

## Disclosure of hospital adverse events and its association with patients' ratings of the quality of care.

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López L, Weissman JS, Schneider EC, et al. Disclosure of hospital adverse events and its association with patients' ratings of the quality of care. Arch Intern Med. 2009;169(20):1888-94.

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<https://psnet.ahrq.gov/issue/disclosure-hospital-adverse-events-and-its-association-patients-ratings-quality-care>

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[Error disclosure](#) is a [practice](#) that was traditionally limited by [fears](#) of litigation independent of the [emotional](#) impact on involved providers. More recent [evidence](#) minimizes the link between disclosure and litigation, and studies demonstrate its [importance](#) to patients. This study analyzed a random sample of medical and surgical hospitalized adults and found that only 40% of adverse events (AEs) were disclosed. Disclosure was more common for AEs that required further treatment and less likely if they were preventable.

Disclosure did appear associated with higher quality care ratings by patients. An invited commentary [see link below] by a leader in the patient safety field, Dr. Robert Wachter, discusses the importance of this study's findings while reflecting on the 10-year anniversary of the landmark [IOM report](#). A past AHRQ WebM&M [conversation](#) and [perspective](#) also discussed the many facets of error disclosure.