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How do patients and families perceive forgiveness in response to medical errors, and what factors influence their willingness to forgive healthcare providers?

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Abstract

Medical errors are an unfortunate yet inevitable part of healthcare often causing psychological, emotional and physiological distress for patients and families. In the context of medical errors, forgiveness is a complicated and multidimensional phenomenon that can have a significant impact on the relationship between patients, families, providers, confidence in the healthcare system, and the broader healing process. This thesis explores how patients and their families perceive forgiveness following a medical error and the factors that shape their willingness to forgive healthcare providers.

A thematic analysis was carried out using publicly available podcasts in which individuals shared their personal experiences with medical errors. Through thematic analysis of these narratives, five superordinate themes were identified. The first theme, *emotional responses of victims*, describes the complex emotional process of grief, anger, and eventually acceptance. The second theme, *desired communication from offender*, highlights the critical role of open, honest and empathetic communication from healthcare providers. The third theme, *the influence of connection*, investigates the influence of trust and continuity in the patient-provider relationship, interpersonal support networks, and perceived compassion as powerful elements in the healing process and willingness to forgive. The fourth theme*, attribution of responsibility*, explores how individuals in the study navigate issues of blame by considering both systemic and human contributions to medical errors. The final theme, *advocating for change*, explores how the individuals in the study find meaning and healing in their journey through efforts to improve healthcare and patient safety.

This thesis contributes to an emerging body of literature on patient-centred responses to medical error, highlighting that forgiveness is not uniform or linear but rather a multifaceted journey shaped by individual experience. The findings further highlight the need for healthcare systems to adopt more transparent, compassionate, and communicative practices to facilitate emotional healing, reconciliation, and forgiveness in the aftermath of medical errors.

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Chapter 1: Introduction

Given the complex nature and high risk of medical practice, medical errors are an unavoidable part of healthcare. Errors frequently occur despite ongoing improvements in patient safety procedures (Berlinger, 2005). The harm caused by such errors extends beyond medical consequences and may cause victims to suffer severe emotional, physical, and psychological trauma (Kohn, 2000). Additionally, there are moral and relational repercussions that affect the patient-provider relationship (Weissman, Betancourt, Campbell, & Clancy, 2012). The trauma to the patient and family members goes much beyond the immediate physical harm and extends to deep emotional distress rooted in feelings of betrayal, loss of trust, and anxiety about future care encounters (Harrison, Manias, & Peters, 2016). This can lead to long-term psychological conditions like PTSD (Brewin et al., 2009). However, a significant but understudied aspect is how patients and families view forgiveness in the aftermath of medical errors, as well as the factors that influence their willingness to forgive healthcare providers.

Medical errors are an increasingly recognised as contributing to mortality, chronic issues and long–term disability worldwide (Bari, Khan, & Rathore, 2016). From diagnosis through treatment and follow-up, errors can happen at any point in the patient care process. In the IOM report, medical errors were reported to be a common occurrence causing an estimated 98,000 deaths each year in the United States alone (Kohn, 2000). In New Zealand it was reported that more than 3,000 people per year were either permanently disabled, or killed as result of medical error, with 1,500 of those cases deemed to be preventable (NZPA, 2006). More recently, a worldwide study found that approximately 400,000 patients annually are victims of a preventable medical injury and over 200,000 deaths annually were a result of an avoidable error (Rodziewicz, Housemann, Vaqar, & Hipskind, 2024). Despite many mitigation strategies, these statistics are clearly increasing.

Forgiveness is a complex process with relational, emotional, and cognitive components. In an interpersonal context the process of forgiveness involves the conscious decision to let go of feelings of resentment or desire for vengeance toward an individual who has caused harm. (Worthington, Scherer, & McCullough, 2014). It does not mean forgetting or excusing the wrongdoing but rather a transformation in emotional response and attitudes toward the offender (Berlinger, 2005). Research suggests that forgiveness frequently improves an individual's psychological and mental well-being (Weissman, Betancourt, Campbell, & Clancy, 2012). A person with a forgiving nature is more likely to be more hopeful, have greater self-esteem, be more satisfied with life, and less likely to be depressed (Brown & Phillips, 2005). This makes the topic of forgiveness particularly relevant to the context of healthcare where unaddressed emotional trauma can have an adverse impact on the course of treatment and recovery. Patients' and families' willingness to forgive can be influenced by a number of factors, including the severity of the error, perceived sincerity of apologies, cultural or religious beliefs around forgiveness, and if the appropriate reparations were made (Scott, et al., 2009). Forgiveness may be crucial for patients and families to prevent long-term psychological distress, in addition to restoring trust not only with medical professionals, but the healthcare industry overall (Fisher, et al., 2018).

Medical ethical standards advise physicians to be candid about medical mistakes and to apologize sincerely for harm caused (Lazare, 2006). A study conducted by Witman et al. (2004) indicated that 98% of patients expected some form of acknowledgement or apology following a medical error. This expectation emphasizes the importance of physicians to have open discussions about errors. In doing so, they not only acknowledge the patient's and families' experience but can start to rebuild the trust that may have been compromised by the error. The act of receiving an apology may help to mitigate feelings of resentment and anger toward health care providers (Mazor et al., 2006). When patients and families feel heard and understood through genuine apologies, they are more likely to move forward in a positive direction rather than dwelling on negative emotions. However, it should be noted that patients and families interpret disclosure and apology in different

ways. While some appreciate sympathy, most individuals are more open to forgiveness when there is a sincere expression of fault and efforts to avoid the same mistakes in the future (Berlinger, 2005; Gallagher et al, 2006).

Emotional responses to medical error play a critical role in shaping recovery and broader perceptions of healthcare. There are feelings of anger, betrayal, and fear in these patients, which negatively impacts their recovery and can lead to decreased satisfaction with care in general (Gallagher et al., 2006). By acknowledging such feelings and the role of forgiveness in healing, healthcare providers could create a more supportive atmosphere for open communication. Understanding patient and families' perspectives on forgiveness allows healthcare providers to strengthen their relationships with these individuals. It creates an atmosphere of accountability and respect when a provider acknowledges their responsibility for a mistake (Berlinger, 2014). The patients' likelihood to continue care and adhere to treatment recommendations is increased with the perception that providers are empathetic and responsible (Witman, 2004).

While there is some literature on the prevalence of medical errors, there remains a significant gap on how patients and families experience an error and perceive forgiveness. This thesis seeks to address this gap by analysing podcast interviews in which individuals shared their personal experiences with medical errors and explore the factors that influence their willingness to forgive healthcare providers. By doing so, this research aims to contribute to a deeper understanding of forgiveness in the context of medical error as an evolving, multifaceted process shaped by individual and systemic factors.

This thesis is organised into several systematic chapters for understanding forgiveness in the context of medical error from the perspective of patients and families affected by medical error. Chapter 2 critically reviews the current literature on medical error, examining its causes, consequences, emotional and behavioural responses from victims, and the evolving research on disclosure and accountability. Chapter 3 focuses on the literature surrounding forgiveness, including

theoretical models, influencing factors, and its role in healthcare settings. Chapter 4 synthesizes the gaps identified in the literature, outlining the rationale for the current study and presenting the specific research objectives and questions. Chapter 5 details the research methodology, including the philosophical approach, data source selection, and procedures for thematic analysis. Chapter 6 describes the findings of the study, organised by superordinate and subordinate themes derived from the data. Finally, chapter 7 critically discusses the findings in relation to existing literature and theory, explores their implications for practice, theory, and policy, as well as proposes directions for future research.

Chapter 2: Medical Errors

Medical errors are a crucial issue within the healthcare industry, with their outcomes bearing physical, psychological, emotional and relational trauma for patients and their families. This chapter defines medical error, outlines its prevalence, and explores the key contributing factors. It also explores how patients respond to these events emotionally and behaviourally and concludes by discussing the role of error disclosure in forgiveness, providing context for understanding forgiveness in the aftermath of medical error, which will be further explored in Chapter 3.

2.1 The Concept of Medical Errors

Defining a medical error can be complex due to the multifaceted nature of healthcare and the subjective perceptions of those involved. Perceptions of medical error may differ across patients, family members, and healthcare providers based on their respective experiences, expectations, and the environment in which care is administered. Typically, errors arise as a cumulative series of interconnected events from several contributing factors in the presence of multiple individuals or of systemic processes (Weissman, Betancourt, Campbell, & Clancy, 2012). Therefore, comprehensive definitions and classifications of medical errors are needed, not only to create effective mitigating strategies, but also to understand how patients and families respond to such errors, particularly in the context of forgiveness.

The Institute of Medicine (IOM) defined a medical error as, "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim" (Kohn, 2000, p. 3). Similarly, Rosser et al (2005) defines medical error as an event that poses a threat to patient wellbeing and potentially affects the quality of patient care. These definitions highlight that errors can result from both human and systemic failures. Notably, the effects of such errors can have serious consequences to both patients and providers. Patients potentially suffer physically, psychologically or even death (Bari, Khan, & Rathore, 2016). Healthcare professionals potentially suffer emotional distress, moral injury, and burnout (Gallagher, et al., 2006). Therefore, a deeper

insight into the nature of medical errors and their causes is essential in enhancing prevention strategies and addressing their psychological impacts.

Evidence indicates that medical error has become the third leading cause of death in the United States, overtaking diseases such as stroke, Alzheimer's, and diabetes (Nitkin, 2016). Ledema et al. (2011) reported that one in seven patients who are hospitalized will experience some type of medical error, further highlighting the prevalence of the issue. Now, research has shown that at least 50 percent of medical errors worldwide could have been avoided (Rodziewicz, Housemann, Vaqar, & Hipskind, 2024). However, underreporting remains a significant barrier to patient safety improvement as research notes that less than 10% of medical errors are formerly reported due to fear of consequences (Ahsani-Estahbanati, Gordeev, & Doshmangir, 2021).

The data highlights an urgent need for systemic change and a culture of transparency, accountability, and learning within healthcare organizations. Understanding the causes and consequences of medical error is vital, not only as a prevention tool but also for influencing how patients and families respond to the harm caused. More specifically, patients and families' perception of accountability and transparency may influence their willingness to forgive. As the current study explores, willingness to forgive is not just an emotional response, but rather shaped by several factors such as disclosure, communication, attribution of responsibility, and preventative recurrence actions taken.

2.2 Medical Error Causes

Medical errors are complex and have multiple causes that extend beyond the individual and include systemic, environmental, cultural, technological, and policy related factors. It is essential to comprehend these causes to create solutions that effectively minimize errors, improve patient safety and inform how patients and families respond to harm in relation to forgiveness. Some of the most common types of medical errors include medication errors such as incorrect prescription or dosage; anaesthesia related errors such as improper administration; hospital acquired infections including

surgical site infections; preventable treatment delays; failure to take appropriate precautions such as inadequate hygiene protocols; technical medical errors which involve equipment malfunctions; inadequate post treatment follow–up or post procedure monitoring, and missed or delayed diagnoses resulting in patient harm (Nitkin, 2016). These errors are caused by a variety of human and systemic factors which are further explored in the following subsections.

2.2.1 Human Factors

Human error is an inevitable element in complex systems such as health care (Reason, 1990). Healthcare providers work under high-pressure situations, multitasking with many activities and responsibilities, which could result in mental fatigue and cognitive overload (Bagnasco et al., 2020). A study on paediatric residents showed that 66% of respondents cited long working hours, stress, and fatigue as a reason for errors (Bari, Khan, & Rathore, 2016). Fatigue hugely impacts the decision-making process, resulting in faults in diagnosis or medication dosage (Schmidt, Muller, & Becker, 2021). Interestingly, it was found that patients are more likely to forgive their healthcare provider when they believe that the provider was stressed and understand the context of the error (Weiner, Lewis, & Linnan, 2010).

2.2.2 Communication Breakdowns

Communication breakdowns have been identified as the most common factor causing medical error (Nitkin, 2016). This is further confirmed by the US Joint Commission's 2015 report which emphasized communication failures as the primary cause of medical errors reported, which reinforces the importance of structured communication protocols. Research indicates that the reasons for communication breakdowns include disruptive patient behaviour, environmental distractions, cultural differences, hierarchy issues, personality differences, language barriers, and socioeconomic variables (Sameera, Bindra, & Rath, 2021). Patient treatment requires the most optimal interprofessional and patient communication. Patients who experience inadequate communication, either through unclear instruction, insufficient explanation of treatment options, or

poor disclosure, often report feelings of betrayal and mistrust (Bari, Khan & Rathbone, 2016). Such experiences can have a significant impact on the willingness to forgive, further highlighting the importance of communication in the aftermath of medical error (Nitkin, 2016).

2.2.3 Systemic and Technological Factors

According to Reason (2000), human error is often the result of system failures rather than individual negligence. For example, poorly designed workflows or communication tools increase the risk of medication errors or failure to follow up on critical test results (Baker et al., 2004; Harrison et al., 2016).

Technology can vastly improve patient safety, but it can also introduce new problems if it is not used or integrated appropriately (Ahsani-Estahbanati, Gordeev, & Doshmangir, 2021). Adverse patient outcomes may result from errors made when utilizing or misusing medical equipment, entering data incorrectly into computerized systems, or encountering software issues. For example, system functionality issues can cause disruptions which could lead to clinicians missing notifications pertaining to severe patient situations or insufficient recordkeeping (Ash, Berg, & Coiera, 2004). In addition, inadequate training of the staff on new technologies or procedures can equally lead to errors (Baker, et al., 2004). These limitations are important to consider as patients attribution of blame may be dependent on whether the error was perceived preventable with better designed systems.

The context in which an error occurs can greatly affect patients' perceptions and subsequently, their willingness to forgive. Research has shown that poorly designed health care systems can lead to various types of medical errors (Nitkin, 2016). This is important to note as further studies revealed patients to be more forgiving of healthcare providers if they feel that the error was due to systemic problems rather than poor individual competence (Weiner, Lewis, & Linnan, 2010).

2.2.4 Patient Demographics

It is also possible for patients to inadvertently contribute to medical error due to demographics such as age, gender, and socioeconomic status can influence medical errors. For example, older adults may experience loss of cognitive function that impairs the ability to communicate effectively with health providers which can result in miscommunication of treatment plans or medication instructions (Harrison et al, 2020). Older adults also often take multiple medications to treat a variety of chronic conditions, which may make the management of their health more complicated and increase the likelihood of drug interactions and adverse effects (Gonzalez, Smith, & Lee, 2020). With so many prescriptions, health care providers may inadvertently prescribe conflicting medications or fail to recognize harmful interactions (Schmidt, Muller, & Becker, 2021). Hearing loss or vision problems, age-associated sensory impairments may create barriers to communication between older patients and health professionals (Berkman et al., 2000).

