CLINICAL decision making

Clinical Decision-Making Case: Pediatric Sexually Transmitted Infections and Consent

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ABSTRACT:

Audience: This clinical decision-making case for the Certifying Board Exam is designed for emergency medicine residents at all training levels (PGY1 through PGY4).

Introduction: Navigating consent for pediatric patients in the emergency department (ED) presents unique ethical and legal challenges. Physicians must understand parental consent requirements and the relevant exceptions that apply in the ED. Studies indicate that residents may lack confidence or knowledge in handling complex or nuanced consent scenarios, particularly regarding adolescents.[1] We aimed to develop a structured educational intervention to address this gap. This clinical decision-making case aims to improve resident competency and comfort in managing these situations.

Educational Objectives: By the end of this case the learner will be able to: 1) demonstrate competency with the new ABEM Certifying Exam Clinical Decision-Making Case format, 2) manage a simulated pediatric care encounter that requires navigating the details of pediatric consent, 3) explain common exceptions to requiring parental consent in emergency situations according to established guidelines as well as state and local laws, 4) report increased comfort managing ethical dilemmas related to pediatric consent in the ED.

Educational Methods: This educational activity utilizes the new Clinical Decision-Making Case format for the American Board of Emergency Medicine Certifying Board Exam. This method simulates realistic ED encounters where residents must gather information, apply ethical and legal principles, and make decisions regarding pediatric consent under time constraints, similar to the new structure used in the board certification process for emergency medicine physicians. Additionally, a short presentation accompanied the debrief of this session to highlight the relevant clinical learning points.

Research Methods: We administered pre- and post-intervention surveys assessing self-perceived comfort

(using Likert scales) and objective knowledge (using multiple-choice questions) regarding pediatric consent, as well as comparing audience vs. participants experience. This study was approved by the Baylor Research Institute Institutional Review Board, approval number 025-322. Informed consent was obtained from all participants electronically.

Results: Thirteen EM residents (PGY1-PGY3) participated in this activity. In the presurvey, only 30.8% of residents reported to be somewhat or very comfortable, while in the post survey, 100% reported to be somewhat or very comfortable with pediatric consenting. When asked to evaluate the learning value of the case, 76.9% selected very valuable and 15.4% selected valuable.

Discussion: This clinical decision-making case provides a standardized, active learning method to address emergency medicine residency training regarding pediatric consent, which has previously been identified as an area of difficulty for EM trainees. [1] The format allows for assessment of not just knowledge, but also application, communication, and ethical reasoning. Providing specific, constructive feedback immediately following the session is crucial for maximizing educational benefit.

Topics: Clinical decision-making case, board certification, pediatrics, ethics, legal.

USER GUIDE

List of Resources:

Learner Audience:
Interns, Junior Residents, Senior Residents

Time Required for Implementation:
Case: Clinical Decision-Making cases are 15 minutes as directed by American Board of Emergency Medicine (ABEM).
Debriefing: 15 minutes

Recommended number of learners per instructor:
one active learner per instructor, with a variable number of observers as is standard practice in your institution.

Topics:
Structure clinical encounter, board certification, pediatrics, ethics, legal.

Objectives:
By the end of this case, learners will be able to:

1. Demonstrate competency with the new ABEM board certification structured interview format.
2. Manage a simulated pediatric care encounter that requires navigating the details of pediatric consent.
3. Explain common exceptions to requiring parental consent in emergency situations according to established guidelines and state law.
4. Report increased comfort managing ethical dilemmas related to pediatric consent in the ED.

Linked objectives, methods and results:
This Clinical Decision-Making Case for the Certifying Board Exam was designed to teach the legal and ethical nuances of pediatric consent through active resident learning. The case is structured to have the learner simulate real-life emergency medicine practice, progressing through the patient care steps consistent with the new ABEM board certification format (Objective 1). As learners manage the simulated encounter, they must navigate the specific details of providing care and addressing confidentiality for a minor patient presenting without a guardian (Objective 2). The case prompts are designed to directly assess the learner's ability to explain the common exceptions to requiring parental consent in emergency situations (Objective 3). By successfully managing this challenging encounter in a protected learning environment, which is followed by a faculty-led debrief, the intervention is designed to meet the final objective of increasing learner comfort in managing ethical dilemmas related to pediatric consent in the ED (Objective 4).

