NCC Pediatrics Continuity Clinic Curriculum: **Communication Basics: Approach to conflict and difficult encounters**

Goals & Objectives:

Goal: Increase your knowledge and skill in navigating conflict and difficult encounters

Objectives: At the end of this module, the pediatric resident should be able to:

- Recognize challenges specific to diffusing conflict and navigating a difficult encounter
- Describe the vital talk elements to diffusing conflict
- Apply vital talk element to clinical scenarios that require conflict and difficult encounters

Pre-Meeting Preparation:

- Watch diffusing ("defusing") conflict videos (Vital Talk)
- Review "Diffusing Conflicts" Chart
- "The Difficult Pediatric Encounter: Insights and Strategies" (*PIR, 2008*)
- Recall a situation where you had a conflict or difficult encounter with a patient and/or parent and be prepared to discuss

Conference Agenda:

- Discuss the Pediatrics in Review article *(Note there are not separate cases or a quiz this module to allow ample time for discussion. Dr. Penney will be present to facilitate discussion on most days.)*
- Review the vital talk videos and communication maps
- Share situations about diffusing conflict or a difficult encounter

Extra Credit:

- Addressing Parental Vaccine Hesitancy towards Childhood Vaccines in the United States: A Systematic Literature Review of Communication Interventions and Strategies. *Vaccines, 2020.*

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Diffusing Conflicts

Step	What you say or do
Notice the conflict	This is an internal step—you might notice that you feel irritation, anger, boredom; or you might notice body language like eye rolling or a sideways glance. You can ignore conflict, but you run the risk that it will reemerge later.
Find a non- judgmental starting point	"Could we talk about what's happening here?" Find a way to raise the issue without attacking. You need to pause before you rush to judgment, and you need to create space for the other person.
Listen to their story first	"Tell me your perspective on this." Give the other person your full attention. Don't start mentally preparing your arguments.
Identify what the conflict is about, and articulate it as a shared interest	"Here is my take on the issue." "It seems to me that we are both interested in ___ [the patient's well-being]."
Brainstorm options	"Could we list a couple of options, then spend a minute talking about the pros and cons?"
Look for options that recognize the interests of all involved	"I see how this meets your interest in ____." "Perhaps we should consider ___ to be a good marker of whether we are going in the right direction?" [proposing a trial of something for a defined period of time may be worthwhile]
Remember that some conflicts cannot be resolved	We talk about defusing because not every conflict has a solution that everyone feels good about. Sometimes you need to agree that you don't agree.

The Difficult Pediatric Encounter: Insights and Strategies for the Pediatric Practitioner

For highlight-free reading, please refer to the Faculty Module.

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Author Disclosure
Drs Asnes and Shenoy have disclosed no financial relationships relevant to this article. This commentary does not contain a discussion of an unapproved/investigative use of a commercial product/device.

Introduction

All pediatric practitioners are familiar with the concept of the "difficult" encounter with a family. Such encounters can range from those that leave clinicians with a slightly uneasy feeling once the family has left the office to those in which actual disputes occur. Barbara Korsch, MD, wrote, "There are certain names on the day's schedule that make the practitioner's heart sink and feel fatigued in advance." (1)

Although the responsibility of an effective partnership between pediatric practitioner and parent is shared, the larger part of the task falls to the clinician. A recent policy statement published by the American Academy of Pediatrics (AAP) refers to pediatric clinicians as "privileged and trusted advocates for the well-being of children." (2) With privilege and trust comes the responsibility to foster relationships with families and to fortify such relationships when they are threatened. The AAP states that "communication and collaboration" are principles of professionalism in pediatric practice to be upheld. In addition, the statement says that pediatric practitioners must recognize that "patients' families and the health care team must work cooperatively with each other and communicate effectively to provide the best patient care." (2)

Our own experience leads us to believe that although not all difficult encounters with families can be overcome or smoothed over, many can. Recognizing patterns of interaction that can lead to conflict with parents and addressing them early can be highly effective in preventing escalation. Many conflicts, once understood, even can lead to an enhancement of the partnership between clinician and family.

