I. Answer and critique

The correct answer is C: Empiric oral doxycycline. This question can be found in MKSAP 16 in the Infectious Disease section, item 23.

Benula burgdorferi polymerase chain reaction testing is not indicated. Although *B. burgdorferi* may be amplified from erythema migrans skin biopsy specimens if the diagnosis is uncertain, this study is generally not needed because of the characteristic erythema migrans rash, such as is seen in this patient, dictates treatment.

Intravenous ceftriaxone is reserved for patients with cardiac or neurologic manifestations of disseminated Lyme disease. Serologic testing for *B. burgdorferi* is not recommended because false-negative antibody test results may occur in patients with early localized Lyme disease and would be negative in patients with southern tick-associated rash illness.

**Key Point**
- Empiric oral doxycycline is the recommended treatment for erythema migrans regardless of the cause.

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- Express personal regret and apologize.
- Elicit questions or concerns and address them.
- Plan the next step and next contact with the patient.

“This is harder than it sounds,” Dr. Levinson said. “I encourage you to do some role playing around error disclosure.”

**Errors by others**

One tricky issue is whether and how to disclose errors made by other clinicians. Ideally, your institution should offer guidance on how to handle this situation, and you should feel comfortable approaching your colleagues to discuss situations that arise.

The disclosure strategy for errors by a colleague likely will depend on the clinical situation, such as whether it involved a physician with whom you were co-managing, or a trainee, or a clinician who didn’t have direct contact with the patient. In the case of trainees, both should participate in the disclosure regardless of who made the error. In the case of a trainee error, the attending physician and the trainee both should be involved, Dr. Levinson said.

Attendants also should handle disclosure of errors made by a clinician who didn’t have direct contact with the patient. This is particularly important when an error was made and the error should be invited to join if desired, she said.

If the error occurred at another institution or is unrelated to current care, the disclosure should be handled by the medical director at the institution currently caring for the patient, after consultation with the clinician who made the error and/or with the outside institution, she said.

**Follow words with actions**

It’s important to remember, too, that words we say to patients, but in some respects what’s more important are the broader set of actions that follow,” Dr. Gallagher said.

Those actions can include institutional changes. Knowing that those are in the works can be a great comfort to patients, who often want to believe that their experience might lead to a positive change for others, he said.

Institutions have begun to embrace the idea that errors are their responsibility as well as the responsibility of individual clinicians, Dr. Gallagher said. “Communicating with patients after an unanticipated outcome is now seen as a broader part of how we think about high-quality health care; it isn’t just about risk management,” he said.

To make their disclosures high quality, institutions should be candid and transparent about unanticipated outcomes, conduct a rapid investigation, offer a full explanation, and apologize as appropriate, Dr. Gallagher said.

Furthermore, where appropriate, the institution should seek to provide for the patient’s and family’s financial needs resulting from the error, hopefully without having to resort to litigation. And the institution should build systematic patient safety analysis and improvement into its risk management plan, he said.

“Currently, ours is often a system of accountability that doesn’t adequately service the patient and family’s financial needs, resulting from the error, hopefully without having to resort to litigation. And the institution should build systematic patient safety analysis and improvement into its risk management plan,” he said.

“Currently, ours is often a system of accountability that doesn’t adequately service the patient’s need for information, for our accepting responsibility, for timely compensation [when appropriate], and for a sense that we’ve learned from the mistake,” said Dr. Gallagher.

“We need to demonstrate to the patient and the public that learning is happening; in many ways, this is the most important thing we miss."

**Legal concerns: Reporting**

The top barier to improving the culture around medical error disclosure is a clinician fear, said Dr. Gallagher. “They are anxious about an unpredictable, punitive response from their institution, regulators, and malpractice insurers. This hampers efforts to learn [from mistakes] and to prevent recurrence.”

Physicians may have more peace of mind if they educate themselves about the regulatory and legal consequences of disclosure, said ACP Member Allen Kachalia, MD, JD, associate professor of medicine at Harvard Medical School and associate chief quality officer at Brigham and Women’s Hospital in Boston.

A big concern is often the National Practitioner Data Bank (NPDB), which stores information on medical malpractice payments made for the benefit of a health care practitioner as the result of a written claim or judgment. Institutions are responsible for reporting claims to the NPDB.

Whether an event gets reported to the NPDB, however, can depend in part on the type of communication and resolution program that an institution employs. If it uses a “reimbursement model,” the patient often doesn’t release his or her claim to sue when something goes wrong.

“The institution will tell the patient what happened and make an offer of compensation, and because the reimbursement is not done in satisfaction of a legal claim, it may not trigger provider reporting requirements,” Dr. Kachalia said.

If an institution uses an “early-offer-and-settlement model,” the patient generally waives his or her right to file suit. Whether this leads to clinician reporting depends on how the claim is settled. If the claim is settled on behalf of the institution, the clinician may not need to be reported to the NPDB. But if the claim is settled on the clinician’s behalf, the physician will be reported to the data bank, Dr. Kachalia said.

“The rules are complex around all this and it helps to know whether your institution employs a reimbursement model or an early-offer-and-settlement model,” Dr. Kachalia said.

Some payers and liability companies also want to know about errors as soon as they occur, as do certain credentialing committees and licensing boards. For these, physicians should be aware of the requirements, he added.

**Ripple effects**

While there is general agreement in the medical community that there is an ethical obligation to disclose errors and that a culture of transparency can improve patient safety, there is also concern that disclosure will lead to more claims and lawsuits, Dr. Kachalia said. Limited published data exist on whether disclosure has a snowball effect, he said.

“Some argue that when you tell a patient you’ve made a mistake, you might be handing over a blank check. Even if you make an offer of compensation, the patient might be unhappy with that offer and still want to sue for more. However, others argue that if you [disclose] sincerely and honestly, patients may be less likely to sue you,” he said.

A disclosure program at the University of Michigan, implemented in 2001, found that apologizing and offering compensation reduced patient claims. Comparing the before/after disclosure period up until 2007, the university saw claims drop by 36%, Dr. Kachalia said.

“Now this doesn’t prove that disclosing and making offers will lower your liability experience, but it shows that one institution did this and their claims experience might lead to a positive change for others, he said.

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*See Errors, page 23*