HPV vaccine, is significant considering how many minors become pregnant and give birth in Illinois each year.  
Pregnancy or parental status is another factor that may affect a minor’s ability to consent to, or refuse, medical treatment. Illinois’ approach to the rights of pregnant minors and minors who are parents dictates that some of these minors will be allowed to make their own medical decisions.  

Many states, including Illinois, have made a movement towards allowing minors greater rights to make medical decisions relating to their own pregnancy, including the right to decide what medical treatments they receive while pregnant and the right to decide whether or not to terminate a pregnancy.  

Most relevant, however, is Illinois’ new statutory amendment that allows a minor who is a parent to make all of his or her own medical decisions.  

This statutory amendment will affect a minor female parent’s right to receive or opt out of the HPV vaccine, as well as all other medical treatments.

In some states, including Illinois, a pregnant minor is allowed to make independent medical decisions.  

According to the Consent by Minors to Medical Procedures Act, a pregnant woman who is a minor possesses the right to consent to the performance of a medical or surgical procedure.  
The Illinois Supreme Court affirmed this doctrine in the case In re E.G.  

The court noted that the Illinois legislature has given minors the legal capacity to consent to certain medical treatments in particular situations and “an individual under 18 who is married or pregnant may validly consent to treatment.”  

In conjunction with the Emancipation of Mature Minors Act, the Consent by Minors Act indicates, “the legislature did not intend that there be an absolute 18-year-old age barrier prohibiting minors from consenting to medical treatment.”  

A minor’s right to consent to medical treatment has been found to include a minor’s decision to terminate pregnancy.  

Following the United States Supreme Court’s finding in Roe v. Wade that an abortion is permissible for any reason until the point of viability, the question arose as to what role, if any, a minor’s parent should play in a decision to abort if the pregnant female is a minor.  
Currently, the answer varies from state to state with the vast majority of states requiring some form of parental involvement.  

In Illinois, a minor can receive an abortion without parental consent.  
However, pursuant to the Illinois Parental Notice of Abortion Act of 1995, a practitioner who plans to perform an abortion on an un-emancipated minor must provide forty-eight hours advance notice to an adult family member.  
A minor may apply for a waiver from this notification.  
Waiver will be granted if the minor can prove by the preponderance of the evidence that she is sufficiently mature to make an independent decision to abort.  
Alternatively, waiver will also be granted if the minor can show by a preponderance of the evidence that notification would not be in her best interest.

Although a pregnant minor retains the right to make medical decisions throughout her pregnancy, there is the question of the extent to which, if at all, that right continues following the birth of her child.  
Until recently, an unmarried minor mother in Illinois did not retain the right to consent to her own health care following the pregnancy.  
In most states, this is still the case.  
Furthermore, the right to consent to medical treatment during pregnancy is limited to those medical and/or surgical treatments “related to the pregnancy.”  
States that follow this standard have had difficulty determining what constitutes medical treatment “related to pregnancy.”  
For example, it is clear under such a standard that while a minor pregnant woman may consent to a cesarean section, she may not consent to an appendectomy.  
What is less clear is what a pregnant minor may or may not consent to when the treatment or procedure is merely affected by the pregnancy.  
May the minor consent to a medical procedure to cure an illness that has been exacerbated by her pregnancy?  
Many courts in states operating under these guidelines have been forced to operate on a case-by-case basis, evaluating the surrounding circumstances of each situation in making a determination.

Illinois has avoided these incongruities. Current Illinois law grants “pregnant and parenting teens the right to consent not just to their child’s medical care, but to their own medical care as well, whether or not it is related to the pregnancy.”  
This decision is codified in 410 ILCS 210/1 and states:  
Consent by minor. The consent to the performance of a medical or surgical procedure by a physician licensed to practice medicine and surgery, an advanced practice nurse who has a written collaborative agreement with a
collaborating physician that authorizes provision of services for minors, or a physician assistant who has been delegated authority to provide services for minors executed by a married person who is a minor, by a parent who is a minor, by a pregnant woman who is a minor, or by any person 18 years of age or older, is not voidable because of such minority, and, for such purpose, a married person who is a minor, a parent who is a minor, a pregnant woman who is a minor, or any person 18 years of age or older, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person of legal age.\textsuperscript{160}

However, despite the specificity of this statute, legal questions still arise if the minor parent is not currently parenting or if the minor parent and/or the child are ward(s) of the state.