The following case vignettes illustrate several types of difficult interactions with families that we have had in our pediatric practices. Each is followed by suggestions that the pediatric practitioner may find useful. Although it can feel awkward, even false, to try these responses when faced with a challenging encounter, the results can be surprisingly and happily effective.

The Justifiably Angry Parent

You are seeing well children in the office this afternoon. You had 10 newborns at the hospital this morning (a practice record), and one who decompensated while you examined her had to be admitted to the newborn intensive care unit. The traffic was terrible on the way back to the office. It now is 2:00 PM, and your first appointment was scheduled for 12:30 PM. You enter the examination room to find a red-faced mother with her sobbing 2-year-old.

It is a fact of life that sometimes, through no personal fault, practitioners significantly inconvenience patients and families. Sometimes, as in the vignette, clinicians run late because other, sicker children have commanded their attention and delayed their schedules. This situation can be particularly challenging to manage effectively simply because a mistake has not been made; instead, appropriate care to patients has been provided. Practitioners know this and mistakenly can expect parents to know it, too. In our experience, this expectation can lead to significant conflict with parents.

The most helpful first step in this common but unavoidable situation is to communicate with families who may be inconvenienced. A timely call to the office staff to let the waiting family know about the likely delay and to apologize demonstrates respect for the family's time. The parent should be offered a chance to reschedule the visit if he or she is unable to wait.

The important point to remember when beginning an encounter with a family who has been inconvenienced or frustrated is that no matter what the reason, the family has been

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inconvenienced or frustrated. At times, we have been unwilling or have seen others be unwilling to see this reality. Rather, we have focused on the validity of the reasons why the family has been kept waiting. In this instance, the pediatrician has had a busy morning, and the healthy 2-year-old has not suffered ill consequences because of the delay. However, his mother has had an arduous 90 minutes trying to keep him happy in your small examination room. The best initial approach is to apologize clearly and sincerely. Although the first urge is to explain the delay, the explanation matters much less to the mother than it does to the doctor. An explanation and an apology are not the same.

An apology does not come naturally when we have not, in truth, made a mistake. Nor does apologizing mean that the practitioner must "admit" to making a mistake. Failing to recognize this often has been the obstacle to prevent clinicians from ameliorating this common situation. Knowing that we can be sorry that someone has been inconvenienced, yet neither being nor feeling at fault, has allowed us to say a sincere and effective, "I am sorry."

The Nonjustifiably Angry Parent

A 13-year-old boy is in your office for a weight check. His body mass index is 35, and he has gained 4 lb since his last visit with you. You have advised dietary changes and exercise in the past. You report his weight to the patient and his mother and ask how the family is doing with implementing your recommendations. The child tells you that he has been doing his best, but reports being limited by the amount of junk food "tempting him" in the house. After this statement, his mother shakes her head and stares at you. She angrily says, "You doctors think you're so great. What do you know about putting a healthy meal on the table? I make sure my children don't go hungry. Sure they snack, but I put dinner on the table every night. I'm not going to deprive them."

In the middle of a busy clinic session, clinicians can be blind-sided by an unanticipated and unjustified angry response from a parent. The clinician in this situation is at high risk of adopting a defensive posture and even becoming angry in response to this unexpected attack. The best possible course begins with an internal pause. Before responding, remember that although this parent is angry, she may not be angry with you. Take a breath. Have a seat and motion for them to do so, as well. Body language speaks as loudly as words. Standing up or pacing may be perceived as aggression or impatience. Sitting down and speaking calmly at eye level to the patient and parent demonstrates that you are willing to spend time and are speaking on even ground with them.

Asking the mother to tell you more about how she is feeling may reveal what is really bothering her. Simply saying, "I can see that you are upset. Can you tell me more about *why* you are upset?" will convey that you do care about her feelings. It is possible that she has not made the changes you have suggested and is embarrassed that she has not done so. Now she may be able to tell you so. Or, she may be in denial that she even needs to make the changes you have advised. Denial is a powerful defense mechanism in a family's arsenal of excuses for not making changes.

