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Resolving Harmful Medical Mistakes—Is There a Role for Forgiveness?

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What ought to happen after one person harms another person he or she was trying to help? Physicians may wonder if the answer to this question includes the word “forgiveness.” A focus-group study of academic and community physicians, published in the *Journal of the American Medical Association* in 2003, reported that physicians “experienced powerful emotions following a medical error [and] felt upset and guilty about harming the patient.... For many physicians, the most difficult challenge was forgiving themselves for the error” [1]. In the opinion of a study participant, “Forgiveness is something that I think is tougher for the physicians to give themselves than to get from the patient”[2]. The study’s authors concluded that “the notion of a ‘blame-free’ culture of errors did not diminish these physicians’ anguish and sense of culpability for errors.... Better institutional support for caregivers involved in errors would help them focus their attention on the affected patient” [3]. A recent book co-authored by Thomas H. Gallagher, MD, the lead investigator for this study, also highlights the psychological impact of making mistakes and disclosing them: “Deciding how to share the facts of the situation and avoid speculation while simultaneously managing feelings of guilt, the urge to assign blame, and the desire to protect oneself is hardly an easy task” [4].

Why Is Forgiveness an Ethical Issue for Physicians and Patients?

Ethics, including medical ethics, always has a social dimension. The values expressed in principles such as “do no harm” concern our actions with respect to persons and things other than ourselves. Ethics is more than rules of conduct, and, as these examples suggest, it involves close attention to the emotions present in an ethically challenging situation, including the physician’s own emotions. In the aftermath of medical harm, ethically sound practice entails the care of injured patients and their families through truth telling, apology, and fair compensation, actions that are likely to involve the physician responsible for the patient’s care at the time of the injury and may involve other professionals and administrators as well. (Fair compensation, for example, will usually require collaboration between the physician and an institution’s risk manager.)

A large literature suggests that the emotional impact on physicians of bad outcomes, such as the experience of being “fired” by a patient or family, should be recognized [5]. The physician whose self-confidence has been shaken by one case is still being relied on to provide care to other patients. The ethical dimensions of medical harm therefore include how the involved physician recovers from such incidents.

This recovery may involve the desire for forgiveness. Forgiveness is a word that has two contradictory meanings. We're accustomed to "forgiving" family members and friends after minor (or major) arguments. In these cases, "forgiveness" is understood to mean reconciliation, or at least agreeing to get along until the next argument. However, we may also "forgive" a loan to a family member, or the library may "forgive" our late fees. In these cases, "forgiveness" is understood to mean detachment, an end to a debt or other obligation between two parties. When we speak about forgiveness after medical harm, which kind of "forgiveness" do we mean? The kind that brings people together? Or the kind that allows them to detach from one another? These are important questions, because medical harm occurs in different types of health care relationships. How does "forgiveness" work in the relationship between a patient and a primary care physician? How does it work in the relationship between a hospitalized patient and the members of a health care team, or between a patient and a medical or surgical specialist who may not have much of a "relationship" at all? How do you forgive a "system" for a "systems error"? And what about "self-forgiveness"? Does that count?

What Are the Sources of Our Ideas about Forgiveness?

How a culture frames the human potential for error can influence how a person shaped, in some way, by this culture thinks about forgiveness as a possible response to human error. For example, in the Hebrew Bible, the word "*het*" appears 595 times, more than four times as often as its nearest synonym. This word for "error" has often been translated as "sin." A more accurate translation of "*het*" would be "to miss the mark," like an archer who takes aim at a target and misses, or a traveler who misses the correct turn, or a physician who orders the wrong drug, or a pharmacist or a nurse who doesn't catch the mistake in the order. The knowledge is there, the skill is there, the intent is there, but the action doesn't go as planned. The experience of making a medical mistake can feel like the experience of "missing the mark."

However, the same incident of "missing the mark" (for example, a harmful medication error) may be framed as a technical error by the culture of medicine; a potential claim by risk management; a systems failure by patient safety; an injury with medical, financial, and psychological consequences by the harmed patient or the patient's family; and a psychologically and professionally traumatic event by the individual clinicians involved. By appreciating the different ways in which the same incident can be framed, one can see how the expectations of each party concerning the resolution of such cases are likely to differ.

So how does the harmed party forgive the person or system that has missed the mark, resulting in the harm? Jewish traditions concerning forgiveness emphasize concrete, interpersonal obligations. "*Kapparah*," a Hebrew word associated with rituals of atonement, refers to the reconciliation of the person who has committed an error with the person he or she has injured. These rituals are enacted by observant Jews each year prior to Yom Kippur, the Day of Atonement. ("*Kippur*" and "*kapparah*" share the same root). Within the Jewish tradition and the Christian traditions that followed from it, forgiveness is a response to two discrete actions or series of actions: an

acknowledgment of the error by the person who has made it, a practice often called “confession,” and efforts by this person to make amends for the harm he or she has done, practices often called “repentance” or “atonement.” Forgiveness is the outcome of this relational ethical process.