Gender is another factor contributing to medical error. Gender biases can lead to diagnostic overshadowing where symptoms may be dismissed or misinterpreted based on gender assumptions (Harrison, Lemaire, & Morrow, 2019). For example, a study by Vaccarino et al. (2018) showed that, compared with men, women presenting with chest pain were less likely to have appropriate cardiac evaluations and thus had delayed diagnoses with a higher risk for adverse outcomes. In addition, treatment can be biased by gender stereotypes. Women are more likely to be prescribed psychotropic drugs in pain management as a result of being considered more emotional rather than examined for the actual physical conditions (Harrison, et al. 2019). Such bias affects not only the precision of treatment but also the level of trust toward health providers when the patient feels their problems are not taken seriously, thereby impacting their willingness to forgive after experiencing a medical error (Buchanan et al., 2020).

Summary

Medical errors are often the result of systemic, communicative, and contextual issues rather than isolated events of individual incompetence. Human limitations, such as stress and fatigue, are exacerbated by communication failures, poorly designed systems, and inadequate technological implementation. Additionally, patient demographics, such as age, gender, and socioeconomic status, can increase the risk of medical and influence patient perceptions. The relationship between communication and forgiveness is particularly relevant to this thesis, which will be further discussed in the following chapter. However, it should be noted that research has consistently revealed that patients are more willing to forgive when healthcare providers are transparent, accept responsibility, offer sincere apologies, and demonstrate a desire to prevent similar errors in the future. This supports the necessity to not only improve patient safety concerns, but also create open, ethical, empathetic, and culturally understanding practices of communication.

2.3 Emotional and Behavioural Patient Responses to Medical Errors

To improve patient care and promote an environment of openness, trust, and ultimately forgiveness in healthcare settings, it is essential to comprehend how patients respond emotionally and behaviourally to medical errors. Emotional and behavioural responses are not just reactive but also impact the psychological adaption of patients and families, as well as influence the possibility of forgiveness (Vincent & Coulter, 2002). If these responses are not addressed, it becomes much harder for individuals who've been affected by medical errors to understand and forgive those responsible for them as they remain psychologically trapped in their suffering (Ocloo & Matthews, 2016).

Due to their dependence on medical professionals for their well-being and the esteem in which they are held, patients instinctively place a great deal of trust in healthcare providers (Berlinger, 2014). This trust is undermined in the event of a medical error, especially in the absence of transparency or empathy, leaving patients and families feeling powerless and vulnerable (Ocloo &

Matthews, 2016). Gaining insight into these emotional and behavioural responses provides a foundation for understanding the psychological processes that underpin forgiveness.

2.3.1 Emotional Responses to Medical Errors

Typical feelings that patients experience following a medical error include grief, betrayal, anxiety, fear, anger, depression, and post-traumatic stress disorder (PTSD) often caused by the perceived betrayal of trust (Vincent & Vincent, 2002). The intensity of such feelings depends on factors such as the severity of the harm caused by the error, the nature of the disclosure, and the availability of support systems (Harrison et al., 2020).

Studies have shown that patients frequently report feelings of abandonment or deception when they believe that their provider has failed them or lied to them regarding an error (Harrison et al., 2020). Another common emotion among patients is anger as they struggle with thoughts of injustice and disappointment, considering it is likely the error was preventable (Heyhoe, et al., 2015). Anxiety and fear frequently accompany worries about possible harm or long-term health effects from the mistake (Schwappach & Wernli, 2010). Severe cases might additionally result in long-term psychological consequences, such as depression and post-traumatic stress disorder (Vincent & Vincent, 2002). Those who have experienced a life-changing injury or the death of a loved one at the hands of a medical error are most likely to experience these conditions and their consequences (Robertson & Long, 2018).

The psychological process that describes the emotional responses of patients and families can be comparable to the Kubler-Ross (1969) model of grief based on denial, anger, bargaining, depression and acceptance. Although some individuals do not experience these stages sequentially, or encounter all stages, the model is useful for understanding how traumatic or life altering experiences, such as medical errors, are processed. For example, patients and families may initially react with disbelief or minimisation, becoming angry with the provider or system, then find meaning or justice, express sadness, and eventually come to terms with acceptance or resolution. Although

the model was originally developed to explain the emotional experience of terminal ill patients, it has since been applied more broadly to experiences of loss (Tyrrell, Harberger, Schoo, & Siddiqui, 2023). This alignment supports the idea that medical harm is not merely a clinical complication but a highly emotional experience that impacts patients' beliefs about the healthcare system, their body, and their future (Berlinger, 2005). It can then be argued that recognising response to medical error in the context of the grief model is essential to understanding perceptions of forgiveness. This will be discussed further in the discussion chapter.

As reported by Prentice et al. (2018), 51% of the patients who have suffered a medical error indicated continuing emotional effects like sadness or anger three to six years later. Many patients also feel guilty or blame themselves, wondering if they could have done anything to prevent the error from occurring (Gallagher, Waterman, Ebers, Fraser, & Levisnson, 2003). There is a common struggle for many patients to understand how such an error occurred and whether it could have been prevented, adding to their feelings of frustration and powerlessness (Gallagher et al., 2003). Additionally, patients who suffer a medical error may feel defenceless and helpless, especially if it causes long term harm and adverse consequences, mainly due to loss of control over their health outcomes (Ocloo & Matthews, 2016). A patient who feels they have no control over their health outcome may struggle to forgive because they associate the error with the loss of autonomy or dignity. On the other hand, empowering patients with open communication and accountability procedures could assist in regaining their sense of autonomy, which could make forgiveness easier to achieve.

Research continuously shows that effective communication is important in determining patients' responses after an error has occurred. Literature suggests that early disclosure of errors coupled with honest apologies may reduce negative emotional consequences (Wu et al., 2000). Open admissions of errors by providers, and descriptions of measures taken to prevent recurrence, make

patients more willing to forgive and preserve their trust in the system (Wu, Huang, Stokes, & Pronovost, 2009).

2.3.2 Behavioural Responses to Medical Errors

In addition to emotional responses, patients and families also exhibit behaviours that reflect how medical errors impact their future interactions with the healthcare system. These behavioural responses are closely associated with loss of trust and patients' perceptions regarding safety, reliability and integrity of healthcare providers (Prentice, 2018).

Some patients become very active in seeking information and questioning decisions made about their care and they become hypervigilant (Fisher et al., 2018). This hypervigilance could be understood as an attempt at regaining control over their medical experience (Mazor, 2013). Some patients may even go to the extent of stopping the use of healthcare services completely because they no longer trust the providers in regard to their care (Heyhoe, et al., 2015). Prentice et al. (2018) reported that 57% of respondents avoided doctors or facilities associated with the error, while others extended this to all forms of medical care as a consequence of the loss of trust in the health care system. These avoidance behaviours can include missed follow-up appointments, delayed treatments, or refusal of care due to mistrust (Mazor et al., 2013). This response carries potential for great harm to patient health and points out the importance of restoring trust after an error has occurred (Gallagher, Waterman, Ebers, Fraser, & Levisnson, 2003).

Patients and families may also file a formal complaint or pursue legal action against the healthcare provider or organizations that committed the error as a way of seeking accountability and justice (Gallagher et al., 2006). Fisher et al. (2018) also note that such actions are less about financial compensation and more about obtaining accountability, recognition, explanation, and reassurance that such situations will not happen to others. These responses emphasize a transition between isolated coping to collective advocacy, possibly caused by the need for validation and disclosure in the aftermath of the error.

The extent and nature of behavioural responses depend on how well patients and families' concerns were addressed after a medical error (Kraman & Hamm, 1999). Those who received appropriate support generally show resilience over time, regaining confidence in healthcare systems but remaining vigilant about their care (Gallagher, Waterman, Ebers, Fraser, & Levisnson, 2003).

Summary

The emotional and behavioural responses highlight the complex impact medical errors have on patients and families. The emotional responses such as grief, betrayal, depression, and PTSD highlight the psychological toll these errors have on patients and families. Since patients depend on healthcare practitioners for their well-being, feelings of betrayal and a loss of trust are significant. Furthermore, patients who wonder if they could have avoided the error frequently experience guilt or self-blame. These emotional responses are reflective of the Kubler-Ross (1969) model of grief, framing emotional processing as nonlinear. In the context of medical error, grief is not just defined by the clinical outcomes experienced by patients and families, but also a loss of the fundamental assumptions of safety, competence, and care.

The behavioural responses provide insight into how medical errors affect patient future interactions with health care providers. While some patients adopt hypervigilant behaviours demanding more control over their care, others may withdraw from healthcare services altogether or refuse treatment. In some cases, patients and families may resort to formal complaints or legal action, driven by the need for recognition, accountability and systemic change.

The way healthcare providers and organizations respond to the error significantly influences emotional recovery and behavioural reactions. Literature shows that transparent communication, sincere apologies, and efforts to prevent future harm provide a foundation for restoring trust.

2.4 Disclosure of Medical Errors

Medical error disclosure is widely considered an ethical mandate for health care providers (Mazor, Simon, & Gurwitz, 2004). It refers to open communication between health care providers,

patients and families about errors that occurred during care, their consequences, and what is being done to prevent similar incidents in the future (Gallagher, Waterman, Ebers, Fraser, & Levisnson, 2003). Patients typically expect their healthcare providers to be honest, transparent, and apologetic (Gallagher, et al., 2006). Most patients prefer to be told the truth in such cases because this would promote trust and show respect for their autonomy over their health (Mazor et al., 2004). This transparency also aligns with patient-centred care principles by respecting patients' autonomy and promoting informed decision-making. (Fisher, et al., 2018).

Evidence has shown that nondisclosure or partial disclosure can result in negative consequences for patients and families such as decreased satisfaction, decreased trust in providers, and increased likelihood of seeking litigation (Mazor et al., 2006). On the other hand, full and empathetic disclosure has been associated with higher levels of satisfaction and trust, even in the event of adverse outcomes (Baker, et al., 2004). Additionally, full disclosure often mitigates feelings of anger or betrayal that might otherwise arise from medical errors (Chan, Gallagher, Reznick, & Levinson, 2005). According to Ledema et al. (2011), patients react more favourably to disclosures that are made with clarity, honesty, and empathy. Better understanding and trust are typically fostered by healthcare providers who avoid technical jargon and speak plainly (Lazare, 2006). Patient satisfaction is positively correlated with prompt disclosure as any delays can lead to increased mistrust and dissatisfaction (Mazor et al., 2004).

2.4.1 Barriers to disclosure

Medical error disclosure is a critical component of healthcare honesty and transparency, however, despite its importance there are several barriers which hinder providers from disclosure. The fear of consequences is one of the most cited psychological barriers to disclosing medical errors as providers are afraid of litigation, disciplinary action, or damage to their professional reputation if they disclose an error (O'Connor et al., 2010). In addition, the feelings of guilt and shame associated with having made an error can inhibit disclosure (Wu et al., 1997). Providers can avoid disclosure to

avoid self-blame and subsequent anxiety about a possible backlash of repercussions (Weiner, Schwartz, & Kahn, 2016). Despite the expectations surrounding disclosure, there remains a gap between healthcare providers' attitudes toward disclosure and their actual practices (Chan, Gallagher, Reznick, & Levinson, 2005). A common theme in the literature is that there is a lack of education about disclosure of medical errors. Many health professionals complete their training years with little or no formal education about this area and report back that they were poorly equipped to handle the situation accordingly (White et al., 2011). Educational interventions have been shown to improve provider confidence and competence in disclosing errors (Chan et al., 2010). However, such programs are not universally implemented across institutions, leaving gaps in knowledge and skills among practitioners (White et al., 2011).

Within some settings, there is a deeply ingrained "culture of silence" where discussing errors is stigmatized (Leape et al., 1994). This culture perpetuates fear and discourages transparency by placing a greater emphasis on individual accountability rather than systemic improvement (Chan, Gallagher, Reznick, & Levinson, 2005). Additionally, the hierarchical structures in healthcare teams avoid open communication regarding errors. For example, junior staff may feel suppressed by seniors or fear punishment for speaking out against those in authority (Suresh et al., 2004).

Legal implications, however, remain one of the most persistent deterrents to the disclosure of medical errors. Providers often fear that admitting fault will expose them or their institutions to lawsuits or regulatory actions (Studdert & Mello, 2007). In an attempt to encourage transparent disclosure, some jurisdictions have enacted "apology laws" in order to protect statements made during disclosures from being used as evidence in court proceedings, though these laws are not universally adopted or well-understood by practitioners (Chan et al., 2010). This legal ambiguity creates apprehension among providers, who worry that transparency could have unintended legal consequences, and thereby undermines open communication in clinical settings (Ledema et al., 2004).

2.4.2. The Role of Disclosure in Forgiveness

Since disclosure plays a foundational role in shaping patient and families' perceptions and emotional responses to medical error, it is crucial to address in the context of forgiveness. Open and honest disclosure of medical errors by healthcare providers sets the stage for trust building, which is one of the critical factors influencing forgiveness (Gallagher et al., 2003). If patients feel that the provider has taken responsibility then they are inclined to forgive (Chan et al., 2010). On the contrary, if there is no disclosure or perceived dishonesty, then it could damage trust and thereby make forgiveness unlikely (O'Connor et al., 2010).

Disclosure also allows patients to fully process the event by obtaining explanations of what went wrong and why it happened (Gallagher et al., 2006). This transparency thus allows them to make sense of the situation, which is important for emotional reconciliation and forgiveness as it validates the patient's experience and demonstrates respect for their perspective (Wu et al., 1997). Effective disclosure can mitigate feelings of betrayal or anger that commonly occur in the wake of a medical error (Leape et al., 1994). By addressing such emotions through open communication, providers can help patients move toward forgiveness rather than resentment or mistrust (Studdert & Mello, 2007). Conversely, inadequate or absent disclosure might exacerbate negative emotions, making it more difficult for patients to forgive even when they wish to do so (Evans et al., 2006).

Finally, disclosure of medical error provides insight into the systemic factors that influence patient forgiveness. For example, institutional policies supporting open communication about errors may create an environment in which patients feel a sense of respect and valuation during difficult conversations (White et al., 2011). Such environments are far more conducive to fostering forgiveness than those where errors are hidden or minimized out of fear of either legal repercussions or punitive measures taken against providers (Studdert & Mello, 2007).

