

# Discussing adverse events with patients improves how they rate their hospital care

November 10 2009

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A survey of patients had who experienced some sort of adverse event during their hospitalization found that, although caregivers discussed the event with patients less than half the time, those patients to whom the adverse event had been disclosed rated the quality of their care higher than did patients whose caregivers did not address the problem. The report from the Massachusetts General Hospital (MGH) Institute for Health Policy appears in the November 9 *Archives of Internal Medicine*.

"Our findings show that disclosure is associated with patients' [perception](#) of higher-quality care, even when they were harmed by an adverse event," says Lenny López, MD, MPH, of the MGH Institute for Health Policy, who led the study. "We believe this is the first study to address how disclosure affects the quality-of-care impression in [patients](#) who actually were harmed during the course of their treatment and may reassure physicians and others who worry about the consequences of disclosure."

The current report analyzes data from a larger survey of patients who stayed in 16 Massachusetts hospitals for at least one night during a six-month period in 2003. Of the almost 2,600 patients who participated in the survey - information for which was collected in 20-minute phone interviews - 603 patients reported experiencing a total of 845 "negative effects or complications" from their hospitalization. Those who experienced such an adverse event - defined as an injury caused by some aspect of medical care and not by the underlying medical condition - were asked whether anyone from the [hospital](#) explained why the negative

effect occurred. Patients also rated the quality of their care on a scale from 1 for excellent to 5 for poor.

Two physician co-authors of the study reviewed the patient responses to determine whether the reported incident fit the study's definition of an adverse event, ranked its severity and evaluated whether it was a preventable medical error - such as administering an incorrect dosage of medication - or an unpreventable event, such as an unanticipated reaction to a new drug.

The study revealed that only 40 percent of adverse events reported by patients had been disclosed to them by hospital staff. Events that led to the need for additional treatment were most likely to be discussed with patients, but preventable events and those associated with a more prolonged impact on the patient were less likely to be disclosed. Patients to whom adverse events had been disclosed were twice as likely to rank their care as good or excellent as were patients whose problems had not been discussed.

"It's quite notable that high-quality ratings continued to be associated with disclosure even when the event was determined to be preventable," López says. "Although rates of disclosure remain disappointingly low, our findings should encourage more disclosure and allay fears of malpractice lawsuits. Patients want to be told the truth, and they perceive [disclosure](#) as integral to high-quality medical care." López is an instructor in Medicine at Harvard Medical School and is also on the clinical staff at Brigham and Women's Hospital.

Source: Massachusetts General Hospital ([news](#) : [web](#))

Citation: Discussing adverse events with patients improves how they rate their hospital care

(2009, November 10) retrieved 5 May 2024 from

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