Recommended pre-reading for instructor:

- Katz AL, Webb SA. Informed consent in decision-making in pediatric practice. *Pediatrics*. 2016;138(2):e20161485. doi:10.1542/peds.2016-1485
- Sirbaugh P. Consent for emergency medical services for children and adolescents. *Pediatrics*. 2011;128(2):427-433. doi:10.1542/peds.2011-1166

Results and tips for successful implementation:
For our institution, we ran this case during our pediatric block in resident conference. We had one resident run the case with the faculty proctor with the rest of the residents running the case as observers. After the case, the proctor delivered a brief lecture on the topic, engaging the audience and connecting the lecture to the case. This is a standard format for our program, and as such we perceived no barriers to learning between the participant vs. observers. We measured our success with both a pre-and-post survey of the residents (both observers and participants) and noted a significant improvement in perceived comfort with the topic of pediatric consent. In the presurvey, 30.8% of residents reported to be somewhat or very comfortable with pediatric consenting (Figure 1). After completing the clinical decision-making case, 100% reported to be somewhat or very comfortable with pediatric consent (Figure 2). Based on faculty availability, we believe this could also be done in a small group setting to optimize engagement. Overall, our residents noted improved comfort on a topic that has been both locally and nationally recognized as a common knowledge gap.

Figure 1. Pre-Survey Resident Comfort Levels

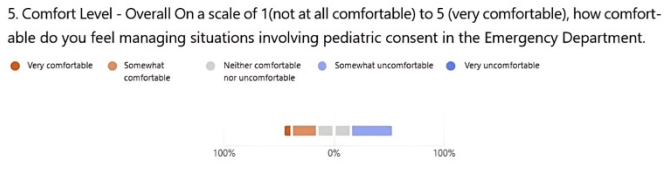
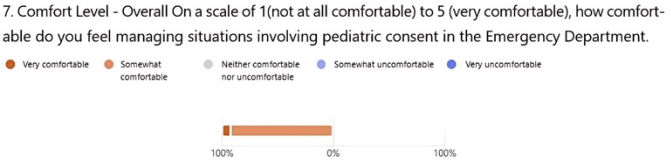


Figure 2. Post Survey Resident Comfort Levels



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References/suggestions for further reading:

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7. Katz AL, Webb SA. Informed consent in decision-making in pediatric practice. *Pediatrics*. 2016;138(2):e20161485. doi:10.1542/peds.2016-1485
8. Sirbaugh P, Diekema D. Consent for emergency medical services for children and adolescents. *Pediatrics.* 2011;128(2):427-433. https://doi.org/10.1542/peds.2011-1166

FOR EXAMINER ONLY

Clinical Decision-Making Case: Pediatric Sexually Transmitted Infections and Consent Summary

Diagnosis: Sexually Transmitted Infection in setting of pregnancy in pediatric age patient

Case Summary: A 16-year-old female, with no significant past medical history, presents alone to the ED via private vehicle for evaluation for abnormal vaginal discharge for the last week. She additionally discloses that she is approximately 10 weeks pregnant, but she has not told her parents yet.

Past Medical History (PMH): No known medical problems
Past Surgical History (PSH): None
Medications: None
Allergies: No known drug allergies
Family and social history: Patient lives with her mother and father who are not aware of the pregnancy.
Sexual history: Occasional sexual encounters with similar aged males with inconsistent barrier protection.
Synopsis of Physical Exam:
T 98.6º F, BP 104/68, HR 98, RR 16, Pulse Ox: 100% on RA

Patient is well appearing. Abdomen soft, non-tender, non-distended. Pelvic exam with copious yellow drainage from the cervical os. No cervical motion tenderness (CMT) or adnexal tenderness.

FOR EXAMINER ONLY

Clinical Decision-Making Case: Pediatric Sexually Transmitted Infections and Consent Examiner Script

Case Introduction:
"Hello Doctor, this is a clinical decision-making case. There is no role playing. In response to the questions I will ask, please give me a LIST of information you would gather to come to a final diagnosis. At times, I may interrupt you to move you through the case; this is not a reflection of your performance. You will have 15 minutes to complete the case. Before we begin, do you have any questions?"

"The patient will be a 16-year-old female with vaginal discharge."

Provide Learner Stimulus #1

HISTORY
Prompt 1:
"Here is the initial information regarding this patient. After you have read it, please give me a list of the additional historical information you would obtain."