Summary

Disclosure of medical errors is not only an ethical duty for healthcare providers but also an important factor that shapes how patients perceive and process forgiveness after experiencing medical error. It becomes clear that open communication lies at the very centre of fostering forgiveness. Full disclosure has been shown to increase patient satisfaction and trust, both foundational elements in forgiveness. On the other hand, nondisclosure or poor communication can heighten feelings of anger, betrayal, or mistrust, making forgiveness much harder for patients and families to achieve. The quality of communication during the disclosure is what matters most. Clear, honest, empathetic explanation in non-technical jargon helps the patient to understand the situation while addressing their needs.

However, systemic issues within healthcare systems hinder the implementation of good disclosure practices. The fear of litigation, organisational pressures, legal ambiguities, and inadequate training continue to deter healthcare providers from engaging in full and empathetic disclosure practices. Additionally, healthcare organizations often harbour cultural norms that are not conducive to transparency, because error discussions are stigmatized and individual responsibility is emphasized over systemic learning. The culture of silence not only destroys the patient–provider relationship but also opportunities for forgiveness by not attending to the emotional needs of the patients.

Chapter 3: Forgiveness

It is becoming more widely acknowledged that forgiveness can enhance both psychological and physical well-being (Hook, Worthington, Utsey, Davis, & Burnette, 2012). Forgiveness can be highly beneficial in healthcare settings when confronting psychological distress brought on by unresolved trauma, interpersonal disputes, or medical errors (Trivedi, 2023). This next chapter defines forgiveness, explores the theoretical framework, its application in the context of healthcare and medical error, and its influencing factors.

3.1 Defining Forgiveness

Forgiveness is broadly defined as the process of cultivating positive emotions, such as empathy and compassion, while decreasing negative emotions, such as resentment or anger, toward an offender (Enright & Fitzgibbons, 2015). According to the *Handbook of Forgiveness* by Worthington and Wade (2019) forgiveness is not synonymous with accepting wrongdoing, forgetting harm, or reconciliation. Instead, it is a deliberate, conscious, and voluntary change in an individual's attitude and feelings towards the offender. The APA Dictionary of Psychology (2023) supports this notion and defines forgiveness as:

"…wilfully putting aside feelings of resentment toward someone who has committed a wrong, been unfair or hurtful, or otherwise harmed you in some way. Forgiveness is not equated with reconciliation or excusing another, and it is not merely accepting what happened or ceasing to be angry. Rather, it involves a voluntary transformation of one's feelings, attitudes, and behaviour toward the individual, so that one is no longer dominated by resentment and can express compassion, generosity, or the like toward the individual"

(American Psychological Association, 2023).

Most research agrees that forgiveness should be distinct from related concepts like reconciliation, forgetting, condoning or excusing (Strelan & Covic, 2006). Researchers also acknowledge that forgiveness has a rich and varied history that reflects the various viewpoints and settings in which it has been examined. However, Enright (2001) discovered that a significant barrier to forgiving is a lack of understanding about what the concept of forgiveness is. For example, it is a common misconception that by saying, "I forgive you," is to deny that any harm occurred or may be an attempt to exert moral superiority. Therefore, to work towards forgiveness, it is important for individuals to be educated on what it is and what it is not.

Philosophically speaking, forgiveness is frequently defined as a change in emotional position toward the offender while maintaining the moral culpability of the wrongdoing (Hieronymi, 2001). Reconciliation with the accountable party or accepting their behaviour is not necessary; it simply entails letting go of deeply ingrained negative emotions towards the offender (Enright & Fitzgibbons, 2000). According to Worthington et al. (2019) forgiveness differs from reconciliation in that it focuses on healing and letting go of negative emotions, whereas reconciliation involves restoring the relationship.

3.1.1 Interpersonal vs. Intrapersonal Forgiveness

Forgiveness can manifest both interpersonally and intrapersonally, while sometimes both happen simultaneously (Worthington, 2006). Interpersonally, forgiveness involves communication or some kind of symbolic behaviour that represents letting go of the issue such as a gift or a letter (Toussaint, Worthington, & Williams, 2018). Intrapersonal forgiveness refers to managing one's emotions and reframing one's thoughts in order to reduce resentment and hostility toward the offender (Toussaint & Slavich, 2016). The differences between interpersonal and intrapersonal forgiveness play an important role in determining patient and family members responses to medical error and how they may come to forgive.

In the context of healthcare and medical error both forms of forgiveness are relevant. For example, patients may process forgiveness interpersonally through open conversations or mediated efforts. On an intrapersonal level, patients may come to terms with harm done without apology or acknowledgement. It is important to note, however, that forgiveness in the context of healthcare is both personal and situational being shaped by several factors (Hall & Probst, 2018). The distinction is particularly important in the context of healthcare as errors occur within obscure and hierarchical systems. For example, patients may often not be provided with open communication, apology or recognition, making forgiveness attainable only intrapersonally as it does not require external validation. By comprehending this process, practitioners and researchers can support emotional recovery in the absence of an interpersonal resolution (Weiner, Schwartz, & Kahn, 2016).

Forgiveness allows patients and families to move from a position of victimhood to empowerment without relieving providers from accountability for their actions (Berlinger, 2014). By choosing forgiveness, patients and families reclaim power over their own emotional reactions without necessarily absolving providers from accountability (Bari, Khan, & Rathore, 2016). Understanding the distinction between interpersonal and intrapersonal forgiveness contributes to the study of forgiveness following medical error as it highlights the way in which patients and families may regain a sense of control and emotional peace without absolving healthcare providers of responsibility (Berlinger, 2014; Bari, Khan & Rathore, 2016).

3.1.2 Decisional vs Emotional Forgiveness

Forgiveness can be further divided into emotional and decisional dimensions, which result from different processes. Decisional forgiveness is a conscious behavioural intention to abstain from revenge or avoidance behaviour (McCullough et al., 1997). Emotional forgiveness, however, is described as replacing negative feelings, such as hurt and anger, toward the offender with positive feelings, such as empathy and compassion (Worthington et al., 2007). This section explains the

differences between these two types of forgiveness and the psychological processes that underpin them.

Decisional Forgiveness

Decisional forgiveness is the deliberate choice or commitment to change one's behaviour toward an offender by resisting revenge or avoidance tendencies (Worthington et al., 2007). Unlike emotional forgiveness, decisional forgiveness does not necessarily involve an immediate change in emotions but focuses on changing outward behaviour toward the offender (McCullough et al., 1997). This form of forgiveness can come about relatively quickly because it does not require deep emotional processing (Exline & Baumeister, 2000). Decisional forgiveness mainly involves cognitive mechanisms associated with decision-making and self-control (Witvliet, Ludwig, & Vander Laan, 2001). Evidence from neuroimaging studies points out that decisional forgiveness activates brain regions linked to executive functioning, including the dorsolateral prefrontal cortex (Ricciardi et al., 2013).

To some degree, decisional forgiveness can serve as an initial step to reconciliation, however, it may not be sufficient for full resolution since underlying negative emotions may not be addressed (Witvliet, Ludwig, & Vander Laan, 2001). In the context of healthcare, patients may engage in decisional forgiveness through ongoing treatment with the same provider or deciding to not pursue litigation, even if negative emotions such as mistrust remain. Research shows that decisional forgiveness can act as a prelude to emotional forgiveness in creating a condition for eventual emotional healing (Worthington et al., 2016). This is particularly relevant to the patient-provider relationship where practical or relational ties still exist following a medical error.

Emotional Forgiveness

In contrast, emotional forgiveness consists of an inner emotional transformation achieved through processes like the development of empathy and regulation of emotions through cognitive reappraisal strategies (Worthington et al, 2007; McCullough et al., 1998). These processes elicit

activations in brain regions involved in the regulation of emotions, including the prefrontal cortex and anterior cingulate cortex (Ricciardi et al., 2013). The cognitive reframing of the offense can be attributed to a better understanding of the situation from the offender's perspective (McCullough et al., 1998).

This process often costs a considerable amount of time and energy because it ultimately requires an emotional transformation from feelings of betrayal or pain, especially in contexts involving significant personal harm (Enright & Fitzgibbons, 2000). However, emotional forgiveness is more likely to lead to long-term psychological healing with a higher possibility of reconciliation because there is real emotional healing rather than just behavioural compliance (Witvliet et al., 2001). Additionally, emotional forgiveness is positively related to traits such as agreeableness and empathy, which enable a person to forgive at a deeper level emotionally (Berry et al., 2005).

3.1.3 Situational and Dispositional Forgiveness

Forgiveness has also been examined in terms of context and personality, which can be categorized as situational and dispositional forgiveness (McCullough & Hoyt, 2002). Situational forgiveness is context-dependent and influenced by the specifics of the situation, such as the nature of the offense or the circumstances surrounding it (Liao, Liu, & Yuan, 2024). Dispositional forgiveness refers to a general predisposition to forgive regardless of specific relationships or situations (Tse & Yip, 2009). Understanding the distinction may enable us to comprehend why some patients are more willing to forgive medical errors, while other struggle despite similar circumstances.

Situational forgiveness is shaped by contextual factors such as severity of harm, the presence or absence of an apology, perceived intentionality, and existing power dynamics (Fehr, Gelfand, & Nag, 2010). Situational forgiveness is especially relevant in the context of healthcare as patient responses to medical error are greatly influenced by several factors such as accountability, open communication, and genuine remorse from healthcare providers (Robbennolt, 2009). Additionally,

whether the patient perceives the error as accidental or negligent, and the severity of harm caused significantly influences their willingness to forgive (Galagher et al., 2003).

Dispositional forgiveness is conceptualised as a personality trait that reflects and individual's overall tendency to be forgiving (McCullough & Hoyt, 2002). Research has found that individuals who are dispositionally forgiving engage in traits that act as a buffer against the emotional burden of interpersonal injustices, such as anger management techniques and are more empathetic (Roberts, 1995). The Big Five personality traits have also been associated with dispositional forgiveness, particularly conscientiousness, emotional stability, and agreeableness (Hill & Allemand, 2010). For example, agreeableness is associated with increased empathetic concern and reduced hostility which makes forgiveness more likely in challenging situations such as medical errors.

The interaction between situational and dispositional forgiveness has significant implications in understanding forgiveness in the aftermath of medical error. While some patients may be predisposed to naturally forgive, the specifics surrounding the error may facilitate or hinder forgiveness. Toussaint et al. (2015) emphasized that dispositional forgiveness can be regarded as a psychological resource that mitigates the emotional effects of severe transgressions, such as medical errors. However, situational factors often determine the capacity to forgive. It can then be considered that forgiveness in the aftermath of a medical error relies on the interplay between personal and contextual factors. While some patients may be more forgiving in nature, they may be less willing to forgive if healthcare providers demonstrate a lack of transparency or accountability. Similarly, less forgiving individuals may be more willing to forgive if healthcare providers show remorse and sincerity.

Summary

Forgiveness is a complex psychological process involving emotional, cognitive, and behavioural elements. It is not synonymous with excusing or condoning mistakes, rather, it reflects a release of resentment while maintaining moral accountability for the offense. Forgiveness can occur

interpersonally, involving symbolic acts, or intrapersonally involving a re-evaluation of emotions and self-control. The distinct pathways of emotional and decisional forgiveness highlight the different psychological pathways individuals may take toward forgiveness. The literature also distinguishes between situational forgiveness, shaped by contextual variables, and dispositional forgiveness, an individual's tendency to forgive across contexts. The distinction plays a vital role in healthcare and medical error which provokes multifaceted emotional and cognitive reactions. Forgiveness in this context is a shaped by personality traits and the behaviour of healthcare providers. Therefore, forgiveness should not be viewed as a single event, but rather an evolving process essential for shaping patient and family outcomes after medical error.

3.1.4 Cultural Aspects

Much of the existing literature on forgiveness originates from Western contexts rooted in Judeo Christian traditions where forgiveness is perceived as an internal and personal process (Gao, Li, & Bai, 2022). Within the Western individualistic framework, forgiveness is a personal journey of emotional healing, self-empowerment, and cognitive reframing (Worthington, 2006). However, this does not reflect how forgiveness is perceived or experienced across cultures.

Collectivist cultures often frame forgiveness within communal values such as the restoration of harmony rather than personal emotional release alone (Hook et al., 2012). This understanding shifts the focus from an individual emotional process to one of restoring balance within the community. Decisions about forgiveness may be guided by values such as respect, honour, or spiritual duty (Worthington, 2006). Although the current study draws on podcast narratives from international sources, it is important to acknowledge that the study is being carried out in a New Zealand context. Therefore, some attention must be paid to how forgiveness is understood within Māori world views. In te ao Māori, values such as *whanaungatanga* (connection), *mana* (dignity), and *utu* (restoring balance) shape how individuals respond to harm (Durie, 2001). Forgiveness in this context is a process that strengthens the community ties and honours the dignity of everyone

involved (Mead, 2003). The forgiveness process may include storytelling, collective dialogue, or acts of restoration that bring the group back into balance (Smith, 2012).

The cultural differences influence the invention and implementation of forgiveness-based interventions on various populations (Hook, Worthington, Utsey, Davis, & Burnette, 2012). Interventions that only emphasize personal emotional healing may not be meaningful to those who have a collectivist background influenced by societal consequence of forgiveness (Gao, Li & Bai, 2022). These cultural nuances are important in tailoring therapeutic interventions aimed at promoting forgiveness across different populations. Forgiveness must be understood as a contextual, cultural process shaped by values, social expectations, and the systems they are a part of. As healthcare becomes more diverse, recognising and respecting these different ways of understanding forgiveness is essential to providing care that is ethical and compassionate.

3.3 Forgiveness and Wellbeing

Forgiveness has been studied extensively in the context of its impact on wellbeing. A growing body of research shows how forgiveness promotes not only psychological wellbeing, but also physical health and interpersonal relationships (Worthington et al., 2007). The following section addresses the relationship between forgiveness and well-being, summarizing empirical studies and conceptual frameworks highlighting its benefits, particularly in the context of medical error.

3.3.1 Psychological Benefits of Forgiveness

Forgiveness has been shown to significantly improve mental health by decreasing negative emotions like anger, anxiety, and depression (Toussaint et al., 2012). Individuals who practice forgiveness report lower levels of stress and higher life satisfaction compared to those who hold grudges (Lawler-Row et al., 2008). Furthermore, forgiveness interventions have been shown to be effective in clinical settings in reducing symptoms of post-traumatic stress disorder (PTSD) among people who have experienced severe trauma (Wade et al., 2014).