Although it is especially hard to take a caring and sympathetic stance toward parents and patients who speak angrily, these may be the very parents and patients who need the most care and sympathy. Two simple statements may diffuse the initial anger: "Changing the way you shop, eat, and cook can be very hard, and I realize I have asked you to do something difficult. Making these changes is never easy for anyone." The mother then may be able to say that her son is her treasure and that if he wants chips, then she wants to feed him chips. She may say that she likes the way he looks now. It is also important to keep in mind that many nutritious foods, such as fresh fruits and vegetables, are significantly more expensive than many processed, less healthy foods. Some families may not have the resources to shop as they are advised to by a well-intentioned practitioner and may be embarrassed to say so. All clinicians should be sensitive to this possibility.

No matter what the mother's response, the situation is likely to be about her son and her household rather than about the clinician. Once the subject of the visit has returned to its intended purpose, you can be supportive, sympathetic, and helpful. Saying, "I know how busy you are and I appreciate you taking time for this visit; we are together in this" shows respect for a parent's time and openly refers to the partnership between clinician and parent.

It even may be helpful to apologize to the mother, which can be a particular challenge. Saying that one is sorry about a perceived (but not delivered) insult does not come naturally. This physician did nothing "wrong." However, expressing regret for inadvertently insulting a parent, even if doing so was beyond your control, conveys that you care about his or her feelings. Try saying, "I am sorry for appearing insensitive to you. I really do know how hard this is, and I want to be as helpful as I can be to you and to your son." An expression of regret from

the clinician is powerful and often can change the emotional climate of a visit dramatically.

Occasionally, a parent may not be able to move past his or her initial anger. In these cases, focusing on the child may be of some use. Stating, "We have the next 20 minutes to care for your son. You and he have my undivided attention now, so we really should focus on him. His health is the most important issue," while remaining neutral and calm may allow you and the family to salvage something useful from the visit.

The Angry Adolescent Patient

A 15-year-old boy and his mother sit in an examination room awaiting your entrance. As you grasp the doorknob, you glance at the chart and read the chief complaint: "Mother concerned about child's behavior." You enter the room to find the mother looking anxious and the boy looking disgusted. His arms are crossed in front of his body, and he studiously avoids making eye contact with you. His mother greets you and says, "Doctor, I so hope you can do something with him. I am at the end of my rope!" The boy glares at his mother and then resumes an angry stare at the floor.

Adolescent patients can present a new frontier of challenging interactions for the pediatric clinician. When an adolescent patient is brought in for care by a parent against his or her wishes, the stage is set for conflict. Common parental concerns for which adolescents are evaluated under these circumstances include poor school performance, aggressive behavior, rebellious or defiant behavior, substance use or abuse, and health issues that the child does not recognize. In each of these cases, the practitioner must obtain information from at least two sources: the parent and the child. In addition, information from other sources, such as school personnel, may be helpful.

First, it is important for the clinician to hear from the parent in this scenario about his or her concerns. This goal may be accomplished best with the child outside the examination room. Information gathered should include examples of the behaviors or symptoms that are worrying the parent as well as the experience of the parent regarding these behaviors. If the child is behaving defiantly, what impact has this had on the family? A careful review of the family's social situation may reveal a previously unrecognized source of stress to which the child is responding. Are the parents arguing? Does a single parent have a new partner? Even when a family is well known to the doctor, basic social questions must be asked.

Perhaps the biggest challenge in this scenario is to establish a connection with the child. An important step toward accomplishing this task is to speak to the child without his or her parent in the room. Once alone with the child, the ice may be broken with a statement such as, "Tell me the top three places you would rather be than in my office right now." Letting a child know that you understand his or her reluctance may pave the way to common ground. Time spent recognizing and understanding the child's unhappiness at being brought in for care sends a message that the clinician intends to serve both the parent and the child. Once a dialogue is started, it is significantly more likely that the child will open up about whatever the parent's concern is, even if he or she is not ready to agree that the concern is valid. Even if the subject is not broached directly, such entrée may allow the patient to answer questions about his or her life, friends, school, and activities that may, in turn, lead to the reason for presentation on the child's, rather than on the parent's, terms.