In Illinois, under a 1994 Consent Decree from *Hill v. Erickson*,\textsuperscript{161} a ward has the right to assume and retain custody of her child.\textsuperscript{162} The 1994 Consent Decree protects parenting wards from arbitrary or retaliatory removal of their children, as well as threats of removal.\textsuperscript{163} However, when the minor parent and/or her child are/is a ward of the state, certain questions arise. In Illinois, where the minor parent retains custody of the child, she retains the right to consent to medical decisions relating to herself and her child.\textsuperscript{164} If the child has been removed from the home, the state obtains the right to consent to medical decisions for the child.\textsuperscript{165} However, Illinois courts have not decided whether, after a child is removed from the home, a minor birth mother retains the right to consent to her own medical treatment.

Prior to the enactment of the Consent by Minors to Medical Procedures Act, Section 1, enacted in 2004, a minor parent did not retain the right to consent to medical treatment following pregnancy. As a result, the above issue never presented itself. However, with the Consent by Minors to Medical Procedures Act now in effect, the question of who qualifies as a “parent” and whether or not one loses that status if she loses parental rights may need to be decided. Some would argue that the statutory language implies a requirement that the minor be “pregnant or parenting,” while others would argue that the role of a parent is an interminable role acquired at the time one gives birth. Black’s Law Dictionary defines a parent as “the lawful father or mother of someone” and indicates that “a person ceases to be a legal parent if that person’s status as a parent has been terminated in a legal proceeding.”\textsuperscript{166} While there are no supporting judicial decisions, this definition suggests that a minor whose parental rights have been terminated is no longer considered a parent for purposes of the Consent by Minors to Medical Procedures Act. In situations where custody of a child has been taken, but parental rights have not been terminated, certain factors should be taken into consideration in determining parental status.

First, a mother’s age as well as background information pertaining to her maturity, responsibility, and accountability may point to the probability that the mother will parent the child in the future. Likewise, the current permanency goal of the child is indicative of whether or not the mother will retain parental status. For example, in the case of a birth mother who is only months away from majority, has consistently proven to be responsible, has unsupervised visits with her child, and whose child’s current permanency goal is a return home, it would seem counter-intuitive to strip that parent of her right to consent to her own medical treatment. It flows logically that a minor who has been granted such rights, even by way of pregnancy, should not lose those rights upon giving birth. On the other hand, a minor who is extremely young, is not responsible for herself, and is not on a path to reunification with her child should not “have the same powers and obligations as a person of legal age.”\textsuperscript{167} Until there is legal precedent to guide it, a court must look at each case individually and determine from both a logical and practical standpoint whether the mother whose child has been taken still qualifies as a “parent.”

This issue may present itself to the courts in the near future. Nationally more than one million American teenagers become pregnant each year.\textsuperscript{168} This is one of the highest pregnancy rates of any western industrialized county.\textsuperscript{169} One in eight women ages fifteen to nineteen will become pregnant each year.\textsuperscript{170} Illinois has a particularly high number of teen parents.\textsuperscript{171} Illinois ranks eighteenth out of all the states for teen birth rates.\textsuperscript{172} The Illinois annual teen birth rate is sixty babies per 1000 teens.\textsuperscript{173} This rate is considerably higher than the national average of 56.8 babies per 1000 teens.\textsuperscript{174} In 2000, 21,108 babies were born to teens in Illinois.\textsuperscript{175} The Consent by Minors to Medical Procedures Act will make it possible for at least a great majority of these teen parents to make their own medical decisions. Therefore, many of these female minors will be able to decide whether or not they will receive the HPV vaccine.

**V. Consent Necessary for Vaccinations**

**I. Consent for Non-Mandatory Vaccines**

Currently, the HPV vaccine is not mandatory in Illinois. However, proposed Illinois legislation would
make the HPV vaccine required for girls ages eleven and twelve. If the vaccine is not made mandatory, then a mature minor or emancipated minor may make the decision to either consent to or refuse the vaccine. These minors can make this decision just as they can make any other medical decision. However, if the legislation passes, mandating the HPV vaccine, a number of new legal issues will arise.