The act of forgiving fosters emotional regulation by helping individuals process their pain constructively rather than ruminating on negative experiences (Worthington & Scherer, 2004. This process is linked with higher self-esteem and a greater sense of personal empowerment because it helps people regain control over their emotional lives (Karremans et al., 2003). Research indicates that emotional forgiveness is associated with long-term improvements in mental health outcomes such as reduced depression and anxiety (Toussaint et al., 2012). Patients who achieve emotional forgiveness are more likely to experience greater psychological healing following a medical error because this type of forgiveness involves confronting the emotional hurt stemming from the incident (McCullough et al., 1998). Longitudinal studies also show that forgiveness provides long-term resilience against mental health symptoms such as chronic anxiety or major depressive episode (Toussaint et al., 2015). Therefore, emotional forgiveness may serve as a vital coping mechanism for patients and families dealing with the psychological aftermath of medical error.

3.3.2 Physiological Benefits of Forgiveness

Beyond the psychological benefits, forgiveness is associated with measurable physiological benefits. Studies using biomarkers have shown that forgiveness can lower blood pressure and decrease heart rate variability during stressful events (Lawler et al., 2003). Chronic unforgiveness has been linked with elevated levels of cortisol, while forgiveness practices are associated with reduced cortisol reactivity and improved immune function over time (Worthington & Witvliet, 2020).

Research has demonstrated that emotional forgiveness is a powerful psychophysiological tool which can reduce stress and improves cardiovascular functioning (Lawler-Row et al, 2008). For example, people who are forgiving have lower risks for hypertension and other stress-related diseases than those who hold onto resentment or hostility (Friedberg et al., 2005). These findings underline the importance of incorporating forgiveness into holistic approaches aimed at improving physical health outcomes. Therefore, in the context of medical error, forgiveness may contribute to the overall physical recovery of patients and families following medical error.

3.3.3 Social Benefits of Forgiveness

Forgiveness plays a critical role in establishing and maintaining good interpersonal relationships since it fosters empathy, trust, and reconciliation between parties in conflict (McCullough et al., 1998). For example, in the context of romantic relationships, couples who forgive each other report higher levels of relationship satisfaction and stability over time compared with those who hold grudges (Fincham & Beach, 2007). More broadly, forgiveness helps maintain social cohesion and prevents cycles of revenge or violence following a conflict (Bartholomaeus & Strelan, 2014). Research in post conflict societies has shown that collective acts of forgiveness can help to promote healing and reconciliation among groups formerly divided by violence or injustice (Staub et al., 2005).

The social dimension of forgiveness is relevant to healthcare settings where trust, communication, and continued relationships are foundational to effective care. Staying engaged with the healthcare system after experiencing an error can be challenging for patients, especially when feelings of betrayal or anger are left unresolved. If forgiveness does not take place, some may avoid medical care altogether, which can result in delayed diagnoses or worsening health conditions (Prentice et al., 2018). In contrast, where patients are able to forgive healthcare providers, particularly when accompanied with transparency and accountability, they are more likely to continue their care with their provider (Wu et al, 2009). In this way, forgiveness can facilitate restoring the relationship between patient and provider, as well as the patient's sense of control and dignity in their healthcare experience (Gallagher et al., 2003).

Summary

Forgiveness has profound implications for individual and collective wellbeing. It is a transformation process leading to psychological resilience, regulation of emotions, and long-term mental health through the reduction of negative emotions like anger, anxiety, and depression (Toussaint et al., 2012; Worthington & Scherer, 2004). Physiologically, forgiveness leads to a reduction in stress

through measurable improvements in biomarkers such as cortisol levels and cardiovascular health (Lawler et al., 2003; Worthington & Witvliet, 2020). Socially, it enables reconciliation of interpersonal relationships through promoting empathy, trust, and reconciliation while fostering community cohesion in broader societal contexts (McCullough et al., 1998; Staub et al., 2005).

The literature sheds light on the profound effect forgiveness has on different dimensions of well-being, such as psychological resilience against distressing emotions, physiological improvement related to the decrease in stress, and improved social connection through the empathy-building process. A better understanding of how forgiveness is fostered across these domains provides valuable insight for providers aiming to support patients and families in the after of medical errors. It also highlights the healing nature of forgiveness for emotional and overall wellbeing.

3.4 Key Models of Forgiveness

Various models have been proposed by researchers to further comprehend the psychological mechanisms that underpin the forgiving process. These models offer structured approaches to understanding how individuals perceive and process forgiveness. Some of the most well-known frameworks were developed by Lazar and Folkman (1984), Enright (2001), and Worthington (2006) as discussed below. The models chosen for this paper make a distinction between emotional and decisional forgiveness, including key constructs such as the role of empathy, commitment, and emotional regulation. Such frameworks are particularly relevant to healthcare and medical error as patients and their families experience complex emotional and ethical dilemmas. By exploring these models of forgiveness, this section discusses how individuals navigate their response to harm, determine the degree of responsibility, and either remain emotionally burdened or move toward psychological healing.

3.4.1 Stress and Coping model of Forgiveness

The Transactional Theory of Stress and Coping was developed by Lazarus and Folkman (1984) and has significantly influenced the understanding of how individuals respond to stressful situations

by using different coping mechanisms. The model was initially developed to explore stress responses in general, however, it has since been applied to research on forgiveness as a coping strategy.

According to this model, stress is not just an event that happens to individuals but is a product of how they perceive and react to difficult situations. This process begins with a primary appraisal in which an individual determines whether an event, such as being harmed by someone or a medical error is harmful, threatening or upsetting (Lazarus & Folkman, 1984). Secondary appraisal involves the individual evaluating whether they have the capability of dealing with the stressful situation (Lazarus & Folkman, 1984). This involves evaluating factors such as personal strength, emotional resilience, support systems, and perceived responsibility (Lazarus & Folkman, 1984). According to Worthington et al. (2007), in the context of forgiveness this phase involves asking, *'Can I forgive?'* and, *'Do I want to forgive?'* Depending on these evaluations, Lazarus and Folkman (1984) describe two types of coping strategies that individuals adopt. Problem-Focused Coping is an approach that involves active engagement with the source of stress or trying to solve the problem that is the cause of distress, whereas emotion-focused coping is directed at managing emotional distress rather than at the source of stress (Worthington et al, 2007).

Application to Medical Errors

Several factors influence patients' perceptions of forgiveness in response to medical errors that are consistent with Lazarus and Folkman's model. Strelan and Covic (2006) indicated that the mechanisms within this theory help explain why some people can forgive while others hold on to anger or resentment. Framing forgiveness within this stress and coping framework, it becomes clear that forgiveness is not simply an emotional response but also a process involving cognitive primary and secondary evaluations of the situation. Factors such as clear communication by health-care providers about the error, expressions of remorse or apology, and efforts at restitution can positively influence such appraisals by promoting trust and reducing perceived threat (Robbennolt, 2009).

In forgiveness, problem-focused coping could mean reconciliation with the offender, having open discussions of what transpired and the impact, and emotion-focused coping could entail developing empathy and understanding as to how the error occurred (Worthington, Parrot & Wade, 2005). Emotion-focused coping is particularly relevant to medical error cases in which the issue cannot be resolved directly due to communication refusal from healthcare providers (Worthington, Parrot & Wade, 2005). Therefore, forgiveness in such cases may include acceptance, belief that the error was not caused intentionally, and the ability to empathise with healthcare providers (Murtagh, Gallagher, & Andrew, 2012).

This framework involves managing stress, understanding the situation, and efforts to work through feelings over time. In the context of healthcare, this model also highlights the important role that providers play in promoting or hindering forgiveness through communication and actions in the aftermath of error as these influence appraisal.

3.4.2 Enright's Model

Enright's model of forgiveness is the more established therapeutic framework, which emphasizes the deliberate process of overcoming resentment toward an offender while fostering compassion and beneficence toward them (Freedman & Enright, 1996). According to the model, forgiveness involves a gradual transformation where a person's thoughts, emotions, and behaviours toward the offender begin to change. Over time, feelings of anger or resentment may be replaced with understanding, compassion, or even goodwill as the individual processes the harm and re-evaluates their perspective (Enright & North, 1998). Empirical studies have demonstrated that participation in forgiveness interventions based on this model result in significant improvements in both psychological well-being and physical health indicators (Lawler et al., 2005).

The model is made up of four phases. Firstly, the Anger Phase involves recognising and exploring feelings of anger and resentment. This step is essential to the healing process as it allows emotions to surface rather than being supressed (Freedman & Enright, 1996). Next, the Decision

Phase involves a deliberate decision to forgive based on a clear understanding of what forgiveness means. This phase is directly related to decisional forgiveness as discussed earlier. In the Work Phase, individuals work to replace negative feelings with constructive ones such as, empathy and compassion (Enright, 2001). This phase involves viewing the offender in a less judgemental way, accepting that the harm cannot be undone, but can be emotionally processed (Enright & Fitzgibbons, 2000). Finally, the Deepening Phase involves realizing the meaning and purpose of the experience, developing a sense of emotional relief and personal growth (Enright, 2001).

Application to Medical Errors

Applying Enright's model of forgiveness to the context of medical errors provides a framework for patients to work through their emotions in a positive way. It is especially powerful because of its emphasis on fostering empathy and compassion, encouraging individuals to adopt a broader perspective about human fallibility while prioritizing personal healing over retribution. The phases on Enright's model in relation to medical error and forgiveness are discussed below.

In the Anger Phase, patients identify their feelings without suppression or avoidance. The Anger Phase ensures that patients do not suppress their feelings but instead confront them constructively. During the Decision Phase, patients consciously decide whether they want to forgive their healthcare provider despite the harm caused. The Decision Phase empowers patients by giving them autonomy over how they respond emotionally to harm caused by medical errors. Factors that might go into this choice include the severity of the mistake, whether an apology was offered by the provider, and disposition (Worthington et al., 2000).

During the Working Phase patients may require support in reframing their thoughts about the error. This can include recognizing that most errors are not intentional or even recognizing systemic aspects of medical error (Berlinger, 2014). Empathy building exercises to help patients view healthcare providers as fallible human beings, rather than solely as perpetrators, may be helpful for this emotional shift (Gallagher, Waterman, Ebers, Fraser, & Levisnson, 2003). Finally, discovering

meaning or purpose in the Deepening Phase can be transformative for patients dealing with medical errors. Some may find solace in advocating for systemic changes within healthcare systems or supporting others who have experienced similar situations (Harrison et al., 2016). This sense of purpose can mitigate lingering resentment and promote emotional closure (Hebl & Enright, 1993).

3.4.3 Worthington's Model

Worthington's REACH model of forgiveness provides a structured framework for understanding and promoting forgiveness with five sequential steps: recalling the hurt, empathizing with the offender, giving an altruistic gift of forgiveness, committing to forgive, and holding onto forgiveness (Worthington, 1998). To cultivate empathy and emotional healing, each step is designed to overcome psychological and emotional barriers to forgiveness, particularly in situations where interpersonal harm has led to deep emotional trauma.

The first step involves acknowledging the offense without magnifying or belittling its significance (Worthington, 2019). This process enables an individual to confront their true feelings about the situation without suppressing them. Once the offense and hurt are acknowledged, empathy plays a central role in understanding the offender's perspective (Worthington, 1998). This allows individuals to recognise human fallibility without excusing harmful behaviour. Next, forgiveness is extended as a altruistic gift without expecting anything in return. Worthington (2019) suggests such an act benefits both parties, since the forgiver will be relieved from emotional pressures and may even possibly reconcile with the offender. Thereby, relieving the offender of guilt and encouraging behavioural reflection. The fourth stage involves an intentional decision to forgive and re-ensuring or reaffirming it with some symbolic acts, like sending the letter or sharing the act of forgiveness with others (Worthington, Scherer, & McCullough, 2014). The final step is to sustain forgiveness over time, through the presence of reminders or triggers of the offense Worthington, 1998). During this stage, rumination or relapse to resentment can be prevented by using techniques like mindfulness and cognitive reframing (Worthington, Scherer, & McCullough, 2014).

Application to Medical Errors

The REACH model has significant relevance for patients and families coping with medical errors. Patients and families who feel betrayed by healthcare providers often experience long-term emotional distress (Bari, Khan, & Rathore, 2016). The REACH model encourages patients and families to address their feelings without suppression, aligning with literature that suggests that acknowledging harm is an essential step towards forgiveness (Ottosen, et al., 2021).

Empathy is at the core of the REACH model, which requires an understanding that errors occur unintentionally, and acknowledging that healthcare providers are human and vulnerable to systemic issues (Wade et al., 2014). In this context, forgiveness is about individual's preserving their own emotional wellbeing. This is consistent with findings indicating that patients who forgive report greater emotional health and less stress (Bari, Khan, & Rathore, 2016).

The model encourages individuals to make an intentional decision to forgive and to maintain that decision over time. Patients' and families' views about forgiveness will be affected by whether they are able to maintain that attitude in the face of reminders of the harm caused by medical errors, such as ongoing treatments or unresolved outcomes (Nation et al., 2018). In these instances, the REACH model offers useful resources to resisting resentment cycles and reasserting a degree of control over emotional responses. The REACH model frames forgiveness as a compassionate and empowering act as it offers a pathway to healing for patients and families, even in the absence of justice or full resolution.

3.5 Comparative Analysis of Forgiveness Models

When comparing the Transactional Theory of Stress and Coping, Enright's Model for Forgiveness, and Worthington's REACH Model, they all present different ways to perceive and practice forgiveness. Collectively, these models highlight the diverse components of the cognitive, emotional and psychological aspects of forgiveness. Forgiveness is emphasized as a multifaceted process, not a singular action, which is shaped by emotional, cognitive, relational, and contextual

factors (Worthington, 2007). Applied to the context of medical error, these models explore how individuals respond to harm, make sense of their experience, and rebuild trust within the healthcare system.

Lazarus and Folkman's (1984) framework highlights the way in which forgiveness can be used as a coping strategy following a harmful experience. This model's strength is its ability to describe how cognitive appraisal shapes emotional response and coping behaviours. Further, it highlights the variability of forgiveness outcomes. For example, patients and families appraising the error as unintentional may be more willing to forgive. However, it lacks specific guidance on how forgiveness can be achieved. This model is more descriptive, rather than transformative and may not acknowledge the relational and moral aspects of forgiveness which are crucial in healthcare settings.