Scoring Guidelines:
Rationale: Learners should ask details about associated symptoms such as abdominal or pelvic pain with vaginal discharge. They should take a sexual history and inquire about last menstrual period, contraception methods, and sexually transmitted infections (STI) prevention. They should ask if patient is currently pregnant, or if they believe they could be pregnant. They should inquire about social history and home life. They should emphasize this conversation is confidential.

General Guidelines:

- If candidate begins managing the case like a standard case, examiner states, "Remember Doctor, there is no role playing in this case. Please list the additional information you want to obtain."

- If candidate does not offer a complete list of historical information, examiner should pause long enough to allow them to list additional items, before asking "why" questions.

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- If candidate mentions "past medical history," or "social history," examiner clarifies by asking, "What specifically do you want to know about PMH/social history?"

Prompt 2:
"How would you plan to address confidentiality with this minor patient given her complaint?"

Scoring Guidelines:
Rationale: Learner should express understanding that because this is a visit related to sexual health and pregnancy, even as a minor, this is a confidential conversation between doctor and patient.

Prompt 3:
"What are the specific consent requirements for treating this unaccompanied minor given her presenting complaint?"

Scoring Guidelines:
Rationale: Learner should express understanding that because this is a visit related to sexual health and pregnancy, parental consent is not required.

PHYSICAL EXAMINATION:
"You are provided with the following additional historical information."

Provide Learner Stimulus #2

Prompt 4:
"Based on what you now know, please give me a list of specific physical examination findings you would be looking for."

Scoring Guidelines:
Rationale: Learner should examine the patient with a focus on the pelvic exam (presence and quality of vaginal discharge, cervical motion tenderness, adnexal tenderness, vaginal bleeding. They should also perform a focused abdominal exam to check for tenderness, guarding, rebound, or distension.

Prompt 5:

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"Doctor, how would a pelvic exam help in a patient presenting with these complaints?"

Scoring Guidelines:
Rationale: Learner should express that assessing for cervical motion tenderness, adnexal tenderness, cervical discharge or bleeding will contribute to making the diagnosis and ruling out emergencies.

DIFFERENTIAL DIAGNOSIS
"You are provided with the following physical exam findings."

Provide Learner Stimulus #3

Prompt 6:
"Based on what you now know, what are the top three items on your differential diagnosis based on the most likely conditions?" (If more than three conditions are mentioned, say, "OK thank you. Please give me your five, and only five, most likely diagnoses.")

Scoring Guidelines:
Rationale: Appropriate differential diagnoses include: cervicitis, gonorrhea, chlamydia, trichomonas vaginitis, bacterial vaginosis, candida vaginitis, pelvic inflammatory disease, tubo-ovarian abscess (TOA), irritant vaginitis, ectopic pregnancy, threatened abortion

DIAGNOSTIC STUDIES
Prompt 7:
"Based on what you know and your working differential diagnosis, what, if any, diagnostic studies would you order?"

Scoring Guidelines:
Learner should at least order wet prep, urinary and STI panel (gonorrhea and chlamydia).

Prompt 8:
"Doctor, you ordered X. Why X?"
ASK THIS PROMPT TWICE ABOUT TWO SEPARATE TOPICS

Scoring Guidelines:

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Rationale: Reasoning for diagnostic studies including importance of evaluating for STI in pregnancy, looking for urinary tract infection, etc.

After the candidate responds, Provide Learner Stimulus #4

TREATMENT AND OTHER ACTIONS

Prompt 9:

"Based on what you now know, what treatments, if any, would you order and/or what actions, if any, would you perform?" Scoring Guidelines:

Treatment with Ceftriaxone and azithromycin

Prompt 10:

"Doctor, why would treatment with ceftriaxone and azithromycin be important in this patient?"

Scoring Guidelines:

Rationale: Learner should explain the importance of empiric treatment for gonorrhea and chlamydia.

FINAL DIAGNOSIS

Prompt 11:

"Based on everything you know about this case, what is your final diagnosis?"

Scoring Guidelines:

Verbalizing cervicitis in pregnancy meets the critical action. If the candidate mentions something like gonorrhea or chlamydia infection, examiner asks "Can you be more specific about the diagnosis?"

DISPOSITION

Prompt 12:

"Based on what you know, what should be the disposition of this patient?"

