CHEST Critical Care

Discussing Harm With Patients and Families in the ICU

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Evidence supports a shift from disclosing errors to talking about harm events, a more comprehensive, practical, and patient-centric concept. Patient harm resulting from health care in the ICU is prevalent, often serious, and can have a significant impact on patients, their families, and clinicians. Some such events are preventable, meaning an error caused the harm, but many are not. Regardless of their preventability, talking about such events with patients and their families—historically called *disclosure*—is imperative; patients and families have information and support needs, and failure to meet those in an effective and timely fashion can have negative consequences for all parties, including the health care system. ICU clinicians recognize the importance of such conversations, but have them infrequently, and they may feel unprepared or unsupported. Fortunately, clinicians can be trained to lead high-quality conversations, and organizational supports can mitigate the challenges clinicians encounter in doing so. Drawing on best practices, guidelines, and medical literature, this How I Do It article defines key terminology, articulates the rationale for discussing harm, and offers a compassionate, evidence-based framework to hold the initial conversation with patients and families affected by harm in the ICU. CHEST Critical Care 2026; 4(2):100238

KEY WORDS: adverse event; apology; communication; harm

Case Scenario, Part I

You are an intensivist assuming care of a busy ICU on a Monday morning. Two days prior, Ms L was transferred to the ICU with septic shock resulting from *Staphylococcus aureus* bacteremia requiring a vasopressor. Sign-out from the weekend team indicates a plan to treat with vancomycin. Her mother was at the bedside all weekend and expressed concern that Ms L was looking worse each day. On your arrival, Ms L has deteriorated and is requiring 3 vasopressors. Laboratory data shows that her vancomycin trough is less than assay, and you note that she has not received vancomycin for > 48 hours. How do you address this event?

Introduction

Harm resulting from health care can include negative physical, emotional, psychological,

ABBREVIATIONS: AHRQ = Agency for Healthcare Research and Quality; CRP = communication and resolution program

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social, and financial effects.[1] Factors specific to ICUs put critically ill patients at heightened risk of experiencing health care-related harm, including increased acuity, frequent testing, invasive interventions, high staff workloads, and polypharmacy.[2-4] Between 18% and 24% of patients in the ICU experience health care-related harm, which is associated with worsened mortality, longer lengths of stay, and higher costs.[2,3,5,6] Patient's families and ICU clinicians also experience negative effects after such events.[7-9]

Patients and families have important information and support needs after harm occurs. Neglecting these needs has serious consequences,[4,9,10] whereas attending to them is associated with less secondary harm.[11] Talking about harm events with patients and their families—historically called *disclosure*—is an ethical and regulatory imperative.[1,12-14] Unfortunately, ICU clinicians discuss harm events with patients and families infrequently.[15,16] In addition to fear of litigation and inadequate institutional support, a lack of education is a barrier.[4]

Effective, patient-centered ways of talking about harm events have emerged over the last 2 decades.[17-21] This article reviews key terminology, outlines best practices, and describes a humanistic, evidence-based framework for talking with critically ill patients and their families who have been harmed by medical care.

Definitions and a Shift in Language

Harm events—also referred to as adverse events—are situations in which patients experience harm as a result of care, rather than their underlying medical conditions (Fig 1).[1,18,22] Harm can occur even when the standard of care is met, such as a complication of appropriately delivered care, in which case it is often deemed *unpreventable*.[3,23] However, harm caused by a failure to meet the standard of care, that is, an error, is often deemed to be preventable. Errors are a failure of intent, execution of care, or both that increase the risk of harm.[18] They have been the historical focus of the concept of disclosure: communicating to the patient, their family, or both that an error occurred.[17,24]

We believe the historical focus on just disclosing errors has been too narrow, neglecting the realities of how harm events occur. Immediately after harm resulting from health care occurs, and often for some time afterward, it may not be clear if an error occurred. Initial impressions often are proven incorrect or incomplete after a thorough event review.[25] Errors may