If permission to do so is granted by a parent, a call to a teacher or school guidance counselor may provide additional and helpful information. A person outside the family who has regular contact with the family may share crucial information that can help the practitioner to understand the nature of a problem and begin to address it effectively.

The Parent Who Refuses or Questions Care

A father brings his 6-year-old daughter to your community health clinic for follow-up of severe eczema. She has been treated with topical corticosteroids, emollients, and unscented and hypoallergenic cleansers. She returns with a flare of her eczema, despite the multitude of therapies used in the past. Her father informs you that he refuses to put another drop of steroids on his daughter: "I read that they can cause growth problems; I don't want my daughter to be small. I took her to see a naturopathic doctor, who promises she has a natural herbal regimen that will work and won't affect her hormones. We've tried your way, and it doesn't help."

Superior care is the result of a trusting partnership between parents and the pediatric practitioner. Preserving this partnership should be the top priority for a practitioner faced with a doubting parent. However, when one's advice is challenged, this priority may fall by the wayside. Before the clinician becomes defensive, he or she must make an effort to understand the parent's reasons for rejecting a prescribed treatment. One reassuring factor in this particular situation is that the family has returned to the clinic for their doctor's guidance, even as they question the wisdom of what he or she has suggested. The practitioner, therefore, is in a position to determine just what has provoked the father's doubts

and possibly to repair his lack of faith. The best possible response is to ask questions that allow the father to explain, in his own words, what is bothering him. Remember that his response may be unexpected, so try not to suggest responses. For example, say, "I know that this has been a difficult issue in your home. Tell me, what worries you the most about your daughter's eczema?" This is different from saying, "I know that using steroids makes you worry about her growth."

Parents often have concerns that practitioners might never guess. The way to uncover these concerns is to ask about them. Simply listening to a father's concerns can be cathartic for him. If he expresses frustration, validate his feelings and open up the discussion to reveal its underlying causes. Giving a parent time to speak, without interruption, is a nonconfrontational opening for real dialogue that should encourage the parent to reveal the source of his worry. For example, he may tell you that on the radio he heard a news program about steroid-induced growth retardation or that he saw a television special on the bullying of short children. Perhaps facts that he has heard recently have reanimated the trauma from his own childhood of growing up as a smaller-than-average child.

Once the cause of anxiety has been identified, it becomes easier to move toward a mutually satisfying outcome. Specific worries, once uncovered, can be validated and addressed. Remember that although a physician may feel comfortable with standard regimens of therapy, family members may be troubled by them in different ways. For example, a child might be falling asleep in school due to sedation from antihistamines or parents may be arguing over how to treat symptoms. Do not forget that parents may have a justified, and possibly an unexpected, need to switch a course of treatment. Asking open-ended questions about the impact of an illness or of a prescribed treatment allows parents to talk about their actual concerns that the clinician then can address directly. For example, "How has that antihistamine been working out? Do you have any concerns?" can be more productive than, "That antihistamine is really helping, right?"

Careful discussion of possible adverse effects is warranted prior to starting any new treatment. Helping parents to know what to expect may prevent much anxiety. Also, realistic expectations of the results of a prescribed therapy should be conveyed to parents: "Hydrocortisone ointment is a temporary solution for your daughter's eczema. She will require intensive moisturization therapy to continue to keep her skin healthy. Some patients require either higher doses or stronger medications." Such education can avoid conflict at a later date. Inviting patients and families to be included in discussions regarding any aspect of their care helps to solidify a successful parent/practitioner relationship.

