Forgiveness

The title of the landmark Institute of Medicine report on medical error, *To Err Is Human*, is derived from Alexander Pope’s “Essay on Criticism” (1711): “To err is human; to forgive, divine” (l. 525). Given how familiar this proverb is in its entirety, it is striking that the IOM report itself contains no reference to forgiveness, divine or otherwise, in its treatment of medical error, even as its title hints at a fundamental relationship between error and forgiveness. A systems approach to medical error, the approach advocated by the IOM and the national patient-safety movement alike, may similarly “forget” to engage forgiveness as a tool for addressing the needs of all parties affected by medical error: patients, families, clinicians, administrators, and institutions. Insights from religion and related aspects of culture may help clinicians, ethicists, and other professionals involved in nurturing “cultures of safety” within health care institutions, or medical educators responsible for introducing students to the sensitive issue of their own fallibility and its potential impact on patients, to recognize the restorative role that forgiveness has long played between individuals and within communities and to incorporate forgiveness into ways of thinking about and addressing medical harm. What follows is a broad “religious studies” rather than a strictly “theo-
logical” or “doctrinal” perspective on forgiveness, one that incorporates insights from Jewish and Christian social ethics, ritual studies, the sociology of medicine, and medical anthropology, as well as from clinicians themselves. Dena Davis defines the task of the religious ethicist working on clinical issues as describing what real people really believe and how they really act, a definition worth keeping in mind whenever the word “religion” comes up in relation to clinical medicine.2

That said, several concepts borrowed from Christian theologian Dietrich Bonhoeffer—“cheap grace” among them—are integral to the argument against what might be termed forgiveness as a self-interpreting principle. What is meant by this phrase is a way of formulating “forgiveness” so that its relational character—the actions that various persons undertake in relation to one another so forgiveness can take place—is forgotten. This relational understanding of forgiveness may be replaced by a cheap grace that, in formulating forgiveness as automatic, either acknowledges no role for the injured person as agent of forgiveness, or assumes that this person should offer forgiveness in the absence of truth telling, apology, fair compensation, or other goods that we might place under the ethical principle of justice. In cases of medical harm, a cheap-grace approach on the part of professional caregivers, including clinicians, chaplains, social workers, or pastors, may also place pressure on injured patients and their families to forgive automatically—by reminding them, in subtle and not-so-subtle ways, that “good” people are “forgiving,” or by assuring them that offering forgiveness will bring them “closure,” or by telling them that, after all, nobody meant to harm them—even as these patients and their families remain profoundly distressed by not knowing what really happened, or by the absence of any acknowledgment of their suffering by those directly responsible for it.

In avoiding nonrelational approaches to forgiveness, we must keep in mind that forgiveness is a “Janus” word, in that it holds contradictory meanings—to engage and to detach—that are often conflated or insufficiently distinguished in everyday conversation and in scholarly discourse: One of the most important questions you can ask about forgiveness is what you mean when you use this word. In the Jewish and Christian traditions, the deepest meaning of forgiveness is detachment. Forgiveness as cheap grace, as entitlement rather than outcome, ignores this deep meaning by refusing to ask what those harmed through medical mistakes may need to achieve detachment, or by pressuring them into engagement or acquiescence, even into a divine, salvific role, instead of allowing detachment to take place over time—in what the Christian Bible refers to as kairos, the
appropriate time, as opposed to *chronos*, chronological time—once justice has been secured. Arguing for a definition of forgiveness after medical harm that holds detachment as the ultimate goal of the process does not mean that injured patients—or clinicians who have made errors—should simply be encouraged to “detach” from incidents of medical harm, and from their feelings concerning these incidents. Even in mundane interpersonal situations, forgiveness-as-detachment can be problematic: After we have succeeded in emotionally detaching ourselves from a painful situation, we may still hesitate to say “I forgive you” if we believe that, by doing so, we are excusing bad behavior rather than affirming changed behavior.