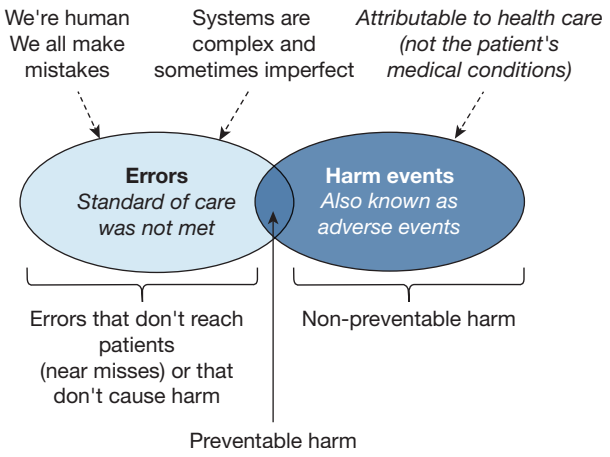

Figure 1 – *Diagram showing the relationship among medical errors, adverse events, and preventability. Adverse events are also referred to as harm events. The proportion of adverse events that are preventable is not to scale and varies according to study and clinical context.*

arise from individual faults, but more often they represent the culmination of multiple individual and system-level factors.[24] These realities make it impractical to base decisions about communicating with patients on the presence or absence of an error.

Additionally, patients' and families' information and support needs exist independent of whether an error occurred or if the event was preventable.[20] We define the term *family* broadly as anyone the patient wants involved in their health care, regardless of whether they are biologically, legally, or otherwise related.[26] Patients want to hear from their medical team when things have gone wrong and their families also need such information to be able to support them. Patients and families value discussions that include an authentic apology, empathy, honesty, transparency, and clear information about corrective actions. They also appreciate opportunities to process the event, ask questions, and receive updates.[4,10,25,27] However, expectations may vary based on personal, cultural, and other factors.[20,28,29]

Accordingly, we believe ICU clinicians need to shift from error disclosure to talking about harm events. *Error* and *disclosure* are familiar terms that appear in many prior publications, but an evolution of terminology is warranted. *Disclosure* is a clinician-centered term that can feel inadequate, obtuse, and even defensive to patients and families, who may interpret disclosure to mean that information has been concealed.[29] Orienting around talking about harm events, rather than disclosing medical errors, reframes these conversations as patient-centric dialogs designed

to address important information and support needs after harm better. Focusing on harm also lowers the threshold to initiate the discussion, because whether an error occurred is no longer a prerequisite.[20]

Case Scenario, Part II

On rounds, you learn that the vancomycin was being dosed by level because of the patient's renal impairment. A vancomycin trough had resulted as low over the weekend, but the weekend team seemingly missed it and did not reorder the antibiotic. This raises concern that Ms L's decompensation may have been preventable. You recognize that it is important not to jump to conclusions, and that several system factors may have contributed. For example, the order entry system does not feature a placeholder or automated reminder for medications that are dosed by level. A thorough multidisciplinary review is indicated.

Discussing Harm in the ICU: What's Known and Unknown

Guidance from critical care professional societies about how harm events should be discussed remains limited. One clinical practice guideline recommends that institutions equip clinicians with the means to discuss medication-related harm events.[30] Although not specific to discussing harm, other multisociety policies and guidelines promote pertinent themes including: proactive and routine engagement of critically ill patients and family members, the use of structured communication strategies, and the implementation of clinician training to promote open communication.[26,31]

Parallels exist between discussing harm and sharing bad news as part of family meetings, and ICU literature supports approaching difficult conversations in structured, compassionate ways with the support of evidence-based frameworks.[32,33] Harm-related communication skills can be taught[34,35] and are a required competency by the Accreditation Council for Graduate Medical Education.[36] We believe the ability to have such conversations should be considered a core competency for ICU clinicians.

