Surgeons' disclosures of clinical adverse events

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Surgeons who reported they were less likely to discuss preventability of an adverse event, or who reported difficult communication experiences, were more negatively affected by disclosure than others, according to a study published online by *JAMA Surgery*.

National guidelines recommend full disclosure of adverse events or unanticipated outcomes to patients and their family members. Evidence shows that such full disclosure involving transparent and honest communication benefits patients and families. Nonetheless, physicians, including surgeons, frequently fail to disclose adverse events to their patients. To sustain open disclosure programs, it is essential to understand how surgeons are disclosing adverse events, factors that are associated with reporting such events, and the effect of disclosure on surgeons.

A. Rani Elwy, Ph.D., of the Veterans Affairs Boston Healthcare System and the Boston University School of Public Health, Boston, and colleagues quantitatively assessed surgeons' reports of disclosure of adverse events and aspects of their experiences with the disclosure process. The study involved a 21-item baseline questionnaire administered to 67 of 75 surgeons (89 percent) representing 12 specialties at 3 Veterans Affairs medical centers. Sixty-two surveys of their communication about adverse events and experiences with disclosing such events were completed by 35 of these 67 surgeons (52 percent). Self-reports of disclosure were assessed by 8 items from guidelines and pilot research.

Most of the surgeons completing the web-based surveys used 5 of the 8 recommended disclosure items; explained why the event happened (55 of 60 surveys [92 percent]), expressed regret for what happened (87 percent), expressed concern for the patient's welfare (95 percent), disclosed the adverse event within 24 hours (97 percent), and discussed steps taken to treat any subsequent problems (98 percent).

Fewer surgeons apologized to patients (55 percent), discussed whether the event was preventable (55 percent), or how recurrences could be prevented (32 percent). Surgeons who were less likely to have discussed prevention (55 percent), those who stated the event was very or extremely serious (66 percent), or reported very or somewhat difficult experiences discussing the event (26 percent) were more likely to have been negatively affected by the event. Surgeons with more negative attitudes about disclosure at baseline reported more anxiety about patients' surgical outcomes or events following disclosure.

The authors write that very little has been done, overall, to assess physicians' experiences with disclosing actual adverse events to patients, a situation that requires skills in immediate, transparent, open communication, and to determine whether these disclosures are following recommended guidelines. "By emphasizing the potential for surgeons being negatively affected after adverse events and disclosures, and recognizing the association between attitudes, perceived seriousness of events, surgeons' experiences with disclosures, and training on how to include specific elements of disclosure in these difficult conversations, future quality improvement efforts may be able to help sustain the implementation of open disclosure programs nationwide while also ensuring a healthy surgeon workforce."

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