Before turning to Jewish and Christian traditions and social ethics around error and forgiveness, one final caution. Though these traditions are powerful, if not always acknowledged, influences on Western culture and Western medicine, they are not universal. Even informal conversations with clinicians and scholars knowledgeable about non-Western religious and cultural traditions and expectations can help to dispel the notion that forgiveness, in particular, is universally understood as a principle, norm, or religious or secular practice. Recalling Arthur Kleinman’s definition of the “category fallacy”—the “imposition of a classification scheme onto members of societies for whom it holds no validity”—is instructive. It would not be appropriate to talk about the “Buddhist” or “Hindu” understanding of forgiveness, not because these traditions are “unforgiving,” but because “forgiveness” as a metaphor for a relationship between autonomous persons simply may not work in traditions in which a concept of the self as independent from other persons or one’s past lives is not the norm. For example, in traditions such as Buddhism in which suffering is recognized as an inevitable characteristic of human existence, compassion (literally, “suffering with”), not forgiveness, may be the predominant metaphor for the repair of damaged relationships. At a time when one in five physicians practicing in the United States was born and raised in Asia, as was one in four foreign-born residents of the United States, it is ever more important to be aware of the extent to which allegedly “universal” norms and rituals concerning error and forgiveness are grounded in Western culture, Western religions, and Western ideas about the self. Those of us who may, on occasion, be responsible for doing religious ethics—for describing what real people really believe and how they really act—must also be aware of any tendencies on our own part to simplify, sentimentalize, or appropriate non-Western metaphors for complex ethical relationships.
Forgiveness in Jewish and Christian Social Ethics

The root word *bêt* appears 595 times in the Hebrew Bible, more than four times more often than its nearest synonym. This word is usually translated into English simply as “sin,” but its oldest meaning—a meaning that has parallels in other ancient Near Eastern cultures—is to “miss the mark,” like an archer who takes aim at a target and misses it, or a traveler who misses the correct turn. *Bêt* is also used to describe breaches of social ethics, as when someone “misses” an opportunity to assist another. It has a theological dimension when one misses with respect to one’s relationship with God, or in the performance of religious rites.

What is interesting about *bêt* is that it truly means “missing the mark”—that is, error, not necessarily “sin” in the post-Augustinian sense of original sin or moral taint—requiring close attention to context to determine whether a given error was intentional, unconscious, or avoidable, a matter of judgment, skill, experience, or character. As such, the word and its associated images may make a hermeneutical contribution to understanding how different actors know medical mistakes. The same incident of “missing the mark” may be framed as a technical error by the culture of medicine, as a risk management problem by hospital lawyers, as a moral wrong, an injustice, perhaps even a sin, by the injured patient or the patient’s family, and as spiritual and psychological devastation by the individual clinicians involved. By appreciating the different ways in which a medical mistake may be interpreted, we may better comprehend how the expectations of stakeholders concerning the resolution of such cases may differ and conflict.

Within the Jewish and Christian traditions, forgiveness works roughly like this: God forgives the error itself, whereas the injured party forgives the individual who has made the error. Thus, forgiveness has both a divine and a human component and encompasses two relationships, one between a human being and God, the other between human beings. Furthermore, forgiveness is a response to two discrete actions or series of actions: an acknowledgment of the error by the person who has made it, the practice often called “confession,” which is inclusive of disclosure and apology; and an effort by this person to make amends for the harm he or she has done, the practice or practices often called “repentance” or “atonement.” In these traditions, therefore, forgiveness is properly understood as the outcome of a relational ethical process.

Jewish traditions concerning forgiveness emphasize human agency to a some-
what greater extent than do Christian traditions, in which divine agency, often represented by clergy, may be more prominent. For example, kapparah, the Hebrew word for atonement, refers to the reconciliation of the person who has committed an error with the person he or she has injured. The error is forgiven only when the injured person has been sufficiently appeased, a process that may involve concrete restitution—the word kapparah comes from a legal term for compensation—and that is ritually enacted by observant Jews each year prior to Yom Kippur. The traditional Jewish understanding of atonement as the reconciliation of persons thus requires the injured party, as the human agent of forgiveness, to play an active role in the repentance of the person responsible for his injury. If taken literally, this expectation may be oppressive to the injured party, who may wish neither to engage directly with this person, nor to be held to her time frame for atonement. In recent years, the Kabbalist concept of tikkun olam, or “repairing the world” through acts that promote social justice, has come to be associated with the traditional rituals of Yom Kippur, extending the idea of atonement beyond the reconciliation of individuals and toward communal responsibility for addressing injustice and the needs of the most vulnerable members of society.

The extensive use of the Lord’s Prayer in Christian worship makes it a window through which to glimpse how individual perspectives on error and forgiveness may be grounded in formative religious influences and internalized norms. The best-known version of this prayer comes from the Gospel according to Matthew and includes the phrase, “forgive us our debts, as we also have forgiven our debtors.” The “debt” language, which has many antecedents in the Hebrew Bible, means God forgives sin by releasing the believer from the error that is holding him captive, and that one human being forgives another by detaching from that person, and the harm that person has caused, as a source of pain, anger, and injustice. The underlying metaphor is the cancellation of a financial debt that can never be repaid; the metaphor itself is grounded in a culture in which debt-slavery was common. The shorter, probably older version of this prayer found in Luke’s Gospel makes even clearer the extent to which these early Christian texts are grounded in the Jewish understanding of how forgiveness works: “forgive us our sins, for we ourselves forgive everyone indebted to us.” God forgives the error, but people must first forgive one another.