The fear of litigation has been a barrier to such conversations. However, the evidence shows that even in situations that involve an error, talking about the event aligns with ethical responsibilities and patient and family preferences and is associated with an unchanged or lower likelihood of litigation.[37-39] Clinicians may find such conversations challenging, especially without education or support, but debriefing safety events may promote positive coping.[7]

Apologies are a key component of discussing harm. They can convey compassion, positive intent, and accountability. The field has come to recognize the distinction between expressions of empathy that use the word *sorry* (eg, "I'm so sorry this happened to you"), which are always appropriate, and the sometimes appropriate fault-admitting apologies that should be offered in the subset of cases involving preventable harm (eg, "I'm sorry our mistake harmed you").[17,21] Because establishing whether an event was preventable often requires a time-intensive and resource-intensive review, it is uncommon that an individual clinician will be positioned to provide a fault-admitting apology during the initial discussion. Determinations about preventability are an organizational responsibility, not the responsibility of individual clinicians; clinicians unsure about what type of apology is most appropriate should confer with their organization's patient safety team.

Case Scenario, Part III

After ICU rounds, the resident from the weekend approaches you and indicates that he forgot to redose the antibiotic. He was overwhelmed trying to learn a new list of critically ill patients and feels terrible about what has happened to Ms L. You acknowledge the lapse in care and offer support to the resident. He wants to tell the patient what happened, but he's afraid to do so. He asks, "What should we do?"

Best Practices for Organizational Responses to Harm Events

Historically, many health care organizations have used a deny-and-defend approach after harm events, but the modern ethical paradigm is known as communication and resolution programs (CRPs).[19] CRPs are a systematic, person-centered approach used by clinicians and institutions to respond with accountability, compassion, and transparency. CRPs incorporate medical, legal, and ethical principles into evidence-based practices to address harm events directly and to reduce the risk of future events. Key facets of CRPs include proactive and ongoing communication; support for patients, families, and clinicians; event review; improvements to patient safety; and in the subset of patients involving serious preventable harm, a proactive offer of compensation.[11,19,25] CRPs result in unchanged or lower rates of claims and defense costs[25,37,40] and

have been recommended as a best practice in patient safety.[25,41,42]

One example of a CRP is the Agency for Healthcare Research and Quality's (AHRQ) Communication and Optimal Resolution program. The AHRQ has published a Communication and Optimal Resolution toolkit that outlines methods for communication, event assessment, and data review that is available freely on the AHRQ website,[42] and the AHRQ recently published a systematic review of CRPs' design and effectiveness.[25] Communication and Optimal Resolution-aligned communication with patients has been associated with a lower risk of prolonged negative emotional impact on patients.[11] In this way, proactive patient-centered communication after harm events can be perceived as a patient safety intervention in and of itself; communication after harm events can prevent secondary, compounded harm.[11]

Organizations increasingly are implementing CRPs, but despite the known benefits and the encouragement of influential entities, many have not yet done so because of numerous challenges including limited resources and commitment to fundamental culture change.[19,43] We encourage ICU clinicians to ask their organization's patient safety leaders if they have a CRP and to advocate for one if they do not.

Case Scenario, Part IV

You contact your institution's patient safety team to review the case briefly and receive coaching on how to talk to Ms L. This includes a plan to apologize for not having given the patient more vancomycin over the weekend, but a recognition that the causes of the event are not yet fully understood and will require more review. The patient safety team reiterates how speculation now could later undermine trust if the formal review identifies a different outcome. You then huddle with the ICU nurse manager and the resident physician to plan your conversation with Ms L and her mother.

An Approach for ICU Clinicians Discussing Harm Events With Patients and Families

Our approach is based on resources from leading patient safety entities, best practices from CRPs, and literature about discussing harm, sharing bad news, and effective ICU communication strategies.[17,21,25,27,32,33,42,44-47] We recommend approaching discussions with patients and families about harm events with an emphasis on timely, open, straightforward, and compassionate communication.

The steps outlined below are in the order in which they typically occur, but they should be adapted to each patient. For example, the ICU team may need to validate emotional responses multiple times before all details of the event are conveyed. Table 1 offers example phrases, but clinicians should not script these conversations. Authenticity is critical for rebuilding trust with harmed patients and their families.