2. Consent for Mandatory Vaccines

A. History

The concept of mandated vaccines dates back to *Jacobson v. Massachusetts*, which was decided in 1905. In response to concerns about smallpox, the Board of Health in Cambridge, Massachusetts adopted mandated vaccinations. An adult man refused to be vaccinated or to have his son vaccinated. The United States Supreme Court held that, while the smallpox vaccination was controversial, the state’s police power allows it to enact health related laws reflecting the dominant medical beliefs of society. At that time, the common belief was that the smallpox vaccine was effective and could improve the safety of the public.

B. Challenges to Mandatory Vaccinations

Mandatory vaccinations have been legally challenged on three grounds: (1) on their inconsistency with the constitutional principles of individual liberty and due process; (2) as an unwarranted governmental interference with individual sovereignty; and (3) as an infringement on the religious freedoms granted by the First Amendment. Since 1905, when *Jacobson v. Massachusetts* was decided by the Supreme Court, all challenges to the general application of mandatory vaccinations laws have failed. While a person may still object on an individual basis, mandatory vaccination laws are extremely difficult to challenge because they are based on the local governments’ police power to protect public health.

C. Current Views on Mandatory Vaccinations

Today, state school mandatory vaccinations are widely thought to serve an important health purpose. There is evidence that shows that incidents of communicable diseases have decreased since school vaccinations were mandated. If the HPV vaccination becomes mandatory in Illinois, absent an exception, each female of a specified age will simply be expected to receive the vaccine. While a minor who is able to consent to or refuse treatment may object to receiving a mandatory vaccine, their objection must fall into one of three recognized categories for challenging mandatory vaccination programs.

D. Exceptions to Mandatory Vaccinations

Most states have statutorily defined exceptions to mandated vaccinations. There are three exceptions: (1) the medical exception; (2) the religious exception; and (3) the philosophical exception. Every state has a medical exception. Under the medical exception, if a physician certifies that a vaccine might be harmful to a particular individual, he or she is exempt from receiving the vaccine. Religious exemptions are available in forty-seven states. Some statutes require that a person disclose their religion, while others just require a general religious objection. In the early 1990s, twenty-two states had some form of a philosophical exception which a parent or a minor who is able to consent could use if they have a non-religious reason to object to the vaccination. However, after encouragement from the Centers for Disease Control & Prevention (“CDC”), many states did away with this exception.

E. Illinois Statutory Regulations on Mandatory Vaccinations

Illinois has created an Immunization Advisory Committee (“Committee”), whose members are appointed by the Director of Public Health (“Director”). The Committee is made up of various doctors and public officials and its purpose is to advise the Director on immunization issues. There is also pending legislation in Illinois that directly relates to mandatory vaccinations. This pending legislation would allow the Department of Public Health to order that a vaccine be administered in order to prevent the probable spread of a dangerous or infectious disease. Each individual would receive written notice of the following with respect to any mandatory vaccination program: (1) that the individual may refuse to receive the vaccine; (2) that if the individual refuses to receive the vaccines, the individual may be subject to isolation or quarantine either on their own consent or by an order of the court; and (3) that, if the individual refuses to receive the vaccine and is subject to isolation or quarantine, he or she is entitled to counsel on this issue. The proposed legislation notes that the Department of Public Health shall “respect and accommodate the religious beliefs of individuals in implementing this subsection.”

Currently Virginia is the only state that has a mandatory requirement for the HPV vaccine. However, as other states consider mandating the vaccine, issues of consent and opting out of the
vaccine will become of greater national importance. Further, although most states plan to include provisions that allow a parent or a “mature minor” the ability to consent to, or refuse, the HPV vaccine, the availability and application of these rights is likely to continue to vary substantially from state to state.