Conversely, Enright (2001) provides a structured guide to forgiveness as a deep emotional transformation, which closely aligns with the emotional process patients may experience as a result of medical error. The model emphasizes empathy, reframing and moral growth enabling a deep emotional processing. However, it is notably time consuming and often requires therapeutic facilitation, which may be less appropriate for time sensitive clinical environments. It may be less responsive in real time contexts of patient-provider relationships and therefore may not be appropriate for procedural efforts following an error to restore trust. It may need to be modified where prolonged reflection is impractical.

Worthington's REACH model addresses this gap as it offers practical steps intended to promptly build empathy and trust (Worthington et al., 2020). This is particularly relevant when addressing medical errors where timely resolution restores trust between healthcare providers, patients and families (Berlinger, 2014). Although Worthington's model encourages individuals to recognize the harm done without downplaying or exaggerating it, some argue that this structured approach doesn't always reflect the deep emotional pain that can follow a serious betrayal. Critically,

its strength in structure is counterbalanced by a potential lack of depth in addressing trauma and moral distress.

A major contrast is the assumed level of agency with each model. The Stress and Coping model allows for variability on the patients perceived agency and ability to respond, although it lacks emotional restitution. Enright's model (2001) places emphasis on the role of the patient in the decision to forgive and move towards emotional healing. However, it also assumes a level of readiness and stability that not all individuals can attain. The REACH model is practical, providing agency in its steps and decisions, however it may overlook the systemic factors of the error. This is particularly relevant to medical error where forgiveness is not just interpersonal but also shaped by broader systemic issues.

Together, these models demonstrate that not one of these frameworks captures all features of the complex phenomenon in the context of forgiveness after medical error. The Transactional Theory of Stress and Coping explains how forgiveness alleviates stress after error. Enright's Model serves to further explain the deeper emotional processing needed for reconciliation over time. Worthington's REACH model provides practical tools to stimulate immediate empathy and trust restoration. Collectively, the strengths of these models suggest an integrated holistic approach to patient and family perceptions of forgiveness after medical error, encompassing both the cognitive-emotional processing of harm, and the practical steps towards forgiveness and emotional healing.

3.6 Factors Influencing Forgiveness After a Medical Error

For most patients and families, forgiveness depends on multiple interconnected factors (Hall & Probst, 2018). These factors include, but not limited to, an honest apology, understanding what went wrong, and being reassured that steps will be taken to prevent similar mistakes in the future (Mazor et al., 2004). This section focuses on the key factors, as identified in literature, influencing patients' and families' willingness to forgive healthcare providers following a medical error.

3.6.1 The Role of Apology

An apology is defined by the Oxford English Dictionary (2014) as a statement acknowledging an error or offense, taking responsibility for it, and expressing regret or remorse with the intention not to repeat similar actions in the future. In the context of medical error, Mazor (2013) identifies several key elements of a complete apology; acknowledgement of the mistake, acceptance of responsibility without deflection or excuse, genuine remorse for harm caused, explanation, assurance that steps will be taken to prevent recurrence, and compensation if appropriate. Each component of a full apology has a specific function in trust re-establishment, validation of the patient's experience, and emotional healing. (Gallagher et al., 2003).

Patients view an apology as evidence that their suffering has been recognized and taken seriously by their health care provider (Witman et al., 1996). This acknowledgement assists in restoring the patient's dignity and respect that may have been compromised due to the negative outcomes of an error (Robbennolt, 2009). Admission of the error demonstrates that healthcare providers are honest and transparent (Gallagher et al., 2003). Additionally, expressing regret shows empathy and concern for the well-being of the patient (Mazor et al., 2013). Promising corrective actions reassures patients that efforts are being made to improve safety and prevent harm to others (Gallagher et al., 2003).

Studies have found consistently that apologies have a considerable effect on patients' and families' willingness to forgive after being harmed by medical errors (Bartholomaeus & Strelan, 2014). Factors affecting decisional forgiveness include perceived sincerity during apologies and efforts by providers to correct their mistakes (Gallagher et al., 2003). Emotional forgiveness can take place when patients believe that the healthcare providers have shown real remorse, empathy, and accepted responsibility for their actions. (Mazor et al., 2013).

Apologies reduce negative emotions such as anger and resentment, through showing accountability on the part of the healthcare provider (Robbennolt, 2009). When healthcare providers

take responsibility for their actions instead of shifting the blame or remaining silent, this shows respect toward the experience of the patient, promotes emotional healing, and eventually forgiveness (Gallagher et al., 2003). In addition, apologies have been shown to repair patient-provider relationships because they convey that steps will be taken to prevent a recurrence of the same kind of error in the future (Robbennolt, 2009).

Physiological research also demonstrates that an apology can minimize stress responses (Lazare, 2006). For example, several studies have found that apologies can lower cortisol levels produced by stress while inducing favourable physiological responses such as reduced heart rate variability in recipients (Lazare, 2006). Such effects may indirectly facilitate forgiveness by alleviating some of the physical manifestations of emotional distress (Gallagher et al., 2003). For instance, the acknowledgement tied to an apology provides understanding and validation which can reduce stress-related hormonal responses. When cortisol levels drop, it creates a healthier and more balanced mental state which in turn makes it easier to forgive others (Lawler-Row, Karremans, Scott, Edlis-Matityahou, & Edwards, 2008).

However, not all apologies are effective (Ledema, et al., 2011). Research makes a distinction between partial apologies and full apologies. Partial apologies refer to those that express regret without admission of fault and may be viewed as insincere or self-serving if they do not actually address the core concerns of patients and families (Gallagher et al., 2003). Full apologies are those that encompass both accountability and remorse and are proven to have a much better effect on forgiveness (Robbennolt, 2009).

Honesty and Transparency

Closely related to apology are the concepts of honesty and transparency. As aspects of a good apology, these concepts form the basis of communication and support the process of forgiveness.

Honesty involves taking responsibility for the mistake without blaming others or minimizing its importance (Gallagher et al., 2003). When healthcare providers are honest about what happened, it affirms patients' experiences and respects their autonomy (Gallagher et al., 2003). Such acknowledgment has the potential to reduce feelings of betrayal or anger, emotions often associated with medical errors, and provide a foundation for forgiveness (Murtagh et al., 2012). Furthermore, honesty shows accountability from healthcare providers which reassures patients that steps will be taken to address the systemic issues that lead to the error (Gallagher et al., 2003).

Transparency supports honesty in the sense that information relevant to a medical error is openly shared with patients affected (Witman et al., 1996). Transparency involves admission of fault, explanation of why the error occurred, and description of measures being taken to prevent recurrence (Gallagher et al., 2003). Patients appreciate such openness because it shows commitment to learning from errors rather than concealing them (Mazor et al., 2016).

Studies have demonstrated that honest and transparent communication can significantly affect patients' perceptions of their relationship with healthcare providers after an error. For example, Gallagher et al. (2003) discovered that when healthcare providers provided honest and transparent apologies, patients were more likely to report satisfaction with how the situation was handled. This satisfaction often resulted in a more significant willingness to forgive.

3.6.2 The Role of Trust

Patients who have been able to maintain a relationship of trust with their health care provider are more likely to perceive an error as an isolated incident rather than a reflection of incompetence or lack of caring (Gallagher et al., 2013). Trust creates a sense of security and belief in the intentions of the provider, which may soften the impact of an adverse event and minimize feelings of betrayal (Mazor et al., 2004). On the other hand, if the level of trust is low or absent, patients may interpret medical errors as systemic flaws or personal disregard, thus making forgiveness less likely (Witman et al., 1996). Furthermore, transparency builds trust which is a major

factor in whether patients feel comfortable continuing care with their provider after an error has occurred (Mazzei & Mazor, 2020). Trust mediates the relationship between transparency and forgiveness. When trust is maintained through open communication, it is easier for patients to let go of negative emotions associated with the incident (Gallagher, et al., 2006).

3.6.3 Severity and Perception of the Error

Research has demonstrated that patients are more likely to forgive minor errors than major ones due to the differences in perceived harm and emotional damage arising from the incident (Witman et al., 1996). Minor errors, such as administrative errors or minor deviations from standard care that do not result in permanent harm, are seen as less intentional or negligent, making forgiveness easier (Gallagher et al., 2003). In contrast, severe errors that result in permanent injury, significant pain, or even death, are associated with heightened emotional responses such as anger, betrayal, and mistrust, making forgiveness more difficult (Mazor et al., 2004).

Patients' perceptions of severity are also influenced by how they perceive the preventability of the error (Witman et al., 1996). Preventable errors are usually seen as an indication of negligence or incompetence, making forgiveness more challenging (Gallagher et al., 2003). For example, when the error results from obvious non-adherence to safety protocols or lack of attention to detail, patients may have difficulty reconciling feelings toward the provider (Woods et al., 2004). On the other hand, if an error were viewed as an honest mistake or an unavoidable complication of medical practice, then patients could more easily empathize with and forgive the provider (Murtagh et al., 2012).

3.6.4 Patient Characteristics

Individual differences among patients also influence their willingness to forgive. Age, gender, personality, education, and cultural background all play a vital role in shaping forgiveness. These factors are discussed below.

Some studies have found that older adults are more predisposed to forgiving because of life experiences and increased likelihood of being empathetic and understanding (Mazor et al., 2004). Women generally have higher levels of empathy than men, which could facilitate forgiveness in some cases (Witman et al., 1996). However, research also notes that women may also have stronger emotional reactions to perceived harm which could make forgiveness more difficult (Mazor et al., 2004).

Education level may also influence forgiveness because it may shape patients' understanding of the complexities of medical care (Murtagh et al., 2012). For example, educated patients may more easily appreciate that, even with best practices, errors will sometimes occur (Gallagher et al., 2003). However, highly educated individuals may also be less forgiving if they perceive incompetence but might appreciate detailed explanations during disclosure (Lazare, 2006). Economic status can shape how patients react to errors. For patients living with limited income, there’s often a sense of having less control or influence in clinical environments, which can intensify feelings of helplessness or mistrust when something goes wrong (Gallagher et al., 2003). At the same time, those who rely heavily on public healthcare or cannot easily change providers may feel they have little choice but to move past the error. In some cases, this reliance may lead to forgiveness, not necessarily because emotional healing has taken place, but because maintaining access to care feels more urgent than holding on to resentment (Exline et al., 2008).

People who have higher agreeableness levels may be more likely to forgive than those with higher neuroticism (Bartholomaeus & Strelan, 2014). For example, agreeableness has been known to relate positively with forgiveness due to the characteristic of keeping harmony in relationships (Exline et al., 2003). Similarly, those with high dispositional empathy would be more likely to take the health professional's perspective and lean towards forgiveness (Worthington & Scherer, 2004). Openness has also been linked to forgiveness as open-minded people are more likely to take into account external factors leading to a fault than just putting the blame on the offender (Exline et al., 2003).

Cultural norms and values can dramatically impact patients' views regarding forgiveness in response to medical errors (Dekker, 2012). In collectivist cultures, where interpersonal harmony is highly valued, patients may be more inclined to forgive in the interest of sustaining social cohesion. For example, studies have found that East Asian patients often focus on reconciliation over retribution in their handling of conflicts or harms done by another person (Hook et al., 2012). On the contrary, individualistic cultures emphasizing personal responsibility may influence patients to dwell on blame rather than seeking closure with forgiveness (Hook et al., 2012). Religious beliefs also shape how individuals perceive forgiveness, especially when closely tied to cultural values. Many religious traditions view forgiveness as a moral dictate where it is expected rather than encouraged which can also influence patients' willingness to forgive (Toussaint & Webb, 2005).

Patients' previous experiences with health care providers influence perceptions about medical errors and the potential for forgiveness. A history of positive interactions with health care providers builds up trust and goodwill that can lower negative emotions when an error occurs (Gallagher et al., 2003). In contrast, prior negative experiences, such as feeling ignored or poorly treated, can heighten feelings of betrayal when an error occurs and make forgiveness less likely (Mazor et al., 2004). Those who have suffered from multiple adverse events or systemic failures within healthcare systems may develop cynicism or mistrust that interferes with their ability to forgive, even in the face of sincere apologies (Gallagher et al., 2003).

Summary

Apologies that are sincere and accompanied with open communication are consistently shown to facilitate forgiveness. Honesty and transparency form a foundation to medical communication or restoring trust and facilitating forgiveness. Trust can also be restored through open disclosure, accountability, and engagement. The severity of harm and perceived preventability of the error further facilitate forgiveness, with minor errors likely to be more easily forgiven. Finally, patient

characteristics such as age, personality, gender, and culture further influence the way forgiveness is perceived and practiced.

The literature outlines how forgiveness may be influenced by factors such as apology, communication, trust, severity of harm, and patient characteristics. However, there is still a limited understanding of how these factors specifically contribute to forgiveness following a medical error. Previous studies explore these factors either in isolation or hypothetically. The current study bridges this gap by examining the lived experiences of those who have been directly affected by medical error and exploring whether forgiveness occurs, including how and why.

Chapter 4: Research Gaps and Rationale

While there has been much research on aspects of medical errors, such as disclosure, apology protocols and litigation risks, little is known about how patients and families perceive and experience forgiveness after medical errors (Gallagher et al., 2020). It is important to address these gaps in literature due to the significant consequences of medical error on trust, emotional and physical wellbeing, and the patient-provider relationship. These gaps in knowledge form the basis for the present study. The following sections address the gaps in literature and the rationale for the current study.

4.1 Addressing the Gaps in Literature

Despite all the qualitative research that has been conducted on medical errors and forgiveness historically, it has mainly focused on the experiences of healthcare providers. For example, studies mostly examine the psychological distress physician's experience after committing an error such as feeling guilt, shame or fear of being sued (Woolf, Kuzel, Dovey, & L., 2004). Wu et al (2021) focussed on organizational strategies for error disclosure, however their findings are not derived from qualitative data with patients or families. Similarly, O'Connor et al. (2023) investigated disclosure practices of clinicians but did not look at how these disclosure practices translate for those who are directly affected. Collectively, these studies are useful for gaining insights into the provider's experience, however they overlook patients and families emotional and moral processing of these events.