Prepare Yourself Before Events Occur

We recommend that ICU clinicians familiarize themselves with their organization's safety-related processes and resources before events occur. ICU clinicians should be able to recognize scenarios that necessitate a response, including events that: involve harm, regardless of preventability; might affect patient or family decision-making about care; might affect the trust between the patient and their family and the ICU team or the health care system; and you would want to know about if it happened to you or your family member.[18,21]

Although this review focuses on harm events, situations exist that do not involve harm in which nevertheless it may be important to talk with patients and families, such as errors that do not reach patients (near misses) or errors that do reach patients but do not cause harm (no-harm events). Whether to talk routinely about such situations is an area of controversy. We recommend approaching situations on a case-by-case basis, considering whether a discussion may promote trust and transparency vs fueling confusion, distress, or erosion of confidence.[27,48]

Care for the Patient

After a harm event occurs, the first priority is to ensure the safety and well-being of the patient by addressing the immediate medical consequences of the event.

Report the Event to Your Institution and Receive Support If Needed

Many organizations strongly encourage, or even require, health care professionals to report situations in which patients are harmed by health care. Doing so can help to connect clinicians to their organization's resources such as CRPs and just-in-time communication coaching.[35] Even in organizations without CRPs, clinicians may receive guidance from

TABLE 1] Summary of Approach to Discussing Harm With Patients and Families

Step	Description	Examples
Prepare before harm events occur	• Familiarize yourself with your institution's safety-related processes. • Understand scenarios that warrant a discussion with the patient and family. • Remember that even nonpreventable harm events should prompt a conversation.	Scenarios necessitating a response include events that: involve harm, might affect patient or family decision-making about care, might affect patient or family trust with health care, and you would want to know about if it happened to you or your family member.
Care for the patient	Ensure the safety and well-being of the patient and address the immediate medical consequences of the event.	With the ICU team, confirm a plan for managing the patient's shock and ensure that all relevant orders have been entered.
Report the event	• Report the event to your institution and obtain help preparing for the conversation. • Confirm who will follow up with the patient about the event.	• "I'm caring for a patient who experienced a harm event. I'd like to review the event with you and receive coaching on how to talk with her and her family." • "Which patient safety professional at our institution can follow up with her about the event review? What's their contact information?"
Plan the initial conversation	• Huddle with ICU team and establish who will lead the conversation. Review the details of the event and the aims of the conversation. • Coordinate a timely meeting with the patient and family. Obtain an interpreter if needed.	(Coordinating within the ICU team) • "We're meeting with Ms L and her mom today at 2 PM in the conference room to review the event and offer an apology." • "We contacted our patient safety team, who agreed to follow up with Ms L and her family." • "Dr R will lead the discussion." • "Do we have an in-person interpreter?"
Set up the initial conversation	• Meet in a quiet location with everyone seated at eye level. • Begin with introductions.	"Thank you for meeting with us. My name is Dr R, and I'm the supervising physician for Ms L's care in the ICU."
Introduce the topic of harm	Introduce the upcoming discussion in a clear way and obtain permission to move forward.	"I'd like to talk with you about an event [or 'the event']. Would that be ok?"
Ask for the patient or family perspective	Ask for the patient or family's understanding of the event, or both.	"What's your understanding of [the event]?"
Share the known facts	• Provide an objective, chronological, succinct account of the event. • Clearly state how it affected the patient and what's being done to correct it. • Acknowledge unknowns. • Avoid speculation and don't blame others.	• "It appears that there was a problem with your care. You didn't receive as much of the antibiotic as you need for your infection." • "This may have resulted in undertreatment of the infection, leading to lower blood pressure." • "We've now ensured you're getting enough of the antibiotic and are raising your blood pressure with medications." • "We don't fully know how this event happened. Our patient safety team will be reviewing what happened and taking steps to prevent it from happening again."
Apologize	• Offer a genuine apology as an expression of empathy. • Avoid fault-admitting apologies unless you've discussed this with your institution's risk management or CRP team.	• "We're so sorry that you did not get as much of antibiotic as you needed." • "We're committed to learning and improving from this."
Process emotions	• Validate and explore patient and family emotions. • Allow for silence as needed. • Avoid answering feelings with facts.	• "What has this been like for you?" • "It's deeply disappointing that the antibiotic was not given. You're right to feel frustrated and disheartened."
Summarize	• Review what happened. • Address outlying questions	• "To summarize" • "What questions do you have?" • "I'll give you the name of a member of our patient relations team. I'd encourage you to