In medicine, this process is set in motion by the discovery that what has happened was, in fact, a mistake, and should not have happened. Truth telling and apology are forms of confession, while providing fair compensation and analyzing and changing how work is performed with the goal of preventing future mistakes are forms of repentance or atonement.

Jewish and Christian traditions around error and forgiveness are powerful, if not always acknowledged, influences on Western culture and Western medicine. The practices that medical sociologist Charles Bosk describes in *Forgive and Remember*, his classic ethnographic study of the surgical mortality and morbidity conference (M&M), are clearly based on these traditions [6]. There is confession through the self-critical “hair-shirt” ritual of publicly describing the incident to one’s peers and superiors. There are acts of repentance through assigned tasks and close supervision. And there is official forgiveness by a senior surgeon, who functions as deity, high priest, judge, pastor, peer group representative, and injured party.

The injured party—the patient, or the loved ones of a deceased patient—is excluded from this forgiveness ritual. Yet patients and families also have ritual needs and expectations in the aftermath of medical harm. A well-designed disclosure process should take these needs and expectations into account by talking with patients and families about their experiences, good and bad [7].

In the Jewish and Christian biblical traditions, the deepest meaning of forgiveness is detachment, of not being bound by error. The metaphor associated with forgiveness is the cancellation of a financial debt that can never be repaid and reflects a culture in which debt-servitude was common. Yet the idea of forgiveness as reconciliation may also be closely associated with these religious norms. Patients and health care professionals alike may base their ideas about what “good” people are supposed to do after one person harms another on lessons they learned as children, whether these lessons were conveyed in terms of religious beliefs and practices, or simply as good manners: “you mess up, you ’fess up.” In the aftermath of medical harm, individuals who hold these values may be unsure whether their goal is the reconciliation of persons. Becoming free from the error itself as a source of continued suffering for patients, families, and clinicians may be an appropriate goal whether or not individual persons wish to be reconciled.

Influential traditions are not universal norms. Not everyone uses the same metaphors, learns the same prayers, has the same parents, or thinks about human relationships the same way. For example, forgiveness as a metaphor for a relationship between individuals may not make sense in religious traditions such as Hinduism or Buddhism in which a concept of the self as independent from other persons is not the

norm. In traditions such as Buddhism, in which suffering is recognized as an inevitable feature of human existence, compassion (literally, “suffering with”) may be the most common metaphor for the repair of damaged relationships. In a culturally diverse society like the United States, where the physician population and the patient population may have been shaped by a variety of religious and other cultural experiences, it is important to recognize the largely Western sources of medicine’s metaphors and expectations concerning error and forgiveness while also recognizing that the metaphors and expectations of individual clinicians and individual patients may derive from other sources or from a combination of traditions.

Is Forgiveness Good for Us?

Research by some clinical psychologists and social scientists suggests that the ability to forgive may be characteristic of an emotionally healthy person, that a refusal to forgive may be associated with behaviors ranging from holding grudges to perpetuating civil conflicts, and that these unhealthy behaviors can be modified [8]. Other scholars and clinicians have criticized efforts to prescribe forgiveness as a therapeutic intervention, arguing that these efforts fail to recognize forgiveness as an individual’s personal response to the experience of being harmed [9]. As legal scholar Martha Minow points out: “Fundamentally, forgiveness cannot be commanded” [10].

This body of empirical research does not, as yet, address forgiveness after medical harm directly, so these findings cannot be applied directly to this situation. However, because the idea that forgiveness is good for people is an attractive one in this culture (witness the popular magazine articles), it is worth seeing whether that idea works when someone who expected to be helped has been harmed. Right away, there is a problem if we identify forgiveness as a characteristic of an emotionally healthy person and then describe an injured patient as if he or she is willfully holding a grudge if he or she cannot offer forgiveness. The routine characterization of harmed patients as “angry” patients reflects this still-common failure to acknowledge that anger is an appropriate response to this situation and also to acknowledge who is accountable for making things right after harm. This can also happen at the organizational level when a hospital characterizes itself as a “blame-free” culture but fails to explain how this helps patients. Will this new culture dismiss patients and families who seek explanations or compensation for harm as troublemakers who are looking for someone to blame?

There is a further caution with respect to prescribing forgiveness broadly as an intervention. As human beings, we may be reluctant to say, “I forgive you” if we believe that we are merely excusing bad behavior rather than responding to changed behavior. Psychologists call the pressure to offer forgiveness prematurely “pseudo-forgiveness” or “role-expected forgiveness,” and some have suggested that therapeutic interventions that aim to produce forgiveness are unsound in that they place responsibility for the resolution of harm on the harmed party, who may also be the less-powerful party [11]. The patient who feels pressured to offer “pseudo-

forgiveness” may get angry—and may eventually file a lawsuit. The discovery of a harmful mistake leads directly to the words “I’m sorry.” But the words “I’m sorry” do not lead directly to the words “I forgive you.” This is not solely a matter of the right words.