Scoring Guidelines:

Verbalizing discharge to home.

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Prompt 13:
"Why would you [admit/discharge] this patient?"

Scoring Guidelines:
Verbalizing no evidence of need for admission at this time, such as tubo-ovarian abscess or sepsis.

TRANSITION OF CARE
Prompt 14:
"What specific actions would you take at the time of [admission/discharge]?

Scoring Guidelines:
Verbalize a final action such as explaining the diagnosis to the patient, recommending following up with Obstetrics to establish care for pregnancy, discussing the need for partner STI treatment prior to resuming sexual activity, and suggesting social work/case management for support for this patient. Reassure that this visit is confidential between doctor and patient.

Prompt 15:
"Would you disclose test findings to a parent or guardian?"

Scoring Guidelines:
Learner should express that sexual health/pregnancy related complaints are confidential despite the patient's minor status and should not be discussed with parent or guardian.

Thank you, Doctor. That concludes this case.
Please tear up your notes.

CERTIFYING EXAM ASSESSMENT

Clinical Decision-Making Case: Pediatric Sexually Transmitted Infections and Consent

Learner: _____

I. History		Yes	No
1a	Elicit that patient is pregnant		
1b	Patient denies abdominal or pelvic pain		
2	Confidentiality despite minor patient		
3	No parental consent required due to complaint related to sexual health/pregnancy		
II. Physical Examination			
4a	Pelvic exam to evaluate for cervical discharge, CMT, adnexal tenderness		
4b	Focused abdominal exam to evaluate for tenderness		
5	To evaluate for CMT or adnexal/uterine tenderness		
III. Differential Diagnosis			
6a	Pelvic inflammatory disease/cervicitis		
6b	STI/gonorrhea/chlamydia		
6c	Third appropriate diagnosis such as trichomonas, bacterial vaginosis, candida vaginitis, TOA, etc.		
IV. Diagnostic Studies			
7a	Wet prep		
7b	Urinalysis		
7c	Panel for STI (Gonorrhea and Chlamydia)		
8a	***Rationale for PROMPT 8 #1		
8b	***Rationale for PROMPT 8 #2		
V. Treatment and Other Actions			
9	Treatment with ceftriaxone and azithromycin		
10	Empiric treatment for gonorrhea and chlamydia		
VI. Final Diagnosis			
11	Cervicitis in pregnancy		
VIII. Disposition			
12	Discharge		
13	No admission criteria such as TOA/sepsis		

CERTIFYING EXAM ASSESSMENT

Clinical Decision-Making Case: Pediatric Sexually Transmitted Infections and Consent

Learner: _____

IX. Transitions of Care			
14	Explaining diagnosis to the patient, follow-up with OB/gyn and offering resources		
15	Sexual health/pregnancy related complaints confidential despite being a minor		

Summative and formative comments:

Stimulus Inventory

Candidate Task Sheet

#1 Emergency Department Admitting Form

#2 Historical Information

#3 Physical Exam Findings

#4 Diagnostic Studies and Results

Clinical Decision-Making Task Sheet
CASE PARAMETERS
• This is a 15-minute case • You will interact with two examiners. • This is an interview style without role playing; you should simply reply to the questions asked. • You may be interrupted to move you through the case; this is not a reflection of your performance.
PATIENT INFORMATION
16-year-old female with vaginal discharge
VITAL SIGNS
• BP: 104/68 • P: 98 • R: 16 • T: 98.6° F • 02Sat: 100% on RA
TASK STATEMENT
Your tasks are as follows: 1. List pertinent elements of a focused history and physical exam 2. Develop an appropriate differential and/or provisional diagnosis 3. Select and interpret appropriate studies 4. Articulate appropriate patient management including discharge instructions

STIMULUS 1. Emergency Department Admitting Form	
Patient Information	
Patient Name	Jane Smith
Age	16
Gender	Female
Method of Arrival	Private vehicle
General Appearance/History of Present Illness	Patient presents with abnormal vaginal discharge for about a week. She also reports she is approximately 10 weeks pregnant but hasn't told her parents yet. She is no acute distress.
Vital Signs on ED Arrival	BP: 104/68 P: 98 R: 16 T: 98.6° F O2 sat: 100% on RA

STIMULUS 2. Historical Information	
History of Present Illness/Description of Event	
• Patient denies any abdominal or pelvic pain. Patient reports she is sexually active with her boyfriend without use of contraception. • Last menstrual period was approximately 8 weeks ago. • Patient has had positive home pregnancy tests. • Patient reports she lives at home with her mother and father and feels safe but is worried because she has not told them about the pregnancy test yet.	
History	
Past Medical History	No known medical problems
Past Surgical History	None
Medications	None
Allergies	No known drug allergies
Social	Patient lives with her mother and father who are not aware of the pregnancy. Occasional sexual encounters with similar aged males with inconsistent barrier protection.