(Continued)

TABLE 1] *(Continued)*

Step	Description	Examples
	• List next steps, including who will follow up with the patient regarding the event, which should be established before the initial conversation.	ask them to update you as the event is reviewed. To ensure we're thorough, sometimes event reviews take a while." • "In the meantime, we'll make sure you get the care you need in the ICU."
Debrief	After meeting with the patient, check in with the ICU team.	"How did that feel? What could have gone better? What might we do differently next time?"
Document	• Focus on clinically relevant aspects of the conversation. • It is OK to reference patient relations as a point of contact provided to the patient and family. • Avoid mentioning risk management, legal, or other entities that may lead to inaccurate perceptions of why the conversation was held.	"Spoke with the patient and family to explain what currently was known, to express empathy, to answer questions, and to describe next steps for the patient's care and noted our request for a review of the event to understand what happened and to identify any opportunities to improve. Will follow-up with the patient and family to answer any remaining clinical questions and shared contact information for patient relations for any further questions about the event."

risk managers, patient relations representatives, other clinicians, attorneys, or organizational leaders.

Our framework focuses on the initial conversation after an event. As the patient's clinical course and the event review progress, follow-up discussions often are beneficial.[17,25] ICU clinicians should anticipate them so they can customize the information they provide during the initial conversation. It is the organization's responsibility, not the ICU clinician's, to conduct a holistic event review. Event reviews may last longer than patients' ICU stay, which may make it impractical for ICU teams to lead follow-up conversations about event reviews. To maintain trust with patients and families, clinicians should be careful not to promise more than they personally are positioned to be able to deliver. Updates about the event review usually are best directed to patient relations professionals or others who can offer continuity and speak definitively about organizational event review findings.

Plan the Initial Conversation

Timeliness is essential. For acute, severe harm events, the discussion should occur as soon as feasible: within hours of the event's recognition.[17,25] Subacute events or those that occurred some time ago should be discussed within 1 day of recognition. These conversations should not be delayed to determine whether an error occurred.

Before meeting with the patient, the ICU team should review the details of the event, walk through the anticipated flow of the conversation, and choose a lead communicator who may be the attending or another senior physician. ICU care inherently is interprofessional, and other team members such as nurses, fellows, or social workers may participate and help lead parts of the conversation. However, large groups can overwhelm patients and families. We recommend limiting the group that has the conversation to a few key team members.

If the patient has capacity, they should be part of the discussion in addition to their family. It is best practice to ask them about their communication preferences, who they would like to be present, and any cultural considerations that could affect how the discussion is received. If interpretation is required, coordinating an in-person interpreter is ideal.

Have the Initial Conversation

Setup: Establish a time and place that works for the patient and their family. Limit interruptions and ensure everyone is seated at eye level. Begin with introductions including name and role or relationship with the patient.

Introduce the Topic of Conversation: Explain that you would like to talk about the event the patient has experienced using direct, concise language.

Perspective of the Patient: Consider asking for the patient and family's understanding of the event, if they are already aware of it.

Share the Known Facts: Moving chronologically, describe what happened, how it affected the patient, and any actions that have been taken in response. Be succinct

and forthcoming with what is known objectively and what is not known. Avoid speculation. If the patient or family ask if an error occurred, be honest and answer based on the level of certainty and guidance from your institution (e-Table 1).

Apologize: Offer an apology as an expression of empathy. If a fault-admitting apology might be appropriate, always confer with your organization's risk manager or CRP team about that idea before the patient and family conversation.