VI. Informed Consent & Mandatory Vaccines

An additional concern arises when a minor is allowed to make her own medical decisions. This concern is informed consent. In order for an individual of any age to receive medical treatment, he or she must first give informed consent.204 The components of informed consent are substantially similar in all fifty states.205 The components of informed consent are: (1) disclosure; (2) comprehension; (3) voluntariness; (4) competence; and (5) consent.206 Consent occurs when “one gives an informed consent to an intervention if and only if one receives a thorough disclosure about it, one comprehends the disclosure, one acts voluntarily, one is competent to act, and one consents to the intervention.”207 Specifically, in Brown v. Murphy,208 the Illinois courts defined informed consent as “consent given by a competent person after that person has received fair and reasonable explanation of contemplated treatment or procedure.”209 Illinois statutory law defines “written informed consent” as:

an agreement in writing . . . which entails at least the following: (1) a fair explanation of the test . . . ; (2) a fair explanation of the procedures to be followed including the voluntary nature of the test; the right to withdraw consent to the testing process at any time . . . .210

When a patient is a minor a parent or guardian must typically give consent prior to the treatment.211 Interestingly enough, however, “[n]o court in recent history has found any health care provider liable for treating a minor more than fifteen years old without parental consent, where the minor consented to his own care.”212

1. Informed Consent and Vaccines

There has been much attention paid to the issue of informed consent in medical practice, yet far less in regards to how the doctrine of informed consent relates to vaccinations in general.213 Many argue that where informed consent would typically be required, “state legislatures have negated informed consent for vaccines by enactment of compulsory vaccination laws.”214 The CDC has taken certain measures in an attempt to alleviate concerns about the lack of informed consent requirements for mandatory vaccinations. First, the CDC publishes a vaccine information report that contains information about the dangers of the disease and the benefit of the vaccine.215 As required by law, these information sheets must be given to all parents to read, evaluate, and understand before a vaccine is given.216 Additionally, an information insert, written and distributed by vaccine manufacturers, is inserted in vaccine packages and states the benefits and risks associated with each vaccine.217 Many people argue that, while information is available, disclosed, and distributed, the average parent is not able to take that information, evaluate it, and make an informed decision.218 This seems to indicate that minors, some of whom would typically be able to consent to medical treatment, may not fully understand the risks and benefits associated with the HPV vaccine. For example, while the standard CDC vaccine information package is available to anyone, it contains very complex and difficult language and many parents do not read it.219 Also, some opponents of the vaccine argue that much of the available information about the HPV vaccine diminishes the seriousness of the vaccine’s medical risks by stating it in complicated and misleading terms.220

2. Arguments For and Against Mandatory Vaccinations

In 1994, Dave Benor, senior attorney for the U.S. Department of Health and Human Services, commented on the concern that mandatory vaccinations circumvent the informed consent requirement.221 He stated “there is no opportunity for informed consent, given that state law at federal urging requires that they [children] take these vaccines.”222 This public health argument is often used in support of mandatory vaccinations, despite the fact that mandatory vaccines do not comply with informed consent standards.223 Many health organizations, including the CDC, the American Medical Association, the American Academy of Pediatrics, the Advisory Commission on Immunization Practices, and the National Vaccine Advisory Committee, maintain that vaccines are both valuable to individuals and essential to the protection of the public.224 This argument is based on the following assumption: the more children that are vaccinated, the more children are protected from a particular disease, including children who are vaccinated but experience a vaccine failure. This argument is also based on the assumption that when nearly everyone is vaccinated, those who are medically incapable of receiving the vaccine are shielded.225
In short, mandatory vaccines are often justified based on the premise that the needs of the many outweigh the rights of an individual to make an informed medical decision for herself. However, this rationale seems to be significantly less compelling in the context of mandating the HPV vaccine, as HPV is not transmitted through non-sexual contact. Notwithstanding this fact, in 2007, twenty-four states and Washington, D.C. introduced legislation that would mandate the HPV vaccine for school-aged girls. If this type of legislation passes in various states, it could effectively bar the need to obtain informed consent from parents, or from minors who are able to make their own medical decisions, with respect to the HPV vaccine.

VII. Public Health Arguments For and Against the HPV Vaccine

In many states proposed legislation relating to the HPV vaccine has led to heated debate. Further complicating these debates is the fact that Gardasil, unlike many other required school vaccines, protects against a disease that is transmitted primarily through sexual contact. While other vaccinations present solely medical questions, the HPV vaccine raises issues of moral and behavioral values as well.

