Harm from Healthcare – Facts and Common Misunderstandings

What is "harm from healthcare"?

Harm from healthcare is when a patient is hurt by their care, not by their illness. This can include pain, injury, disability, or death. Often called an "adverse event" (a problem caused by care).

What is "harm response"?

Harm response is what healthcare teams do after harm happens.

Common misunderstandings	What we know from science and experience
Harm from healthcare is rare and not serious.	Harm from healthcare is common and can be serious: • Hospitalized patients: ~1 in 4 experience an adverse event; ~1 in 3 of those are serious. • Patients receiving clinic-based care: ~1 in 14 experience an adverse event; ~1 in 5 of those are serious.[1]
All bad outcomes are harm from healthcare.	Not all bad outcomes are caused by care. Many are from illnesses themselves.
Only physical harm is "real" or counts as harm.	Harm is not just physical. People may also feel emotional distress, trauma, loss of trust, and financial strain. These "non-physical" harms matter deeply. When we recognize all of these harms, we can better support people. This also helps rebuild trust and improve care.[2]
Only patients are affected by harm events.	Harm affects more than patients. **Families** may experience similar harms, like stress, loss of trust, and financial strain. **Clinicians** may feel distress or guilt, and their jobs or reputation can be affected. **Healthcare organizations** can see more legal cases and costs.[3]
"Non-physical harm" goes away quickly.	Some harms can last for years or may be permanent.[4]
Only severe harm "counts."	Even mild or moderate harm matters. Small harms can add up and affect daily life and future care.
If everything is called harm, the word loses meaning.	A broader view of harm can help us see problems more clearly, support people, and improve care. When using the word harm, we need to use it the right way. We need to understand what happened, why it happened, how it affected people, and how we can prevent it in the future.
Harm means someone made a mistake.	Sometimes mistakes in care (errors) can cause harm. But often, harm is caused by good care that was meant to help. Harm can happen even when care was appropriate, such as side effects of treatment or known risks of procedures. The best way to understand what happened is through careful review.

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Common misunderstandings	What we know from science and experience
If there was a mistake, it means someone meant to cause harm or was careless.	Most mistakes in care (errors) happen because people and systems of care are not perfect. They rarely involve recklessness, negligence, or bad intent.
Harm mainly happens because people make mistakes.	Many harms are linked to system issues such as poor communication, workflow problems, or staffing pressures, rather than a single person's mistake.
If there was harm, it must have been preventable and compensation is due.	Harm just means someone was hurt by their healthcare – it does not always mean it could have been prevented. Good care that was meant to help can sometimes cause harm. Compensation means money or extra support beyond usual care. Compensation is sometimes offered when a mistake in care causes serious harm.
Most harm is reported.	Most harm is not captured by reporting systems. Many events are missed or not reported. People may be unsure what to report. They may fear blame. Reporting systems can be hard to use. To better find harm, we also need other approaches, like chart review, reports from patients and families, and software that looks for harm.[5]
Harm events are easy to identify.	Harm is not always clear. It can be hard to tell if harm happened. It can develop over time, have many causes, and be hard to recognize at first. It can also be hard to know if care played a role. This is especially true when illness and care both affect the outcome.
If harm was not preventable, there is little to be done.	Even when harm is not preventable, the response matters. A good response can support healing, rebuild trust, and make care safer.

References

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