STIMULUS 3. Physical Exam Findings	
Physical Examination	
General Appearance	Awake, alert, no acute distress
Dermatologic	Warm, dry, no rashes
HEENT	Atraumatic, normocephalic, moist mucous membranes
Neck	Supple, no cervical lymphadenopathy
Respiratory	Clear to auscultation bilaterally, no respiratory distress
Cardiac	Normal rate and rhythm, no murmurs, rubs, or gallops
Abdominal	Soft, nontender, no distension, no rebound or guarding
Extremities	Good pulses, no edema or cyanosis
Neurologic	Alert & oriented x3, cranial nerves II-XII intact, strength 5/5 all extremities, normal sensation
Pelvic	Normal external female genitalia. No bleeding noted. Cervical os is closed. The cervix is erythematous with copious yellow discharge. There is no CMT, adnexal or uterine tenderness on bimanual examination. No masses are felt.
Psych	Mildly anxious, normal affect, no suicidal ideation

STIMULUS 4. Diagnostic Studies and Results		
Wet Prep	WBC	Moderate
	Yeast	Absent
	Clue Cells	None
	Trichomonas	Absent
Urinalysis.	Appearance	Clear
	Color	Yellow
	Glucose	Negative
	Ketones	Negative
	Sp Gravity	1.020
	Blood	Negative
	pH	6.0
	Protein	Negative
	Nitrite	Negative
	Leukocyte	25
	WBC	6-10
	RBC	0-2
	Squamous Cells	0-5
	Bacteria	Absent
Urine HCG	Positive	
Transvaginal US	CLINICAL INDICATION: Rule out ectopic pregnancy. Confirm intrauterine pregnancy and viability. Estimate gestational age. Patient reports vaginal discharge. Last menstrual period 8 weeks prior. COMPARISON: None. TECHNIQUE: Real-time transvaginal grayscale and color Doppler ultrasound imaging of the pelvis was performed. Images were obtained in multiple planes. IMPRESSION:	

	Single live intrauterine pregnancy. Estimated gestational age based on Crown-Rump Length (CRL) is 8 weeks and 0 days, consistent with the provided last menstrual period. Closed Cervical Os No sonographic evidence of ectopic pregnancy. No adnexal masses or significant free fluid.

DEBRIEFING AND EVALUATION PEARLS

Clinical Decision-Making Case: Pediatric Sexually Transmitted Infections and Consent[7,8]

Emergency Medical Conditions (EMC): In situations where a pediatric patient presents to the Emergency Department with a life-threatening condition or an emergency medical condition where treatment cannot be safely delayed, providers must proceed with stabilization. Consent is implied in these scenarios when a legal guardian is unavailable, and physicians should document that the treatment was initiated for an EMC to prevent harm to the child.

Condition-Specific Consent Exceptions: Once an EMC has been excluded, minors generally require parental consent, but exceptions exist for specific diagnoses that can include sexually transmitted infections (STIs), pregnancy-related care, sexual assault, and chemical addiction.

The "Mature Minor" and Emancipation: Educators should distinguish between specific condition exceptions and the care of an emancipated minor; a minor is considered legally emancipated (a "mature minor") if they are on active-duty military service, married, or living apart from guardians and financially independent. These minors have the legal capacity to consent to all their medical care, not just protected services.

State-Specific Legal Variability: It is critical to note that consent and emancipations laws are not federally uniform and vary significantly by jurisdiction, particularly regarding "mature minor" status and privacy laws for adolescents. For example, criteria for emancipation or consent for contraception found in one region may not apply in other regions. Providers must actively consult their specific state statutes and institutional legal guides to ensure compliance rather than relying on general rules. We recommend the facilitator become familiar with their laws specific to their region prior to the session.