Patients and parents, of course, have a right to inquire about their health and to broach alternative treatments about which they have heard. Perhaps an herbal therapy could be helpful in this situation. An offer to speak with the naturopathic doctor about the new regimen could be educational for all parties. If it is certain that no harm is associated with an alternative therapy, the clinician may be able to endorse it. When the practitioner realizes and respects that it is a patient's or parent's choice to pursue alternative therapies, the door is left open for parents to come to the practitioner with questions or concerns. In addition to prescribing treatments, the pediatric practitioner can be instrumental in educating patients and parents about how to make informed decisions about medical care.

The Negligent Parent

Your next patient in continuity clinic is a 9-month-old girl who has only had her 2-month immunizations. You scan her chart and note multiple missed appointments as well as documentation of repeated telephone outreach to the child's mother by your office staff. You feel frustration, even anger, as you turn the handle on the door and enter the examination room.

A desire to help and care for children unites clinicians who have chosen pediatrics as a specialty. Among the most challenging problems are parents who fail to care for their children. No matter the reason, the mother in this case has not acted to provide basic health care for her child. A feeling of frustration is natural; even a feeling of anger can be understandable. Expressing these feelings, however, especially at the beginning of an encounter, may alienate the mother and inhibit future cooperation. In the interest of the infant and of the clinician/parent relationship, the best approach is to assume a neutral stance and gather information.

The tone that the clinician sets for this encounter may have far-reaching consequences. Simply greeting this mother with a smile and a word about your happiness in seeing the baby again may defuse unspoken tension in the room. This mother knows that she has missed appointments and that she has been unresponsive to your staff's efforts to get her to the office. She even may come in with a provocative stance as a way to guard against an anticipated rebuke from you. Greeting the infant warmly, even if you cannot greet the mother warmly, conveys your desire to help.

It is appropriate to address the poor compliance directly, but by taking a neutral stance. Try saying, "I see that you have missed several appointments. Can you tell me what happened?" We have heard many answers to this question. One mother was a victim of domestic violence and was compelled to miss appointments by her abusive partner when she had outward signs of trauma. Another mother reported that she had been evicted from her apartment and had been living in a shelter, three bus connections away from the clinic. We learned of these obstacles because we asked about missed visits from a position of concern and with a desire to help.

Some parents, of course, do not have reasonable answers to this question. They show no outward signs of financial hardship or other strife. The noncompliant parents who come to clinic, set the car seat holding the baby on the floor, and proceed to talk loudly on cell phones provoke the most frustration from practitioners. However, these often young and unsupported parents may be no less deserving of a caring practitioner's help in seeing the importance of attending health supervision visits and keeping immunizations up to date.

Overall, we have found it helpful to remember, and to remind our trainees, that the children do not fail appointments. In the interest of helping all children to be healthy, taking a charitable stand toward their parents is most likely to improve care for children. Once the possible reasons for missing visits have been discussed, the practitioner can explain the importance of the visits and immunizations.

Certainly, some parents will be unable or unwilling to comply with care, even when the practitioner has made every effort to help them to do so. In these cases, a link to social services or a referral to the local child protective services may be warranted.

The "Experienced" Parent

A 2-month-old is in your office for a health supervision visit. You enter the room to find the baby lying on the examination table next to a propped bottle and her mother sitting in a chair across the room talking on a cell phone. You politely request the mother to finish her call and begin the visit. When you ask about the baby's diet, the mother reports that she gives her baby water frequently to avoid constipation. She also gives her 2 teaspoons of honey "because she is sweet." Review of the baby's growth chart indicates that she has failed to gain weight appropriately. As you begin talking about the dangers of water and honey, you are interrupted. "I have six children. They are all healthy, and they all ate the same things. I don't need to hear this from you."