Christian paradigms of error and forgiveness may stress personal salvation (the repair of one's relationship with God) over the concrete making of amends to the injured party (the repair of one’s relationship with another human being).
These tendencies can lead to a truncation, even a perversion, of the process of forgiveness that Bonhoeffer memorably characterizes in *Discipleship* as “cheap grace . . . cut-rate forgiveness . . . grace as doctrine, as principle, as system.” In this “system,” disclosure, apology, and repentance—all the traditional, specific responsibilities of the person who has harmed another—are eliminated, as forgiveness is elevated to a “general truth.” These are tough, even shocking words, coming from a Lutheran pastor whose tradition taught that Christians did not earn forgiveness through their own deeds, but had it freely bestowed upon them by God: As Luther himself famously wrote, “Everything is forgiven through grace.”

Yet what is free is not without value, and Bonhoeffer lambastes his church for treating a divine gift as though it were “bargain-basement goods”: “The world finds in this church a cheap cover-up for its sins, for which it shows no remorse and from which it has even less desire to be set free.” Bonhoeffer’s “world” is Nazi Germany, and “this church” is one that, by and large, acquiesced to evil rather than defying it, allowing itself to be used by the regime rather than working on behalf of the regime’s victims. In Bonhoeffer’s analysis, the Nazi-affiliated Reich church is the ultimate failed system.

Bonhoeffer’s cheap-grace formulation has been used by Christian feminist ethicists to critique what Pamela Cooper-White calls “an ethic of instant forgiveness” among well-intentioned pastors and other counselors who encourage trauma survivors to forgive abusers who refuse to acknowledge or repent of their actions, and to do so even before “uncovering enough of the factual story to know what really happened.” It is also useful to discussions on the ethics of medical harm, in its criticism of forgiveness understood in terms of a “principle” or “system” that reflexively protects those who cause harm, even inadvertently, at the expense of those who suffer as the result of harm. When forgiveness is embraced, unexamined, as a self-evident principle—something that good people do because it’s the right thing to do—rather as the outcome of a process that requires something of the one whose actions have led to harm, it may be misunderstood as a surrogate for the ethical principle of justice: The right thing to do after I have harmed you is for you to forgive me. And when discourse on medical error misuses the language of “systems” to dodge the issue of individual responsibility, or when the “factual story” about a patient’s health, including injury resulting from error, is withheld from that patient, the ethical principle of respect for persons is undermined. In either case, what is ignored is what Bonhoeffer, in his *Ethics*, calls the “concrete place” of ethics—here, the reality of human suffering resulting from harm—and its attendant responsibilities.
In recent years, forgiveness has captured the attention of science. A Campaign for Forgiveness Research, an initiative of the John Marks Templeton Foundation that promotes the scientific study of forgiveness, has sought to support 60 research projects on “the power of forgiveness and reconciliation” in four categories: forgiveness among individuals, among families, and among nations, and the biology and human evolution of forgiveness. Although none of the projects funded to date focuses on forgiveness after medical harm, information published online by Templeton-funded researchers focusing on “forgiveness among individuals” appears to suggest that responsibility for repairing damaged interpersonal relationships lies with the person who extends or withholds forgiveness. Thus, the Heartland Forgiveness Project at the University of Kansas describes “persons who are stuck in unforgiving, unproductive patterns of interacting with themselves, other people, or situations” as those who may benefit from “forgiveness interventions.” The Stanford Forgiveness Project, which asserts “all major religious traditions and wisdoms extol the value of forgiveness,” describes its focus as “training forgiveness to ameliorate the anger and distress involved in feeling hurt . . . the need for forgiveness emerges from a body of work demonstrating harmful effects of unmanaged anger and hostility on health,” and offers its “unique and practical definition of forgiveness,” which “consists primarily of taking less personal offense, reducing anger and the blaming of the offender, and developing increased understanding of situations that often lead to feeling hurt and angry.”

Clinical research by developmental psychologist Robert Enright and others strongly suggests that the ability to forgive is a marker of psychological health and may be indispensable to the healing of relationships. However, identifying forgiveness as a norm or virtue characteristic of a physically, emotionally, and morally healthy person without closely examining the roles that disclosure, apology, and repentance play in allowing one person to forgive another potentially conflates someone who has been injured through medical harm or other trauma with someone who has a tendency to “feel hurt” and “take offense.” As the sole agent of forgiveness in this scenario, the injured person must both be good and be God, responsible for saving herself and other people from her own unhealthy, “unproductive” anger.

