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Forgiveness: An important principle in medical ethics and palliative care?

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Essay/Personal Reflection

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During my first year of medical school, I participated in a course where students gathered to discuss, among other topics, medical ethics. At the time, my classmates and I were introduced to four core principles of the field: beneficence, nonmaleficence, autonomy, and justice. We employed these principles, implicitly or explicitly, while advocating for our stances on a wide range of ethical subjects. I am grateful for the clarity provided by these principles and for the rigor demonstrated by my classmates and instructors.

But years later, having finished a second edition of that course as well as my third year of medical school, I am struck by something that received much less attention during my introduction to medical ethics: forgiveness. I am now in the second half of my undergraduate medical training, but already I have seen the tremendous toll enacted on my peers in their efforts to live up to professional ideals. Those ideals are not, by any means, wrong or misplaced, but it seems safe to suggest that they are not often taught with a view to the ways in which even the most ideal professionals are, in the end, still people. To err is human, the saying goes; but to forgive, divine. Anyone knows this who does enough living. And so, as I reflect on the rates of burnout in medicine and on the fact that, despite our best efforts, we still err, I wonder whether, among all our ethical principles, we might need a greater focus on this virtue (Rotenstein et al., 2018).

In the remainder of this essay, I will provide a brief historical background to the idea of forgiveness in medical ethics; discuss why forgiveness should matter to clinicians and ethicists; and argue for its special importance in palliative care. I will not attempt to systematically place forgiveness within a particular set or hierarchy of ethical principles. My hope is simply that palliative care clinicians will take an interest in forgiveness as an important aspect of medical ethics and agree that forgiveness — for clinicians, for patients, and for our imperfect world and health care system — may have an explicit place wherever our professional ethics are discussed.

In a widely read article from 1984, Dr. David Hilfiker describes several medical errors made over the course of his career (Hilfiker, 1984). In his reflection, Hilfiker is not primarily interested in the ethical questions with which my classmates and I have grappled in class: Should one always disclose medical error? Should one admit to being personally at fault when errors occur? Hilfiker is more interested in forgiveness itself, and these are not questions about forgiveness but about right and wrong. Hilfiker, who seems quite grounded in his sense of right and wrong, is wrestling with the barriers that prevent us from talking frankly about our mistakes, and the guilt that accumulates behind those barriers.

In a more recent article, Drs. Delbanco and Bell write that clinicians "often suffer alone after making mistakes, agonizing over the harm they have caused, the loss of their patients' trust, the loss of their colleagues' respect, their diminished self-confidence, and the potential effects of the error on their careers" (Delbanco and Bell, 2007). They argue that the first steps toward resolving such agony "might include creating a structured curricula" and "removing stigma from transparent reporting systems" (Delbanco and Bell, 2007). These recommendations do move some distance toward addressing the problems raised by Hilfiker, but in all their language of structure, systems, and experts, there remains something missing from the healing he describes.

Forgiveness might be what is needed. In their study on the process of coping with medical error, Plews-Ogan et al. find forgiveness to be among several core themes that help physicians "cope positively" with their mistakes (Plews-Ogan et al., 2016). In a recent essay, the Harvard epidemiologist, Dr. Tyler VanderWeele even argues that forgiveness "is important to public health" (VanderWeele, 2018). But forgiveness, in these examples, is not mere excuse or pardon. To forgive "is neither amnesiac nor an exacting of payment" but "a dynamic recovery of what is lost": in this case, the recovery of actual wholeness from the lost ideals of ourselves as perfect or perfectible individuals (Jones, 2013). Far from compromising the rest of medical ethics, forgiveness grounds our abstract principles in the raw matter of reality.

In medical training and professional development, such grounding could involve the emphasis that all of us, over the course of our careers, will make mistakes; and this emphasis would, ideally, yield itself to a common culture in which each of us feels confident in attaining forgiveness, both personal and professional, when needed. To begin fostering such a culture, ethical training in medical school, residency, fellowship, and continuing medical education

could include assigned readings about the philosophical, psychological, and spiritual traditions surrounding forgiveness: the philosophical difference, for instance, between forgiveness and excuse; the psychological and neuroscientific effects of forgiveness; and the spiritual traditions that treat forgiveness not as a palliative measure for uniquely bad people but as the natural response to our imperfect human conditions. Students and practitioners could also read about, and participate in, the growing literature on forgiveness and health. Finally, explicit policies of forgiveness could be developed in our hospitals and institutions, and communities created in which clinicians offer forgiveness to one another as individuals or in small groups.

The benefits of forgiveness are not restricted to professional circles. In their writing on medical error, Delbanco and Bell suggest that patients and families suffer when the natural process of apology and forgiveness is stifled by institutional policy or the fear of professional repercussions. When providers do not seek forgiveness — whether following medical error or a lapse in ethical judgement — patients and families may go without deeply desired validation and emotional comfort: "What we needed was for someone to reach out and connect with us in human terms" (Delbanco and Bell, 2007). The act of disclosure, apology, and asking for forgiveness provides substantive opportunity for such human connection.

We should note, also, that forgiveness offers its own sort of ethical training. Dr. Farr Curlin, in his review of Dr. Nancy Berlinger's book *After Harm: Medical Error and the Ethics of Forgiveness*, highlights "a complex challenge for the medical profession: how to form medical professionals who will, in the face of real threats to their own reputations, pride, and financial security, willingly disclose medical harm, [apologize] for their errors, and take concrete steps to fairly compensate patients for what has been lost" (Curlin, 2005). This challenge is at least partly answered by a collective focus on forgiveness, because an awareness of forgiveness and its accessibility can (in ways that ethical deliberation on its own cannot) offer the security to openly acknowledge one's mistakes and correct them in the company of others. As VanderWeele suggests, forgiveness offers us not a free pass on ethical judgement, but rather a "space to change" into continually wiser clinicians and people (VanderWeele, 2018).

Before concluding, I want to touch on the unique place of palliative care in all this. Palliative care clinicians are, for the most part, familiar with moral injury and moral distress, given the deep ethical and spiritual contexts in which their work takes place (Rushton et al., 2013). In turn, the specialty is no stranger to forgiveness (Leget, 2020). Because of this deep connection, I argue that palliative care could lead the medical profession in a deeper exploration of forgiveness within its academic literature and clinical training. Judging from the rich philosophical discourses on forgiveness, palliative care clinician–ethicists would fill a large gap in the medically facing scholarship by examining opportunities for, and obstructions to, forgiveness in modern health care (Hughes and Warmke, 2017). How can clinicians and patients seek and receive forgiveness? How do our caregiving institutions facilitate and block this process? How might we train our medical students, residents, and fellows to promote a culture of openness and reconciliation? These are exciting and important questions, and I think that palliative care clinicians would have substantial credibility in answering them.

If the stated aim of our ethics is primarily to do good, to avoid harm, to honor individual decision-making, and to pursue justice, we will eventually find ourselves having failed that aim one way or another, and without forgiveness will be faced with the real distance between our professional philosophies and our historical realities. I would like to see forgiveness integrated throughout training and practice in medical ethics: emphasized by leaders, advocated for in our discourse, and practiced between one another. I think that palliative care clinicians are well-positioned to spark this integration — one that seems, to me, the best way to healing.

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