Respond to Emotion: Allow space and time for the patient and family to express themselves, and use open-ended questions to invite reflection. Help them feel heard: name, validate, and explore emotional responses and avoid responding to feelings with facts. You may need to provide additional information about the event, but focus first on meeting their emotional needs.[47]

Summarize and Outline Next Steps: Recap the conversation and describe next steps including any follow-up conversations and a contact person for questions.

1. Clinicians working in organizations with CRPs should be able to promise patients and families that an organizational representative will follow up with them about the findings from the event review.
2. Clinicians in organizations without CRPs may want to be more cautious, for instance: "Our patient safety team will review the event. I'm going to give you the name of one of our patient relations professionals, and I encourage you to ask them for updates as the event review progresses."

Debrief and Document

1. Soon after the conversation, check in with staff who were present and close the loop with organizational resources.
2. Document the conversation in the medical record as you would any other important clinical conversation. To limit inaccurate perceptions that the conversation was prompted by risk management or legal concerns, avoid mentioning those entities in such documentation; these are best viewed as clinical conversations, even as much as they may have risk or legal implications.

Support the Clinicians Involved

Clinicians have their own information and support needs after harm events.[7,8] Access resources for yourself and refer others that you think may benefit.

Case Scenario, Part V

You, the ICU nurse manager, and the resident physician meet with Ms L and her mother at the bedside. The resident physician walks through the events, explaining how the lack of vancomycin over the weekend likely contributed to worsening shock. You note that you do not yet know fully how this could have happened, but that the event will be reviewed. You describe what's been done to care for Ms L, including resuming antibiotics. Together with the resident, you offer an apology: "We're so sorry that you did not receive vancomycin over the weekend. We don't yet understand fully how this happened, but we are committed to learning and improving from this."

Ms L and her mother express frustration and fear over the situation. They also express relief: "We knew something was wrong." You validate and empathize with their emotional response, reiterating that this is a frightening and frustrating situation. Her mother asks if anything could have been done to prevent the current situation. Affirming that you also want to understand how this breakdown occurred and prevent recurrence, you explain that additional information will be communicated as it becomes known and that steps will be taken to prevent similar issues in the future. You conclude the meeting by offering a summary, inviting questions, and outlining the next steps including information for the patient relations team member who will follow up with Ms L and her family.

Limitations

We recognize that ICU clinicians have varying levels of skill, familiarity, and confidence with such conversations. They also experience different resources, levels of support from the leaders, and cultures, including variation in who conducts follow-up conversations, the reliability with which they occur, and their content. We encourage clinicians to attend to their patients' information and support needs as best as possible and to seek professional development opportunities to advance their communication skills.

Additionally, the above framework does not address comprehensively how to support involved clinicians; dedicated reviews can be found elsewhere.[49] Clinicians need to know how they will be treated when events are reviewed, and ideally they are supported by an organizational just culture framework. Organizations should identify and attend to clinicians' educational and emotional needs proactively. We encourage clinicians

working in organizations that lack CRPs, just culture, communication coaching, or care for the caregiver programs to advocate for their implementation in the spirit of providing best care for patients in the ICU.

Case Review, Part VI

After meeting with Ms L and her mother, you debrief with the resident physician and ICU nurse manager. The resident expresses ongoing guilt but also relief, and he agrees to be connected with peer support resources. You close the loop with your institution's patient safety team so they can continue discussions with Ms L and her family as the event review progresses. Finally, you document the discussion in the chart.

Summary

Responding effectively after patients in the ICU are harmed by their care requires timely, open, and caring communication by ICU clinicians with patients and families. Shifting away from error disclosure to focus on responding after harm is a more clinically oriented, practical, and comprehensive approach to meeting patient and family information and support needs. We propose a framework based on up-to-date evidence, guidelines, and best practices to support ICU clinicians having the initial discussion after a harm event. Key recommendations for clinicians include addressing harm events soon after they occur; activating institutional resources, especially any CRP; and offering a clear, honest apology. Organizations bear responsibility for many aspects of the response after harm events. ICU clinicians are encouraged to advocate on behalf of their patients, families, and colleagues for organizational implementation of best practices.

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