Forgiveness Rituals in Western Medical Culture

Forgiveness after medical mistakes — of certain persons, by certain persons — is built into the culture of Western medicine. Charles L. Bosk’s classic sociologi-
cal study, *Forgive and Remember: Managing Medical Failure*, provides detailed and by all accounts still-relevant descriptions of forgiveness norms and practices among surgeons. Bosk reports that among his subjects, the practice of forgiving errors “operates as a deterrence” to future errors, as the “subordinate” who is forgiven by his or her superior “becomes more vigilant” in patient care and more likely to ask for help when confronted by complications (178). And because what these surgeons describe as the “‘hair-shirt’ ritual” of “self-criticism, confession, and forgiveness” is enacted before one’s peers during the Mortality and Morbidity Conference, the ritual “also serves to reintegrate offenders into the group” and reaffirm group norms: “Since in time all make errors in techniques, all are obliged in time to go before the group and humble themselves. Through this practice of confession and forgiveness, the group exacts the allegiance of all its members to its standards” (178–79).

Bosk’s richly descriptive account of the hair-shirt ritual of M&M as practiced by surgeons allows readers to identify vestiges of ancient Jewish and Christian practices concerning forgiveness. Both Jewish and Christian communities have long incorporated ritualized confession into their most solemn rites, most notably on Yom Kippur in the Jewish tradition and on Ash Wednesday in the Roman Catholic and other Christian traditions; Bosk notes that such practices are common in monasteries (178). The “hair-shirt” that functions here as a metaphor for “self-criticism” was (and is) a real garment, woven of animal hair and worn as an act of penance during religious rites and as an ascetic practice. We can even see, in the sequencing of ritual actions — confession, forgiveness, and then repentance through professional vigilance — a parallel with the reordering of Christian penitential rites in the late medieval period, as the practice of individual confession, followed by absolution and then by the performance of penitential acts assigned by one’s parish priest, took hold. Viewed through the lens of Western religious tradition, the M&M hair-shirt ritual and related penitential practices are neither modern nor wholly secular, whether contemporary participants recognize the ancient cultural roots of their professional ritual.

What is perhaps most striking in Bosk’s account is the part played by the erring surgeon’s superior, who combines religious and secular roles, functioning as deity, high priest, judge, pastor, peer group representative, and injured party, forgiving both the error itself and the person who makes the error. According to a taxonomy devised by moral philosopher J. L. Austin, who catalogued the ways rituals can fail to fulfill their cultural, religious, or psychological functions through “infelicitous performances,” this conflation of roles constitutes a “ritual
misapplication": a legitimate ceremony that fails because of the involvement of inappropriate persons. The hair-shirt ritual, qua ritual, fails because it excludes the patient, whose roles as injured party and as human agent of forgiveness are usurped by the erring surgeon's superior. (The surgeons who participate in this ritual do not perceive this failure, because they would not expect patients to be part of their community and its professional rites.) The patient has no role, no voice, and no representation within this private ritual and cannot rely on it for justice and for the possibility of being able to forgive and to heal. This is not to say that injured patients should be included in M&M. It is to say that the ritual of confession, repentance, and forgiveness may be as culturally important to patients as it is already understood to be among physicians, and it should be available to them in an appropriate venue.

The hair-shirt ritual may be infelicitous in another way. When clinicians and hospital chaplains talk about the topic of forgiveness after medical error, self-forgiveness emerges as a constant theme. Members of both of these professions stressed that some form of self-forgiveness was essential in restoring confidence and morale after incidents of medical harm, even as one physician acknowledged that although self-forgiveness is "something we all have to face when we make an error that harms someone... It is hard to get physicians to think in these terms." Clinicians do not tend to characterize existing institutional processes, such as M&M, as capable, in and of itself, of helping those who have made errors to forgive themselves. Instead, the ability to have private, unguarded conversations with colleagues (what one physician called a "cadre of friends") or chaplains (described as a "safe space") in which they could discuss incidents of medical error and their own roles in and emotions concerning these incidents, appeared to be the single most important factor in the clinicians' ability to forgive themselves.