1. Arguments in Favor of HPV Vaccination

The public health argument for the HPV vaccine is similar to the argument in favor of any other vaccination. Proponents argue that: (1) the vaccine has been medically tested and is safe; and (2) vaccination can protect the public from future HPV infections and the subsequent cancer risks that may accompany the virus.

A. Medical Findings in Support of the Vaccine

HPV vaccination proponents point to the recent studies that show that Gardisil reduces the incidence of HPV infections and pre-cancerous lesions by ninety to 100% in young women between the ages of sixteen and twenty-three. Additionally, there is evidence that all of the 21,000 women recipients of the vaccine studied developed higher antibody responses to HPV than their non-vaccinated counterparts. Studies on younger girls, ages nine to fifteen, show that the recipients of the vaccine exhibited a greater antibody reaction to the virus than young women. These findings clearly support the movement towards seeking to vaccinate girls against the HPV virus at an early age.

B. Public Health Arguments in Support of the Vaccine

Proponents of the HPV vaccine herald it as a breakthrough in medical technology and a necessary public health mandate. Notably, Gardisil is the first vaccine that helps prevent cancer. Proponents also point to the large number of women infected with HPV every year and see the HPV vaccine as the only effective way to prevent transmission of the disease among sexually active teens and young adults. They claim that the public can benefit from the vaccine in a number of ways. The vaccine will reduce the number of HPV infections, cervical cancer occurrences, and death. Proponents claim that any health risks or moral objections are outweighed by the great good the HPV vaccine can do for the public.

2. Arguments in Opposition to HPV Vaccination

A number of groups have criticized the HPV vaccine and are fighting against making the vaccine mandatory. The HPV vaccine has mainly been criticized on three grounds: (1) lack of research on its effectiveness and safety; (2) the possibility that the HPV vaccine will increase promiscuity; and (3) the vaccine’s interference with individual and family autonomy.

A. Lack of Medical Studies on Safety and Long-Term Effectiveness of the HPV Vaccine

Opponents of the HPV vaccine note that the long-term effects of the HPV vaccine are not yet known. Opponents also argue that the current studies are not sufficient to show that the vaccine is safe. Since 1990 the Vaccine Adverse Event Reporting System (“VAERS”) has received over 123,000 reports of adverse reactions to vaccines in general. During the last six months of 2006, 385 adverse effects reports regarding the HPV vaccine were made. By February 2007, the CDC received more than 500 complaints about adverse reactions to the HPV Vaccine. Up until June 30, 2007, VAERS had received 2531 reports of potential adverse side effects following the HPV vaccine. Although none of these reactions were life-threatening, over two-thirds of the cases required additional medical care. Typical reactions include soreness at the injection site, fainting or dizziness, and fever or nausea. Although there have not been any serious adverse reactions to the HPV vaccine, there have been minor reactions and not enough studies have been completed to rule out the possibility of more damaging results.

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In addition, opponents note the lack of long-term studies and question the effectiveness of the HPV vaccine. Women who received the vaccine have only been studied for five years at the most. Some opponents suggest that there may be a need for booster doses of the vaccine, which would both lower the effectiveness for those that do not receive the booster shots and raise the overall cost of the vaccine.

B. The HPV Vaccine May Lead To Increased Sexual Behavior

Some opponents of the HPV vaccine worry that it may cause girls and young women to engage in more sexual activity. A study completed by the University of North Carolina found that one in ten parents is concerned that giving children the HPV vaccine will encourage them to have more sex. Although the same University of North Carolina study presents evidence that vaccinations do not lead to greater risk-taking behavior, many parents remain concerned.

C. Interference with Individual Autonomy

Opponents of the HPV vaccine argue that the vaccine should not be mandated because it does not prevent a disease that is transmitted through casual contact. HPV is transmitted through vaginal, anal, and oral intercourse; and in extremely rare cases, through the vaginal delivery of a child. Non-sexual contact with an infected individual, however frequent, will not result in transmission of the virus. While opponents may not have a problem with the government requiring vaccines against diseases that are easily passed through casual contact, they are opposed to mandating the HPV vaccine. They argue that because HPV is only transmitted through sexual contact, the government's police power is not great enough to justify mandating the HPV vaccination. A recent study at the University of Michigan found that only forty-four percent of parents are in favor of a school mandated HPV vaccine. Thirty percent of parents were neutral on the issue. Twenty-six percent of parents disagree with making the HPV vaccine mandatory. Opponents of the HPV vaccine are asking for the autonomy to make an informed medical decision about whether they, or their children, should receive the HPV vaccine.