Some studies have made initial efforts to include patient perspectives. For example, a study by Gallagher, Waterman and Ebhers (2003) explored patient expectations following a medical error, concluding that almost half of the patients expected full disclosure of the error, acknowledgement, apology, and explanation on how it would be prevented in the future (Gallagher et al., 2003). While this study demonstrated the significance of communication after medical error, it did not go in-depth into how these factors influence forgiveness or whether forgiveness was achieved. In a follow up

study, Gallagher et al. (2011) expanded on their previous research by investigating the involvement of family members' roles during disclosure conversations regarding medical error. The findings of the focus group showed that family members often felt excluded from the discussions after an error occurred and many of the participants emphasized the importance of transparency, not only with patients but also with their family members (Gallagher et al., 2011). However, this study did not examine whether the involvement of families worked to increase their willingness to forgive and how family dynamics might affect collective decisions about forgiveness.

Other studies have touched on relational and emotional outcomes but remain limited in scope that directly focuses on forgiveness. Mazor et al. (2006) explored the impact of healthcare professionals' apologies on patients' decisions to pursue legal action following a medical error. The researchers studied hypothetical scenarios presented to 958 respondents using surveys and revealed that apologies reduced participants' anger and increased trust (Mazor, et al., 2006). While the findings revealed that sincere apologies reduced anger, and increased trust, their study framed forgiveness as a potential to mitigate litigation, rather than as an intrinsic psychological process. Similarly, Harrison, Manias and Peters (2016) conducted a qualitative study of the long-term psychological effects of harmful medical events for patients. The researchers discovered that many people suffered from anger, mistrust of medical professionals, and persistent emotional distress several years after the incident (Harrison, Manias & Peters, 2016). Some participants were willing to forgive under certain conditions, such as receiving a sincere apology or witnessing systemic change (Harrison, Manias & Peters, 2016). A follow up study by Harrison et al. (2021) investigated the psychological impact of medical errors on patients and their families and highlighted strong emotional responses to medical error such as anger, betrayal, sadness and disappointment Although the research was not specifically related to forgiveness, some participants who perceived healthcare providers to be sincere in their acknowledgement and apology were able to eventually forgive over time.

Despite these contributions, existing literature provides limited insight that specifically focuses on forgiveness following medical errors, the influencing factors, and how it evolves over time. For example, while Harrison et al. (2016) found that unresolved trauma following medical error can persist for many years, there have been very limited studies to date to that explore whether and under what conditions patients will eventually achieve forgiveness. Furthermore, few studies have explored how familial relationships influence forgiveness despite it being proven that family members experience secondary trauma when a loved one experiences medical error (Gallagher et al., 2011). This oversight is interesting considering decisions to forgive are frequently influenced through collective negotiation within the family unit (Gallagher et al., 2011). In many collectivist cultures, where relational interdependence and shared decision-making are central, forgiveness may emerge through a communal process that involves shared emotional validation, and consensus (Hook, Worthington, Utsey, Davis, & Burnette, 2012). Understanding these dynamics can potentially foster healing within households affected by medical error.

The current study addresses an important but underexplored area in the aspect of health, ethics and psychology. Medical errors are an inevitable reality within healthcare organisations. However, despite the potential that forgiveness has to facilitate healing, restore trust, and improve patient-provider relationships, there remains a limited understanding of how patients and families experience the forgiveness process following medical error. The literature shows that forgiveness extends beyond just apology and disclosure and involves a multitude of complex dynamics. Therefore, this thesis aims to contribute to the current body of literature by focusing on the perspectives of patients and families exploring forgiveness as a potentially healing process.

4.2 Rationale for the Current Study

Given these research gaps, the current study seeks to contribute to the body of related literature by making patients and family members central and addressing forgiveness as the primary phenomenon. A limited number of qualitative studies have explored how forgiveness is narrated or

experienced by individuals who have been affected by medical error. Additionally, most studies focus on healthcare provider or organisation responses, and forgiveness in the context of medical error has so far been treated as a peripheral concern. The current study is driven by the necessity to move toward the lived experiences of patients and families, exploring how they process the aftermath of medical error and the factors that shape their willingness to forgive.

A qualitative approach is best suited for the current study as it allows for the exploration of lived experiences (Harrison, Manias & Peters, 2016). Forgiveness is not necessarily a quantifiable response as it is embedded in personal values, emotional regulation, interpersonal dynamics, and cultural beliefs (Weiner, Schwartz, & Kahn, 2016). A qualitative framework grounded in thematic analysis will allow for a rich and conceptualised understanding of how individuals make sense of harm and forgiveness in their own language (Braun & Clarke, 2006). The current study deviates from the traditional use of qualitative data sources by using podcasts as a naturalistic data source. Podcasts are an emerging source of qualitative data where individuals are more authentic when sharing their stories (Markham & Harris, 2021).

This study seeks to address the gaps in literature by focusing specifically on how patients and families perceive forgiveness following medical errors and identifying the factors that influence their willingness to forgive healthcare providers. Through thematic analysis of podcasts as qualitative data, this study aims to capture authentic narratives shared in more naturalistic settings (Markham & Harris, 2021). This may lead to deeper insights into the emotional and psychological dimensions of forgiveness compared to more traditional methods.

4.3 Research Objectives

- To explore patients' and families’ views on forgiveness in the context of medical errors.
- To analyse patient and family member narratives shared through podcasts as a source of qualitative data.

- To uncover common themes and patterns within the patient and families' perceptions regarding forgiveness through use of thematic analysis.
- To identify factors that affect patients' and families' willingness to forgive healthcare providers after medical errors.

4.4 Research Questions

1. How do patients and families' view forgiveness in response to medical errors?
2. What are the factors that influence patients' and families' willingness to forgive healthcare providers after experiencing medical errors?

Chapter 5: Methodology

This chapter describes the methodological approach through which this study aims to explore patients and family experiences of forgiveness following medical error. Given the subjective, emotionally complex, and contextual nature of forgiveness, a qualitative research design was adopted to enable an in-depth exploration of patients and families' perceptions as conveyed through publicly available podcasts. The chapter discusses the rationale for the research design, the process of data collection, data analysis, limitations and the ethical considerations for the current study.

5.1 Research Design

This study employs a qualitative research design to investigate how patients and families view forgiveness in the context of medical errors and the various factors that affect their willingness to forgive healthcare providers. A qualitative method was deemed most appropriate to answer such a research question because it offers a more sensitive account of the subjective experience, emotional complexity, and perceptions that quantitative approaches may not capture entirely (Creswell Poth, 2018). Given forgiveness is a deeply personal and subjective experience, this methodological approach was adopted to capture its nuance and lived meaning.

This study's theoretical foundations were underpinned by hermeneutic phenomenology, which emphasizes the importance of participants lived experiences (Sundler, Lindberg, Nilsson, & Palmer, 2019). The interpretation of and via language is known as hermeneutics, and it is crucial to how people perceive their experiences (Ricoeur, 2012). Hermeneutic phenomenology is particularly suited to the study of forgiveness as it recognises the evolving layers of the human experience, unlike descriptive phenomenology, which seeks to provide objective descriptions of these experiences (Sundler, Lindberg, Nilsson, & Palmer, 2019). This study analysed participants' narratives as interpretive texts through podcast episodes, providing deeper insights into lived experiences regarding forgiveness within healthcare contexts. Listening to and analysing personal narratives is, therefore, an interpretative and empathetic task (Ricoeur, 2019).

Thematic analysis is complemented by hermeneutics as a theoretical lens through which patients' narratives can be explored not only for what was said, but also for what was implied (McClung, Houck, & Kearney, 2018). The current study was grounded by hermeneutic phenomenology as the philosophical foundation and thematic analysis as the analytic tool. Given the lack of research regarding patient perception on forgiveness in the context of medical error, this study is exploratory and inductive in nature. Inductive reasoning is also made possible through thematic analysis where themes appear directly from the facts rather than predicated on current theories or frameworks (Braun & Clarke, 2006). This ensures that the emerging themes are grounded directly within the participants lived experiences. Additionally, this study adopted Braun and Clarke's (2001) reflexive thematic analysis to interpret the data. Reflexive thematic analysis allows the researcher to actively engage with the dataset to find recurring patterns while acknowledging their own interpretative lens (Braun & Clarke, 2001).

5.2 Data Source Collection Methods

For this study, the primary data source was podcast episodes in which patients and families discuss their experience with medical errors and forgiveness. Podcasts are increasingly becoming recognised amongst qualitative studies as a rich, naturally generated data source which enables individuals to express their lived experiences beyond the more rigid research environments (Markham & Harris, 2021). In comparison to interviews or focus groups, podcast narratives offer a natural flow that may include deeper emotional dimensions.

A comprehensive search was conducted on Spotify and Apple Podcasts using related keywords such as "medical errors," "forgiveness in healthcare," "patient stories," "healthcare mistakes," "reconciliation after medical harm," and "healing after medical errors" to identify relevant episodes. Since there is a limited research and discussion around medical error from the patient or family members perspective, the initial podcast search proved to be challenging. The search then aimed to identify content through variations of the listed keywords. It proved challenging to find one

podcast channel that discussed patient experiences of medical error which specifically included topics of forgiveness. However, podcast episodes were eventually able to be sourced through a range of different podcast creators and channels.

The selection process applied an inclusion and exclusion criteria to the search results. The inclusion criteria required episodes to include clear first-person narrative of patients or family members affected by medical error, and explicit or implicit reflections on forgiveness or reconciliation. Episodes were excluded if they lacked evidence of forgiveness, or if they were narrated by healthcare providers without a patient or family member narrative.

A total number of 10 podcast episodes were selected for thematic analysis. The chosen podcasts showcased various guests, such as patients who experienced medical errors personally, as well as relatives who had lost family members due to medical errors. Below is a table representing the patient demographics from the chosen podcasts including a brief background of their experience (see table 1).

Table 1

Participant Demographics.

Podcast	Pseudonym	Background
1	James	Parent whose child's treatment for a terminal disease was initially successful but a mistake made during the last treatment resulted in the child's death.
2	Sally	Sally's family experienced 2 medical errors: her child's untreated condition that resulted in permanent brain damage, and her spouse's misdiagnosed cancer that ultimately caused his death.
3	Lisa	During what was supposed to be a routine surgery, Lisa experienced serious complications due to the way anaesthetic was administered.
4	Amy	Amy was suffering severe exhaustion and sleep issues. She faced medical error which deteriorated her health. Years later, she was finally given a correct diagnosis which doctors were still unsure on how to treat it, making her condition worse.

5	Kayla	Concerns about menstrual issues were dismissed by her GP. Years later, she underwent surgery to remove a cyst which was misdiagnosed as benign. She experienced symptoms after her surgery that led to a diagnosis of stage 3 ovarian cancer. Later, a review of her care revealed significant inconsistencies.
6	Claire	A tear occurred during delivery that went undetected for over a year, caused by a suction device that didn't get examined properly prior to being used. As a result, she experienced significant adverse impacts on physical health, mental health, and her career.
7	Mary	Mary has had years of pain and complications after an improperly performed surgery resulted in a mesh implant where permanent stitches tore into her vaginal wall. The physical trauma, consequent repeated painful procedures to remove the mesh, and loss of access to her medical team caused severe depression.
8	Amber	Amber survived two very serious medical errors: one involving a brain haemorrhage, the other involving spinal surgery with unsterilized equipment, including two delayed confessions from involved parties.
9	Layla	Layla's child died after a series of medical errors. While she doesn't go into explicit detail of the errors, she explains that she took her child to the hospital and 2 days later, after multiple medical errors, her child was dead. She now works as a patient liaison consultant in the risk management division at the same hospital.
10	Sarah	AI misinterpreted the size of a cyst which she needed surgery for. After undergoing surgery, her doctor found the mistake and stated that the performed surgery was not needed. She had her records corrected and she received a formal apology.

5.3 Data Analysis Approach

This section discusses the data analysis approach using Braun and Clarke's (2006) six phase framework of reflexive thematic analysis. This approach offers a way to explore in depth participants' narratives while considering my own active participation as the researcher in interpreting these accounts.

5.3.1. Familiarisation with Data and Transcription

The first stage included familiarisation with the data by listening to the audio recordings several times for accuracy ensuring that every detail of the spoken content is comprehended correctly and to gain a comprehensive understanding of each account. Careful attention was paid to tone, pauses, and emotional emphasis. In this process, initial notes were taken as ideas or patterns of recurring themes that could potentially be associated with forgiveness and influencing factors. The repeated exposure to the content, along with note taking, allowed for a deeper understanding of both explicit information, such as direct words about forgiveness, and implicit details like tone, pauses, or emotional inflections, that may shed light on patients or family members experiences.

The podcasts were recorded using Otter.ai software. While the software records the conversation, it transcribes the recordings at the same time. In order to accurately preserve all spoken words, pauses, and intonations, the podcasts are transcribed verbatim (Nowell et al., 2017). Verbatim transcription was preferred for the current study to capture subtle linguistic features such as hesitations or inflections that might inform us about patients' perceptions (Riessman, 2008). Filler words like “um” and “uh” along with pauses and other non-verbal sounds like laughter or sighs are transcribed exactly as they happened while documenting every spoken word. However, it is noted that transcription software tools should be complemented by manual review to ensure accuracy due to possible errors in the recognition of accents or special terminology (Seale, Gobo, Gubrium, & Silverman, 2020). For this reason, the transcripts were reviewed at least three times each to ensure accuracy and allow for contextual notes on aspects that could possibly affect how things are interpreted in the analysis. Each transcript was then copied into a word document for each separate podcast. Transcription was done at a high quality, therefore accuracy and reliability of the data is present throughout subsequent coding and theme development stages (Oliver, Serovich, & Mason, 2005).

5.3.2 Coding

A crucial stage of thematic analysis is coding, which involves methodically grouping unstructured data into coherent pieces (Braun & Clarke, 2021). As previously mentioned, an inductive approach was adopted due to the exploratory nature of the research topic, and codes were generated directly out of the data without the need of prior frameworks (Thomas, 2006). Each transcript was read line by line, and segments related to forgiveness, emotional response, interpersonal dynamics, and coping mechanisms were coded into a word document for each podcast. This allowed emerging themes associated with participants' experiences of forgiveness to surface naturally. Codes were regularly reviewed and refined to ensure they remained grounded and sensitive to the podcast guests' meanings.

5.3.3 Generating Themes

After coding across all transcripts was completed, codes were combined into broader themes based on similarity and conceptual coherence. This was a repeated process to achieve consistency, due to the constant circulation of data and emerging themes. Broader patterns were divided into superordinate themes, while more specific patterns were divided into subordinate themes to provide granularity (Braun & Clarke, 2001). Careful consideration was needed in this stage to ensure that themes cover significant aspects of participants' perceptions and the influencing factors in the process (Bingham & Witkowsky, 2022). Based on these findings, a master table (Appendix C) was created to represent superordinate themes, subordinate themes, and related quotes.