One physician questioned the appropriateness of the term "self-forgiveness" and the theological premise underlying it: that one could be the agent of one's own salvation. Taken literally, self-forgiveness would be another example of cheap grace, in which the other—the injured party, God—is pushed out of the frame, whereas the person who has made the error is forgiven without any assurance that the relational actions traditionally described as confession and repentance have taken or will take place. This physician suggested an alternative definition for so-called self-forgiveness—"freedom from guilt and self-hatred"—while arguing that forgiveness itself must be understood to be relational: "there must be a self-transcending aspect to forgiveness—or it does not occur."
Among clinicians, the need for self-forgiveness was held in tension with the belief that there was not "much of a possibility" of being forgiven by a patient or a patient's family after medical harm. There is in these words a poignant echo of Christopher Marlowe's version of the Faust legend: In his despair, Dr. Faustus believes—incorrectly—that his "offense can never be pardoned" (Dr. Faustus [1604], Scene 14). Lest the contemporary reader imagine spiritual despair to be a quaintly "religious" notion or literary conceit, here are some of the words that clinicians used to describe their responses to their own mistakes: "devastated"; "heartsick . . . demoralized, worthless." These clinicians also reported that even peripheral involvement in an error—referring a patient for a procedure, then learning that the patient was injured while being moved, or knowing a patient by sight, then learning that this patient has committed suicide—can result in feelings of "devastation" and "failure" among many staff members. The word "devastating" also came up with respect to legal liability, both in terms of what being sued can do to one's career and in terms of "the folk wisdom" among physicians concerning the percentage of patients who do sue. Given this snapshot of the psychological and spiritual dimensions of how medical harm is experienced by clinicians, it is not surprising to learn that, according to a director of pastoral care who also serves as a medical school instructor and chaplain, "theological concepts can be useful even if you don't use [theological] language" when counseling clinicians after critical incidents.

Although there is virtually no literature on the role of professional hospital chaplains in providing emotional support to medical students, physicians, and other clinicians after medical mistakes, these and other conversations indicate that some chaplains are regularly involved in counseling clinicians after mistakes, and that chaplains in general view the provision of pastoral care to hospital staff as a "recognized part of [their] ministry." A chaplain who had previously worked as a nurse for more than 30 years said she could imagine creating a "ritual of forgiveness" on her unit to help hospital staff come to terms with their own errors: "I could picture me doing it—I don't think it's far-fetched at all." However, what is true for the M&M hair-shirt ritual is also true for any alternative rituals that are practiced or being developed elsewhere within hospital culture. The injured patient is not a member of these "congregations." As such, these rituals do not provide the patient with an opportunity to forgive if he chooses to do so, because they do not ensure that the patient has first received justice.

And what might the justice-making project encompass following medical harm? Recalling the recovered Jewish tradition of tikkun olam, with its under-
lying image of the repair of a shattered world and its attentiveness to the social context of justice, the concluding chapter of this book consists of some practical suggestions derived from the needs, concerns, and cautions identified in the previous chapters. This is not intended as an all-or-nothing list of ethical responses to medical harm, but aims to describe practices that can be incorporated into the cultures of community hospitals and university medical centers alike—and that, for the most part, do not cost the institution anything to implement. Even the proposal that hospitals provide fair compensation to injured patients is cost-effective, when weighed against the costs of litigation. In their frequently cited analysis of the financial impact of the Lexington Model of full disclosure, discussed in the previous chapter, Steve S. Kraman and Ginny Hamm observed that the policy had “resulted in unanticipated financial benefits” due to the decrease in legal and administrative costs incurred in defending malpractice suits, and concluded that “an honest and forthright risk management policy that puts the patient’s interests first may be relatively inexpensive.”

The assignment of suggested practices into the traditional Western religious categories of “confession,” “repentance,” and “forgiveness” is necessarily subjective. In general, practices listed under “confession” involve truth telling, apology, and other communications between those held accountable for medical harm and those who have suffered as the result of medical harm. Practices listed under “repentance” include actions that those held accountable may take following the disclosure of medical harm to ensure that any medical, financial, or other needs of injured patients and families are addressed. Practices listed under “forgiveness” may be thought of as existing in kairos time, in that they are envisioned as taking place whenever appropriate, which may mean “often,” “all the time,” or “before the next patient is injured.”

In the cheap-grace material that introduces Discipleship, Bonhoeffer excoriates institutions that seek to protect themselves at the expense of justice. To create patient-safety systems that acknowledge the suffering and protect the interests of injured patients and their families, allowing them to detach and to forgive, administrators, clinicians, educators, and others involved in patient-safety efforts within health care institutions must learn to be ever attentive to Bonhoeffer’s “view from below,” which is always in the first instance the perspective of the harmed patient and family. In so doing, they may avoid the cheap grace of presuming that it is enough for the institution to confess to and to forgive itself, for harms done to those in its care.