What about Self-Forgiveness?

Forgiving oneself for harming a patient is not at all the same thing as making it possible for this patient to choose to offer forgiveness. However, a physician who, through his or her actions, supports the ability of a patient to forgive may also need to practice self-forgiveness, so he or she is able to get back to work. But what does “self-forgiveness” mean beyond an intuitive sense of wanting to be free of the burden of guilt?

Philosopher Charles Griswold rightly distinguishes between forgiveness, which can be granted only by the injured party, and self-forgiveness. In self-forgiveness, according to Griswold, “the injury that one has done to oneself—precisely in injuring another” is the catalyst for confessing to oneself [12]. So if the discovery of the mistake leads directly to the words, “I’m sorry,” the discovery of the harmful mistake also initiates a parallel process that can lead to self-forgiveness, as the physician grapples with the “existential blow” of having harmed a patient [13].

Jeffrey Blustein, a philosopher and medical ethicist, argues that self-forgiveness, like forgiveness, is a feature of “taking responsibility for one’s past” [14]. In Blustein’s view, “the past” should not be reduced to a moral checklist of what we have done and what we have failed to do, but should be viewed in psychological and narrative terms: “what one has shown oneself to be like by what one has done” [15]. Our own past, as we understand it, is something that ought to be accessible and useful to us; physicians, for example, are accustomed to drawing on their years of clinical training and experience. If we are unable to forgive ourselves for something in our past, there will be a break in the story as we know it. We are going to have difficulty understanding the content of our own character. And we may have difficulty anticipating how well we will respond to a similar situation in the future.

Blustein reminds us that any genuine process of forgiveness is not automatic:

Self-forgiveness, like forgiveness of others, is ordinarily a process that has to be gone through: it takes time and often not a little effort to suppress or forgo one’s self-directed negative feelings.... One cannot forgive oneself for what one has done if one is not prepared to take responsibility for it, and the explanation of the failure to take responsibility for some problematic part of one’s past might be that one cannot or will not forgive oneself for it.... insofar as it is a flaw in a person that he is not self-forgiving, it is also and for the same reasons a flaw in a person that he does not take responsibility for his past [16].

What do we make of this tough-minded philosophical account? On the one hand, a physician who is not self-forgiving either fails to acknowledge his or her own certain

fallibility or else views himself or herself as a moral monster, irredeemably flawed. Neither of these is a trustworthy position from which to move forward and to help others. On the other hand, making self-forgiveness into a mere refrigerator-magnet affirmation means the physician is skipping the hard work of figuring out what, exactly, he or she is on the hook for.

The process of self-forgiveness is likely therefore to be a messy one, as the physician wrestles with his or her own emotions and sense of responsibility concerning his or her own actions and also, perhaps, wrestles with emotions directed toward others involved in a systems error: Why didn't that pharmacist catch the mistake in my order? Why didn't that nurse question that order? Do they share responsibility for this harm, or is it all on me? And how can I talk about this with them so we can continue to work together?

In the same essay, Blustein writes that self-reproach makes sense only “for something over which one had some control” [17]. Separating one's emotional response to a distressing situation (what happened to that patient was terrible!) from one's praiseworthy or blameworthy actions within those areas under one's control (what was my role in what happened to that patient?) involves reflection on these questions: Do I feel bad about this situation because it's inherently tragic? Or do I feel bad because I had an opportunity to do some specific good or prevent some specific harm—and I blew it? This is a complicated question, because medical mistakes happen inside of complex systems.

Richard Cook, an anesthesiologist who studies systems such as health care that are “intrinsically hazardous” and “possess potential for catastrophic failure,” points out that working in such a system “requires intimate contact with failure” [18]. That is, the physician or other worker should be able to imagine how a tolerably safe situation (what Cook calls “the envelope”) can slip into an unsafe situation, and “how their actions move system performance towards or away from the edge of the envelope” [19].

Conclusion

So what should physicians do in the aftermath of medical harm, with respect to forgiveness? What helps the injured party? And what helps the physician recover from this incident? The physician should not expect to hear the words “I forgive you” from an injured patient or family, even after disclosure, apology, and assistance in securing fair compensation have taken place. Asking for forgiveness may be oppressive to a patient or family still grappling with the fact of the harm, the impact of the harm, and their own emotional response to the harm. Asking them, during a time of crisis and even bereavement, to offer a premature, formulaic response is simply too much to ask. The process of forgiveness may be the work of months or years.

At the same time, however, the physician can work toward self-forgiveness, by taking responsibility for his or her past, by working to understand his or her role in

an incident that slipped beyond the envelope of safety, and by responding to the needs that have been created as the result of harm. Valuing forgiveness as a desirable and authentically human response to human error in medicine requires physicians and their colleagues to create the conditions that will help those who have been harmed to offer forgiveness, and that will also help those whose actions have caused harm to be restored, as healers.

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