5.3.4 Reviewing the Themes

The themes were regularly reviewed for internal consistency to ensure they offered meaningful insights rather than just descriptive summaries. In this process, reflexive journaling was used to bracket researcher assumptions in order to be sensitive to the views of the podcast guests (Nowell, Norris, White & Moules, 2017). Braun & Clarke's (2006) two step approach was adopted by reviewing whether each theme is supported by appropriate evidence and secondly, ensuring that

important details of the dataset are represented under at least one or more themes. In case of any overlap in topics or data that had not yet been organised into a specific category, the thematic framework was adjusted in order to make the analysis clear and consistent. Miles & Huberman (1994) state that reviewing themes is a crucial step to make sure that the findings are valid. For example, if the data revealed a theme discussing the significance of the apology in the process of forgiveness, the data was rechecked ensuring that the given theme has been established by other participants and not just from a single perspective.

5.3.5 Defining the Themes

Once satisfied with the cohesion and coverage of the thematic framework, each theme was explicitly defined by conveying its fundamental ideas. Defining the theme involves stating the central concept, the idea or phenomenon that binds all constituent codes together (Braun & Clarke, 2006). Each theme definition was reviewed to ensure it concisely conveyed what the theme is about, enough to differentiate it from other themes (Nowell, Norris, White, & Moules, 2017). Short descriptive summaries were written for each theme to ensure clarity and precision of these definitions and were tested against the coded extracts.

5.3.6 Connecting the patterns

Thematic connections across the narratives were explored with a focus on convergence and divergence. The analysis considered not only what participants said but how they said it, drawing on the hermeneutic principle that meaning is shaped by context, language, and relational positioning (Ricoeur, 2012). Patterns were interpreted and connected based on the literature review while remaining open to new emerging insights.

5.4 Ethical Considerations

Ethical considerations were discussed with my thesis supervisor (Don Baken) during multiple stages of the project development. These discussions focused on ensuring compliance with ethical standards while addressing potential concerns related to privacy, consent, and data sensitivity. My supervisor and I discussed the appropriateness of using publicly available podcasts as a data source. Together we reviewed whether analysing such content would require additional permissions or informed consent from podcast creators/speakers. This was further discussed with Prof. Dr. Leon De Wet Fourie (Associate Dean at Waikato Management School), Dr. Kathryn McGuigan and Dr. Gareth Terry from Massey University and it was determined that since these podcasts are freely accessible online and intended for public consumption, additional permissions were not necessary. However, we agreed on requesting permission from podcast creators to use their episodes as data as a safeguard.

The study was concluded to be low risk. Therefore, ethical approval was not needed to be sought or given. However, a low risk notification was submitted to the Massey University Ethics Committee on 28/02/2025 which was guided by The Massey University Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (revised code) (Massey University, 2017). It was then selected for audit and the auditors agreed with the decision. The ethical considerations are further discussed below.

5.4.1 Informed Consent

There is much debate around informed consent for using podcasts as qualitative data in research due to the issue of whether podcast guests are fully aware of the potential risks and benefits of their narratives being explored as a research topic. Nowell et al. (2017) state that the voluntary online sharing of podcast stories by creators may not include expectations regarding academic research analysis of their content. Some claim that the participation in the podcast requires informed consent so that participants are made aware of the slightest risks concerning the

act of giving out personal information and opinions in a public forum (Johnston, 2017). However, other researchers argue that informed consent is not required in podcast participants because they are already sharing their information and opinions on the internet on a public basis (Nusbaum, Douglas, Damus, Paasche-Orlow, & Estrella-Luna, 2017). This is also agreed by Markham & Harris (2021) who state that when people intentionally share content in the public domain, consent can be waived. According to Zimmer (2010) the sharing of information in unrestricted public forums creates a public domain through which the information becomes accessible for free analysis by anyone.

It is apparent that there are no set ethical guidelines regarding informed consent for using podcasts as qualitative data. The best way to approach ethical decision-making when there are no clear guidelines is to use practical judgment that is sensitive to the specific context (Markham & Harris, 2021). When observing the few studies that have been conducted in this field, it appears unusual to ask podcast participants for their permission to be used in a research experiment conducted after the fact (Lindgren & Bird, 2024). One study that also focussed on a sensitive topic using podcasts as qualitative data (the grief of co-victims of crime or violence) also did not seek consent from the podcast participants (Slakoff, Boling, & Tadros, 2022). I would argue that it is the responsibility of the podcast creator to make their guests fully aware of the potential benefits and consequences of sharing their personal information on a public domain, requiring guests to consent to the sharing of this data prior to it being made publicly accessible.

The Association of Internet Researchers (AoIR) states that researchers can conduct ethical analyses of public open-source data that is freely accessible online without security measures such as a login or password (Mark & Buchanan, 2012). According to Linke (2025) informed consent for podcast guests is obtained once guests approve recordings after receiving essential information about audio capture techniques as well as broadcast platforms and audience demographics and content usage agreements. Understanding that their recorded statements will be publicly distributed and re-used constitutes a standard element in the agreement (Osborne & Linke, 2025). Therefore, it

can be argued that informed consent was already obtained prior to the podcast episode being published online.

For the purpose of this study, it was concluded that obtaining permission from the podcast creators to use their episodes as datasets demonstrated respect for ethical principles. This step also meant an opportunity for creators to give some more insights or perhaps clarify any concerns. I reached out to each podcast creator through email (Appendix A) to inform them of my intentions to use some of their episodes in a thematic analysis. I received almost immediate responses granting permission and expressing gratitude for the work being done in the space of medical errors and forgiveness.

5.4.2 Privacy and Confidentiality

Protection for personal privacy when addressing sensitive subjects such as medical errors and forgiveness can still be affirmed (Beninger, et al., 2014). To address this, I removed all identifying information such as patient names and healthcare provider names when they appear in this study. Although the participants personal information has already been made public through the podcast platforms, due to ethical considerations this study anonymized any identifiable information when presenting results and use pseudonyms for participant names (British Psychological Society [BPS], 2021). Privacy ensures that personal details shared by participants are not unnecessarily exposed or misused.

5.4.3 Beneficence and Nonmaleficence

The study poses minimal ethical risks to participants because they remain uninvolved, anonymous, and have already shared their stories publicly. I followed ethical guidelines by presenting participants' statements with complete accuracy while avoiding any distorted interpretation of their intended meaning. The study maintained the ethical principle of beneficence through its positive contribution to research by investigating patient and family member perceptions of forgiveness following medical errors. This was enforced by the response of the podcast creators who were

enthusiastic about the research paper. Nonmaleficence principles are adhered to because the usage of publicly accessible content minimizes potential harm to individuals. Additionally, anonymisation further reduces the risk of harm. I also considered the effect the findings could have on public perception of healthcare providers and patients who are involved in medical errors. The study was carefully designed in order to not reinforce harmful stereotypes about patients or healthcare providers who make medical errors. To achieve this, I relied on the factual data, used neutral language and care was taken to avoid any unconscious biases when working through the analysis. The analysis endeavoured to be without bias or judgment and neutral in interpretation (BPS, 2021).

5.4.4 Researcher Reflexivity

My interest in forgiveness following medical error stems from personal and professional curiosity. I have witnessed how deeply medical error can affect people physically and emotionally. I have noticed that forgiveness is often mentioned as a goal, however the process is rarely understood from the perception of those who are directly affected. This curiosity motivated me to explore how patients and families experience forgiveness following an error. What makes it possible? What makes it feel out of reach?

I acknowledge that my own background, values and interpretive lens will inevitably influence the current study. As this study uses a hermeneutic phenomenological approach, I understand that my role is not only to report the data in terms of what was said, but to interpret it. My interpretations were not objective as they were shaped by my preconceptions and the interactive process of engaging with lived experience narratives. I approached the data with sensitivity to the emotional depth of each individual's experience by maintaining an awareness of my own biases and assumptions. I took notes throughout the analytical process and engaged in ongoing reflexive journaling to question my biases and remain open to anything that challenged my initial expectations. Additionally reflective journaling allowed me to track my thoughts and keep my interpretations rooted in the perspective of the participants as opposed to my own assumptions.

Throughout this process, I received consistent feedback from my supervisor, Don Baken, which not only guided my analytical decisions but also encouraged deeper reflexivity. This allowed me to further challenge my assumptions, refine my interpretations, and remain attentive to the way the individuals in the study made sense of their experiences.

Finally, I have been conscious of the fact that this study is situated within a Western Context. Although this study is not New Zealand based, as the podcasts were sourced internationally, it is important to acknowledge that this is where the study is being carried out. I personally align with Western cultural beliefs of forgiveness. However, Māori and Pacific worldviews often view forgiveness with collective cultural beliefs. Therefore, I have endeavoured to remain mindful of the cultural lens I was using. This has raised questions for me regarding how different cultures understand forgiveness and how easy it can be to overlook those differences when working with Western theories with a Western background as a researcher. Although the individuals in the study were all from English speaking backgrounds, I tried to leave space in my interpretations for any cultural or spiritual meanings that might not always be initially visible.

There is always an inherent risk of subjective interpretation and personal bias, however, I acknowledge that the findings were shaped through my interpretive lens while maintaining transparency and respect in representing the narratives of those who experienced medical error.

Chapter 6: Analysis

The superordinate themes and related subordinate themes that emerged from the analysis are covered in this chapter. The aim was to explore how patients and families perceive and experience forgiveness following medical error. Based on Braun and Clarke's (2006) approach to reflexive thematic analysis, guided by hermeneutic phenomenology, the analysis derived meaning in the lived experiences of the podcast guests, their emotional responses, and the contextual factors that influenced their willingness to forgive. Following the thematic analysis, five superordinate themes emerged: (1) Emotional Responses of Victims, (2) Desired communication from offender, (3), Influence of Connection, (4), Attribution of Responsibility, and (5) Advocating for Change. The themes reflect the complex and multifaceted journey of forgiveness and emotional healing following medical error. The themes are represented in Table 2 below:

Table 2.

Superordinate and Subordinate Themes.

Superordinate Themes	Subordinate Themes
1. Emotional Responses of Victims	1.1 Navigating Grief 1.2 Acceptance and Letting Go 1.3 Navigating through Challenges
2. Desired communication from offender	2.1 Communication Issues 2.2 Responsibility and Apology
3. Influence of Connection	3.1 The importance of Trust in the Patient-Provider Relationship

	3.2 The Value of Interpersonal Relationships
4. Attribution of Responsibility	4.1 Systemic Issues versus Individual Responsibility 4.2 Understanding Human Fallibility
5. Advocating for Change	5.1 Being a Part of the Solution 5.2 Building Supportive Communities

Superordinate Theme 1: Emotional Responses of Victims

Grief, acceptance, and emotional adaptation emerged from Theme 1 which explores the complex emotional experiences of individuals affected by medical error. The podcast guests describe navigating several interconnected emotional phases that eventually contributed to their capacity to adapt and move toward forgiveness. The subordinate themes, 'navigating grief,' 'acceptance and letting go,' and 'navigating through challenges,' describe these emotional phases and how the individuals in the study made sense of their experiences over time.

Subordinate Theme 1.1: Navigating Grief

Individuals in the study reported intense grief as the most common and immediate emotional response triggered by shock and the disruption that followed the error. The individuals expressed distress and confusion while they each dealt with grief differently depending on personal circumstances, coping techniques and accountability of healthcare providers.

Sally, who experienced multiple medical errors involving her child and husband, reflects on her emotional pain surrounding her grief:

> I grieved profoundly. I don't talk about that much. It's like I know what it's like to hit rock bottom, and I did, but I was a mom and a wife, and we had another baby, and I had to be present for that, and so I really had to visit my soul.

Her words "*hit rock bottom,"* indicates that her emotional state reached its lowest point, while her unwillingness to share her grief during the initial aftermath of the error reflects how she internalised her pain, adding to her sense of isolation. However, her emphasis on her roles, *"mom and a wife,"* highlight a struggle between personal suffering and the importance of carrying out her caregiving roles. Her account not only represents the intensity of her suffering, but also emphasizes resilience as her words, "*visit my soul,"* suggest a process of reflection.

Lisa recalls how her grief and emotional trauma manifested physically:

> It took quite some time to recover from the surgery, but the emotional toll was even greater. I was in this state of mental chaos. You know, I had this knot in my stomach that I was constantly walking around with.

Lisa's description of *"mental chaos,"* and metaphor of, *"knot in my stomach,"* emphasizes the physicality of processing emotional pain after medical error. This physical feeling indicates that her grief was pervasive and consumed broader aspects of her life, including her well-being. Her description of "*mental chaos*" highlights the cognitive disarray that often transpires in the early stages of processing a traumatic event like a medical error. This initial phase is where many of the individuals found themselves unable to understand or fully process what they are going through which can be attributed to the suddenness or unexpected nature of medical errors.

Mary's reflection describes the connection between shock and grief:

> I had to go through a process of grief, and I went through a period of feeling sorry for myself. I still do. You know, I hate being a burden to my family, and I can't go out and do the things that I used to be able to do.

Mary's statement tells us how she not only grieved the error event, but also her sense of self. Her words describe just how quickly grief can turn into thoughts and feelings of inadequacy or self-criticism. She states that the effects of the medical error, including her grief, left her feeling like *"a burden,"* describing the emotional burden of mourning combined with guilt of how it was weighing on the people she loved.

In many of the narratives, anger emerged as a prominent aspect of the grieving process which heightened the emotional complexity of the experience. The individuals in the study discussed feelings of injustice, frustration and betrayal as they attempted to process their circumstances. For some, anger becomes their biggest emotional obstacle. This is illustrated by Sally's account:

> Was I going to curl up and mourn and grieve angry for the rest of my life, or was I going to come out swinging? And I decided that I couldn't, I couldn't not go forward and try to make change, because what I saw was wrong, and I needed it personally to heal.

Here, Sally acknowledges her initial inclination towards anger, however she reframes her emotions as a choice and channels her emotions into constructive action. Her words, *"come out swinging,"* communicates a sense of empowerment and motivation to transform her pain into advocacy. However, the narratives also show that the experience of anger is not universal and appears in various forms, or not at all.

James reflected on how he skipped the anger phase altogether:

> I skipped over the natural second stage of grieving, which is anger and rage. Everybody tells me… How can you sit there and say you didn't feel angry?

