



HARM COMMUNICATION: **PREPARING FOR A DISCLOSURE MEETING**

Providers should always contact Risk Management before harm communication. Always call Risk as soon as a possible adverse event is recognized, so they can assist with disclosure and management, start investigations, and consider reporting to regulatory agencies. Risk staff will help with meeting preparations and consider what should and should not be said about causation, apology, and compensation. Then, consider the following:

- Define the goals of the conversation.
- Identify special personal or family dynamics, disabilities, language, ethnic, racial, or cultural sensitivities. Use trained interpreters when needed. Provide easy access to involved parties.
- Determine where and when discussion should occur.
- Consider who should attend, on both sides. Make it clear a family attorney is welcome. Try to let patient/family preferences guide provider selection (there may be someone they want, or do not want, to see). Ask for help if needed!
- Prepare a prop, diagram, or x-ray if appropriate.
- *Practice your words!*

KEY STEPS FOR DISCLOSURE MEETING:

- Provide a warning like, “I have to tell you something that might be hard to hear.”
- Clearly disclose the adverse event. Be honest and transparent. Use clear language, e.g. “we gave you the wrong dose” instead of “you received...” or “a wrong dose was given.” Avoid technical jargon.
- Answer questions, but do not speculate. Providing erroneous information could cause great stress and result in legal exposure. Try, “Right now, we don’t know. We’re looking into this and will update you as soon as we have an answer.” Check understanding where appropriate.
- Provide a clear apology, including personal responsibility when appropriate.
- Make them feel HEARD. Reflect and validate emotional reactions. Don’t negate or “silver-line” them with “at least...” statements.
- Tell them what’s being done to prevent future events. Offer a chance to participate in this process, e.g., by being interviewed for their perspectives on the event or its management, when possible.
- Tell them how you’re fixing the problem: corrective medical care, forgiving bills, compensation—if you know. If not, statements like “I’m not in charge of billing, but our institution is committed to taking care of injured patients. I’ll advocate that you aren’t billed for anything related to this mistake.” Offer to reach out to Risk Management if needed.
- Follow through. Harm communication is a process, not an event. Give the patients a contact person they can reach out to with questions. Tell them you’ll let them know what the investigation finds and what changes are made—and do it!
- Document your disclosure—discuss this process with Risk Management.

The difficult task of harm communication deserves careful preparation and great respect. Individuals can prepare for these discussions with practice and review of resources, but institutions should prepare clinicians for this task with training and support them in the moment. Clear, empathic communication offers a chance to avoid involvement in malpractice claims, and reduce costs to institutions ([Michigan model site](#)). Making amends also advances the healing journey of the clinicians involved.

More importantly, remember that adverse events can cause lasting physical, psychological, and financial harm to patients and families. An injury is bad enough, but people generally understand that clinicians are human and make mistakes. They are understandably less forgiving if they are stonewalled or lied to, or fail to receive honest, compassionate, and empathic disclosures. As patient and family advocate Carol Hemmelgarn put it, “The first injury was an accident; the second was intentional.” Harm communication meetings are the best opportunity to begin healing the injured parties and rebuilding trust. Compassionate communication mitigates the long-term harm of adverse events.

Key References:

1. McDonald T, Challenging and Complex Conversations with Patients and their Loved Ones After Harm Events. Collaborative for Accountability and Improvement. 2010;1(12): http://communicationandresolution.org/wp-content/uploads/2019/12/Collaborative_IssueBrief1_2019_McDonald.pdf
2. Prentice JC, Bell SK, Thomas EJ, et al. Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey. *BMJ Qual Saf.* 2020;29(11):883-894. [doi:10.1136/bmjqs-2019-010367](https://doi.org/10.1136/bmjqs-2019-010367)