One of the most challenging tasks in pediatrics is to ask parents to recognize a problem that they do not perceive as a problem. In this case, the baby does not appear to be ill. Further, this mother has fed five other children who are healthy. The practitioner must overcome such obstacles and persuade this mother to alter her habits. One approach is to choose focus on one or two topics. Although leaving the infant unattended, propping bottles, and using a cell phone in your office all are important, the clear priorities are giving excessive water and feeding honey. Running through a laundry list of this mother's "wrongs" is likely to anger and alienate her and will not improve the infant's nutrition. Try starting sentences about the baby's failure to thrive with "the baby" or the child's name rather than "you," and also try using "we." For example, "Clara is not gaining weight as she should, and I see how we can solve this problem." Contrast this with, "You are feeding her too much water so she is not gaining weight." Choosing words with care to prevent this mother from feeling defensive will speed her understanding of the problem and help her to do what is right for her child.

Recognizing the mother's experience and commenting on it are likely to be helpful. "You have raised a lot of children and clearly know how to take care of them" conveys respect for her experience. "However, we have a significant problem here that needs to be addressed." Showing her the growth chart may be helpful in this case. Concur with the mother that she has raised other children successfully, but note that each child is different and has his or her own unique issues. Although there was not a problem in the past, there is a major issue now. A focus on the uniqueness of this baby takes the spotlight off of the mother's behavior: "I know you know what you are doing, but this baby is throwing us a curve ball. She is different and needs a different style." This allows you to give needed advice without criticizing.

The Worried Parent of a Well Child

You pick up your messages from the last several hours and are disheartened to see that one mother has called . . . again. She has a question about her son's toileting habits. The message notes that your receptionist offered to have her speak to your (excellent) nurse, but she insists on speaking with you. This woman has called you at least weekly, sometimes more, since her son was born 8 months ago. In addition to her health supervision visits, the mother has been seen for urgent visits on an average of three times per month since her infant was born. Her concerns have ranged from minor upper respiratory tract illnesses to worries about constipation to questions about his skin, as well as countless

other issues. The boy has grown and developed well since birth. You have no concerns about his well-being or health.

Parents who repeatedly present their children for care without evidence of true illness can be among the most frustrating with whom to interact. Pediatric clinicians are taught not to ignore the concerns of a parent; a worried parent always must be heard and addressed. However, when it becomes clear that a parent's degree of concern does not correspond to the child's condition, the practitioner's response is likely to be one of irritation. In this case, a careful review of the encounters that have transpired is likely to offer a clue about what underlies this family's overuse of the medical system, and where, along a spectrum of worrisome causes, a particular family may fall.

One explanation that we have uncovered is an ongoing discrepancy between the parent's assessment, "My baby has a terrible illness, does not sleep well, won't eat well, and won't play!" and the clinician's assessment: "This is a well baby who has a viral upper respiratory tract infection." Both parties are correct. To a parent, an infant who has a viral upper respiratory tract infection may be a catastrophe. He stops sleeping through the night (as does the parent), he is cranky, and all the food on which the clinician focused in the health supervision visit is not being eaten. The infant even may have lost weight, and the practitioner always pays attention to his weight. The clinician knows that this is a minor, intercurrent illness that will resolve with no ill effects. The clinician who tells a parent of an infant who has a bad cold that "it is just a virus" sometimes is sending the message that "he is not really sick." With so much evidence to the contrary, and with so much discomfort at home, parents may present a child repeatedly until the practitioner agrees that the baby is, in fact, unwell. We have learned to tell such parents that we know how miserable their infants (and they) must be and to counsel carefully about supportive care. Upon hearing that the baby is sick and having treatment prescribed, some parents no longer feel the need to present the child continuously for care.

Further along on a spectrum of concern, the vulnerable child syndrome is a well-defined phenomenon that refers to "a physically healthy child who is viewed by his or her parents as being at greater risk for behavioral, developmental, or medical problems, usually following a serious childhood illness." (3) This syndrome can be identified by taking a careful history and uncovering an event, real or imagined, that has led to undue anxiety about a child's health. A difficult path to fertility, a preterm birth, a hospitalization during infancy, and even an innocent heart murmur that has resolved can lead to the misperception that a child is more vulnerable to illness than are others. Once identified, the clinician can address the previously unrecognized connection between the antecedent event and the parents' worries and educate the parents about the child's health and more reasonable interpretations of his or her signs and symptoms.