VIII. Conclusion

Currently, medical research and findings on the HPV vaccination are limited and the long-term effects of the vaccine are unknown. There are currently sound arguments both for and against the vaccine's use and the wisdom and propriety of the federal or state government mandating the vaccine. However, as the vaccine is not yet mandated in Illinois, the standard rules of consent apply to a decision of a teenage girl to consent to, or refuse to receive, the HPV vaccine. Whether a minor has the ability to make this judgment for herself, in Illinois and other states without a mandatory HPV vaccination, will likely continue to be dictated by the specific circumstances of each case and how applicable state statutes bear upon and interpret those circumstances. In Illinois, absent new statutory guidance, the general law regarding a minor's right to consent to, or refuse, medical treatment will likely apply to, and govern, the HPV vaccination debate. In this context, it is important that a minor's rights to make medical decisions under applicable Illinois law and common law principles are understood and respected.

Endnotes

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2 Id.


4 CDC Fact Sheet, supra note 1.

5 Id.

6 NCSL HPV Vaccine, supra note 3.


8 Id at 1905.

9 CENTER FOR DISEASE CONTROL, HPV & HPV VACCINE—INFORMATION FOR HEALTH CARE
“intoxicated person” is a person whose mental or physical functioning is substantially impaired as a result of the current effects of alcohol or other drugs within the body. Alcoholism and Other Drug Abuse and Dependency Act, 20 ILL. COMP. STAT. 301/1-10 (2007).

72 410 ILL. COMP. STAT. 210/4.
73 Id.
74 Id.
75 410 ILL. COMP. STAT. 210/3(b) (2007).
76 Id.
84 Id.
85 Id.
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87 405 ILL. COMP. STAT. 5/3-503(a).
89 210 ILL. COMP. STAT. 15/1 (b).
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92 In re E.G., 549 N.E.2d at 325-26.
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96 Id. at 27.
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99 O’Connor, supra note 56, at 27.
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117 Id.
118 Id.
119 Id. at 324.
120 Id. at 325-26; See also infra Section III.
121 In re E.G., 549 N.E.2d at 326.
122 Id. at 327-328.
123 In re Estate of Longeway, 549 N.E.2d 292, 299 (Ill. 1989).
124 Id.
125 In re E.G., 549 N.E.2d at 328.
126 Id.
127 Id.
128 O’Connor, supra note 56, at 26.
129 750 ILL. COMP. STAT. 30/3-2 (2007).
130 O’Connor, supra note 56, at 25.
131 Id.
132 Id.
133 Id.
134 O’Connor, supra note 56, at 25; see 750 ILL. COMP. STAT. 30/5(b) (2007).
135 O’Connor, supra note 56, at 25; see 750 ILL. COMP. STAT. 30/5(a) (2007).
139 410 ILL. COMP. STAT. 210/1 (2007).
140 Id.
141 Id.
142 In re E.G., 549 N.E.2d 322, 325 (Ill. 1990).
143 Id.
144 Id. at 326.
147 Id.
148 Id.
149 See Abortion Parental Consent Act of 1977, 720 ILL. COMP. STAT. 515/1 et seq and Abortion Parental Consent Act of 1983, 750 ILL. COMP. STAT. 70/9. Both of these Acts were repealed by The Parental Notice of
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Abortion Act of 1995, 750 ILL. COMP. STAT. 70/1 et. seq., which came into effect on June 1, 1995.

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186 Hodge & Gostin, supra note 183, at 834.
187 Id.
188 See infra Section V.2.D. This section explains specific exceptions that may apply to vaccination requirements. Id.
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191 Id.
192 Id.
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194 Id.
195 Id. at 261.
196 Id.
198 Id.
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201 Id.
202 Id.
203 NCSL HPV Vaccine, supra note 3.
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225 Id. at 107.
226 Roll, supra note 42, at 421-22.
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