Finally, parents may seek care for well children by using fabricated symptoms rather than exaggerated concerns. These parents may be suffering from a mental health problem, and their children may be victims of abuse. When parents ask that children have repeated, especially invasive, diagnostic tests or procedures, or when children who have been well suddenly present with dramatic symptoms such as hematemesis or seizures, child abuse must be considered. Parents who have factitious disorder by proxy (Münchhausen syndrome by proxy) may fabricate or induce symptoms in a child to prompt unnecessary interactions with the medical system. (4) If a practitioner suspects abuse, prompt consultation with a child abuse specialist is indicated.

When The Clinician Misses or Makes an Incorrect Diagnosis

Your partner is covering the practice for the weekend. She calls you at home on Saturday morning to tell you that she just examined a 3-year-old boy you follow at the hospital. You saw him on Thursday for poor oral intake and malaise and diagnosed a viral illness. Your partner informs you that the boy was seen in the emergency department overnight and was diagnosed as having a ruptured appendix. He has had surgery, and a long-term course of intravenous antibiotic therapy has been initiated.

One of the hardest conversations to have with a parent occurs when the physician has been wrong. Parents and patients look to pediatric clinicians to be all-knowing and benevolent. That harm can come to a child under the care of a trusted health-care practitioner is unthinkable to most families. However, mistakes do happen. In this case, the physician missed the diagnosis, resulting in an unfavorable outcome. Pediatric clinicians know that appendicitis is a tricky diagnosis to make in young children and may comfort themselves knowing this. However, although this may be an understandable mistake, it still is a mistake.

The affected practitioner should broach the subject that a mistake has been made, take responsibility for the error, and apologize to the family. Although the clinician can enumerate reasons for the mistake, including how

hard it can be to diagnose a certain problem in younger children, he or she should not articulate such reasons to the family, at least not initially. As has been said previously, an apology and an explanation are not the same thing. Families may ask for and benefit from an explanation, but this does not diminish their right to an undiluted apology.

In our experience, families are much more forgiving of practitioners if they are swiftly forthcoming with a description of the mistake and a simple, direct apology for it. In this case, the clinician might best visit this child and his family in the hospital immediately and say, "I did not recognize that your son's appendix was inflamed on Thursday, and this has led to his need for an extended hospitalization. I am so very sorry for not having recognized it." Many clinicians fear that admitting to a mistake and apologizing for it will lead to litigation by parents. In fact, recent evidence from medical centers that have institutionalized full disclosure programs suggests significant decreases in the number of malpractice cases and litigation costs since such programs have been implemented. (5)

Making a clinical mistake, particularly one that has adverse consequences, is one of the most painful experiences a pediatric practitioner can have. The feelings of guilt and regret are very powerful, so clinicians may seek comfort by avoiding the family of a patient with whom a mistake was made. We suggest that this temptation, if present, be identified and studiously avoided. Parents still need and trust a clinician who has made an error and, therefore, will feel abandoned if he or she pulls away. Continued close attention to the family in the case while the boy recuperates is likely to be very well received by his parents, although many practitioners do not perceive this to be the case. Making a mistake does not mean that the clinician cannot continue to care for and about a family. Rather, continuing to care is likely to make all parties, including the practitioner, feel significantly better.

Summary

These vignettes do not include every difficult encounter confronted by the pediatric practitioner. They are offered as examples of an approach to handling such encounters. A unifying theme in these cases is the clinician's obligation to take responsibility for diffusing and ameliorating challenging, awkward, and frustrating interactions with families. Individual practitioners may choose different words than those we have offered. What matters is that clinicians see the role they have in improving relationships with families when relationships are stressed. Pediatric practitioners may not always feel generous, sympathetic, caring, or contrite when interacting with challenging families. Clinicians, however, need to treat these families with generosity, sympathy, care, and sometimes, contrition. Doing so is not only an obligation, but often results in a positive outcome to an initially negative encounter.

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