His account suggests that while anger is often anticipated or even expected following medical error, some individuals may avoid it, highlighting that the experience is not linear or universal. Similarly, the path from grief to forgiveness is not linear or inevitable. While some individuals may move toward

forgiveness, others may seek acceptance or understanding instead. Jame's account highlights how individual differences and values play a significant role in shaping emotional responses.

Subordinate Theme 1.2: Acceptance and Letting Go

The process of acceptance was described by the individuals in the study as an active and often transformative engagement with their circumstances. This subordinate theme reflects a psychological reframing that allowed the individuals to become resilient and embrace a new way of living. Instead of focussing on loss or injustice, the individuals describe attaining a mental and emotional resilience that allowed them to let go of what they couldn't control and refocus on what was remaining.

Kayla reflected on this shift:

> I just accepted that this is how my life was meant to unfold. And when you embrace that and you allow it to make you better instead of bitter, you know, there's not much I can't deal with.

Here, Kayla highlights the transformational potential of acceptance. She conveys a sense of emotional resilience by deciding to see her circumstances as an inevitable part of her life's path, rather than an obstacle. Kayla is explicitly contrasting *'better'* with *'bitter,'* implying that bitterness may be something that would keep her from being able to cope well with the challenges of life. Her use of the phrase, *'meant to unfold,'* suggests a sense of fate and a sense of coherence to an otherwise traumatic and chaotic event.

Similarly, Amber reflects on the importance of adaptability:

> My grandfather once told me that life is like a game of poker. You are given this life, and you play it to the best of your ability. And whenever I am faced with a new card or a new hand or new situation that comes up, I can only move forward and deal with it the best that I'm able to.

Amber's perspective suggests that acceptance acknowledges what you cannot control and instead focuses on being proactive. Her use of the poker metaphor is an indication of her acceptance in life's unpredictability. Poker players have no control over the cards they are dealt, likewise, individuals often cannot control the challenges faced in life, such as those associated with medical errors. But, as in the case of skilled poker players, who focus on making the best decisions possible based on their own hand, rather than pining away to their bad luck, Amber stresses the importance of responding in a constructive manner to bad situations. Amber's words, *"I can only move forward and deal with it the best that I'm able to,"* reflects her choice of acceptance instead of being consumed by circumstances that are out of her control. This also reflects resilience in the face of adversity by suggesting that she chooses to adapt positively in response to stressful or traumatic situations.

Mary reflected on acceptance in the context of focusing on what she deems important:

> You realize that you know, you can't take any of this stuff with you, and all you really want is to have the people who love you around you. All this stuff that we put so much importance on, like the house, the car, clothes, hair, makeup, you know, you learn that, you know, everybody's, you know, everybody has wounds, that everybody's struggling in some way.

Mary's perspective demonstrates how acceptance often means putting things into perspective in a way that holds less power over you. Mary's reflection suggests that shifting the focus away from the losses and focusing instead on emotional recovery and strong connections with your loved ones could facilitate healing. Another important part of Mary's quote is her acknowledgement that *'everybody has wounds,'* and *'everyone's struggling in some way.'* Here she acknowledges the vulnerability of being human in that we are not immune to pain or tribulations. Mary's comment, *"and all you really want is to have the people who love you around you"* reinforces how supportive relationships with those who care about your wellbeing can facilitate acceptance of circumstances.

For Amy, self-focussed goals transitioned to broader community orientated goals and symbolises acceptance in the form of redefining values:

> They just kept throwing out guesses. And these guesses sometimes resulted in the wrong medication which were quite harmful to my condition, quite often. But, I do feel like in some ways, getting this illness has made me a better person, because I think my pre life, I was very motivated and focused and had all these goals, but they were really like my own personal goals to move myself forward, and now my goals are more focused on things that affect a broader group of people beyond me. Especially through my work with our nonprofit and my writing, our goal is to create awareness in the public, to help people beyond me.

Here, Amy acknowledges that healthcare providers were providing treatment based on *"guesses"* regarding Amy's diagnosis, and how incorrect medication worsened her condition. However, Amy's narrative demonstrates her acceptance of her condition as a crucial point where her identity and priorities were completely changed. Her idea of acceptance suggests that it does not necessarily mean resigning to circumstances but about finding meaning and purpose within them. Her acknowledgement that her chronic illness has made her *"a better person,"* highlights how instead of suffering from limitation, she reframes it as an opportunity for growth. Amy's phrase, *"my pre-life, I was very motivated and focused and had all these goals,"* highlights how she was previously focused on individual success. However, her experience with medical error and chronic illness transformed her mindset, *"now my goals are more focused on things that affect a broader group of people beyond me… to create awareness in the public."* Her shift in perspective acknowledges her acceptance of a new reality and deliberate decision to let go of goals that no longer align with her.

Subordinate Theme 1.3: Navigating Through Challenges

Navigating through challenges depicts accounts of self-reflection, learning from experiences, and continuing forward in the midst of challenges. The individuals in the study discussed their process of recognising setbacks caused by medical error, how they overcome them, and how they've been let down by the healthcare system.

Amy's narrative reminisces about her initial attempts to adhere to the prescribed treatment that ultimately worsened her condition:

> But then I did further research, looked at some more authoritative resources, and realized that some of the protocols that they were telling me that I should do, such as exercising more, which initially I love the thought of that, or cognitive behavioural therapy were actually doing me more harm than good, and it actually caused a setback in my health.

Amy's recognition of certain protocols worsening her condition is not only an acknowledgement of harm, but also a catalyst for growth. Initially, Amy trusted the advice given to her by healthcare professionals, as most patients do when seeking treatment. However, when her treatment resulted in a decline rather than improvement, she was forced to face the inadequacies within her medical treatment. This signifies her transition from receiving care to actively participating in her healing journey. Self-education about her condition demonstrates how she proactively navigates through her own challenges and acquires knowledge for personal empowerment.

In Claire's narrative we see the importance of spiritual growth as a way of navigating through her challenges. She stresses the impacts emotional wounds have on physical health:

> I embarked beyond this whole healing journey that was, that's been amazing. It's been tough, but it's amazing. I truly believe that when your soul, when you're when you carry around these emotional, spiritual wounds, it really does affect your physical body.

Claire reflects on multiple dimensions of navigating through challenges such as acknowledging emotional and spiritual wounds, embracing healing as a complex journey, and recognising the connection between mind, body and spirit. Claire's perspective describes how navigating through challenges involves addressing physical symptoms as well as confronting emotional and spiritual wounds. Claire also describes her journey as both *'tough'* and *'amazing'* implying that navigating the challenges after medical error is not easy but can be transformative.

Kayla addresses her journey focusing on how navigating through challenges does not only involve moving past *"tragedy"* but becoming actively involved in it to facilitate healing:

> I always contend that cancer brought many blessings and many gifts. More so for me than you, you know. And it's, it's a, it's difficult, and there's a lot of bad stuff that came with it, but, um, you know, it was a, it was a real eye opener. So in a way, with this horrible tragedy came a lot of good, and I've even noticed it in my own family, because there's an Aboriginal legend that when you heal yourself, you heal seven generations behind you and seven generations ahead of you. So I'm focused on healing my soul, and like I can't heal my body, but I'm going to heal my soul.

Kayla's narrative illustrates how she was able to find meaning in her suffering rather than viewing it as just a negative experience. Despite being victim to multiple medical errors before her diagnosis, Kayla chose to navigate through her challenges through self-reflection and transformation. Her use of phrases like *"blessings"* and *"gifts"* suggests that she perceives her circumstances as valuable in the sense that it allowed her to grow spiritually and emotionally. Her words, *"healing my soul,"* also suggests reconciliations with herself and her circumstances. Kayla's statement also underscores the nature of intergenerational healing suggesting that growth is not only about personal healing but about contributing positively to the lives of others.

Superordinate Theme 2: Desired Communication from Offender

The theme, *desired communication from offender*, highlights the importance of communication following medical errors. As shown in the narratives, patients and families are often left feeling betrayed and isolated, underscoring the significant role that communication plays in determining forgiveness. Within this superordinate theme emerged two subordinate themes, 'communication issues' and 'responsibility and apology.'

Subordinate Theme 2.1: Communication Issues

The narratives highlight several communication failures that occurred post medical error. This was a dominant concern across the narratives where the individuals consistently noted avoidance, silence, or defensiveness from healthcare providers. The importance of empathetic and open communication emerged as an ethical and relational issue.

Lisa's account underscores how being excluded by a lack of communication made her feel isolated:

> I felt cut off from hospital communication, how no one would talk to me. No one would talk to [doctor] about what happened either, partly from fear of being subpoenaed, so he hid his emotions. We had both been isolated.

Here she talks about how her and her attending doctor who caused the error were both excluded from hospital communication. Reflecting a systemic failure to engage with affected individuals after an error, Lisa reports that no one was willing to talk to her about her concerns such as what had happened, why it happened, the changes that will be made. In addition, the fear of legal repercussions created further barriers to open communication. From Lisa's perspective, the intentional lack of acknowledgement or communication prevented her from understanding what went wrong, leaving her feeling abandoned by the healthcare system.

Claire's story highlights another dimension of communication issues involving missed opportunities for prompt disclosure and explanation given after an error:

> And the thing about SAP checked at the time, if you take the time to do a prompt examination and carry out the repair at the time, there's a huge chance that I would not have suffered anything… It just wasn't taken, and there's been no explanation as to why he didn't do that.

Claire identifies both procedural and communicative failure. In addition to the physical consequences she experienced, she expresses frustration that there was no clarity as to why corrective actions

weren't taken when they could have been. Claire's narrative suggests that timely action could have prevented her suffering or at least mitigated it. Corrective action was not taken in a timely manner, and no communication was made as to why this window was missed. The lack of timely intervention may cause a breakdown in trust between Claire and the healthcare professionals. The second issue focuses on a lack of an explanation as to why timely intervention had not occurred. Claire's words, '…*it just wasn't taken, and there's been no explanation as to why he didn't do that,'* depicts the absence of communication. She could not rationally or contextually understand what happened without knowing why corrective actions were not taken when they should have been.

Amber's story shows that lack of transparency or even avoidance by healthcare providers can diminish trust:

> I felt betrayed because I wasn't feeling like my doctor was honest about the situation… I felt that the person who had the scalpel at the time of the mistake should have come into my room…and apologised to me face-to-face.

Amber's emphasis on betrayal highlights that she highly appreciated honesty with her doctors, but she felt that her doctor was no longer on her side. She expected the providers that made the error to come into her hospital room and apologise for the mistake straight away. Later Amber explained that they had not talked to her about the situation for 6 weeks after the mistake. Amber also points out how delaying communication can amplify emotional wounds. She waited six weeks for an apology, which amplified her unresolved anger and could have been avoided through timely communication.

Subordinate Theme 2.2: Responsibility and Apology

Closely connected to communication, emerged the theme of 'responsibility and apology.' The individuals in the study expressed a need for responsibility through apology of the error, not as a legal formality but as a moral gesture to validate their experience.

Lisa's account illustrates this, *"Against all advice he wrote me a letter that said he was sorry* [for the error event]*, that he didn't expect a response, but he was there if I wanted to talk."* Lisa highlights the courage it can take for a healthcare provider to admit fault while potentially being exposed to legal or professional risk. The phrase *'against all advice'* indicates that the provider was faced with some resistance, probably from legal advisors, institutional policies or colleagues who may have discouraged a public acknowledgement of an error that could lead to litigation or unfavourable publicity. Yet, the provider showed vulnerability and sincerity by not only taking responsibility but also providing a genuine apology which reinforced their accountability. By going against advice and putting themselves at risk they are indicating their strong acknowledgement of responsibility and willingness to do what they could even it might hurt them.

Layla also stated that "*what people actually hear in the moment is really not how it will actually feel… months or years later."* It is therefore worth noting that individuals may process information differently over time, however communication is important in order for patients to grasp an immediate understanding which may affect long-term reflection.

Sarah's experience demonstrates the impact of detailed explanations on patients' achieving closure:

> I achieved closure because he really took accountability, explained that it was an AI error, explained how it was going to be prevented in the future, and also ultimately asked about my health care and how I was doing, which is really all I was asking for, but I was sceptical in that health program.

Here, Sarah addresses not only the matters of responsibility, but also the clarity about what caused the error. By fully explaining what went wrong and outlining preventative steps, the healthcare provider demonstrated transparency, responsibility and an active approach to patient safety improvements. This act, of taking responsibility, directly helped Sarah achieve closure, because it demonstrated to her that her suffering was not being ignored or minimized. This was the starting point for Sarah's ability to move forwards emotionally. Additionally, Sarah's use of the term *'closure'*

implies that the act of taking responsibility, explanation on what happened and how it was going to be prevented in the future brought her to a point of closure over what had occurred. However, noting that she was still sceptical about her healthcare program.

Layla's experience illustrates that responsibility is not only about disclosing the facts but also creating a space for communication for individuals who need time to process what occurred:

> I also think about how people hear something in the moment is not how they will feel most likely, not how they will feel about it after months or years later. And these are not events that people write off, right? Like these are. These are life changing events. And as people change and grow and learn, and they may reflect on it differently than the way they did that day, and that's okay.

This is a statement filled with the understanding that responsibility alone may not heal the past but does provide a foundation for trust by acknowledging reality rather than hiding it. Her statement, "…*how people hear something in the moment is not how they will most likely feel over months or years later,"* could imply that healthcare providers need to realize that their attempt to accept responsibility and to be transparent may not bring instant relief or closure but will pave the way for future healing. Layla's acknowledgement, '*these are life changing events,'* reinforces that medical error results in long lasting consequences that require time for individuals to process.

Superordinate Theme 3: Influence of Connection

Trust and relationships prove to be powerful in the healing process. Within the superordinate theme, 'influence of connection,' emerged two subordinate themes, 'the importance of trust in the patient-provider relationship,' and 'the value of interpersonal relationships.' The analysis of the subordinate theme, 'the importance of trust in the patient-provider relationship*,'* sees trust with healthcare providers emerge as essential factor that influence patients' and their families' ability to forgive medical errors. Through the narratives we see that trust creates a foundation for understanding after medical error. The subordinate theme, 'the value of interpersonal relationships,'

describes how connections and interpersonal relationships foster emotional resilience, provide support during crises, and facilitate pathways toward forgiveness.

Subordinate Theme 3.1: The importance of Trust in the Patient-provider Relationship

Trust, preexisting and present, emerges as a critical subordinate theme. It highlights the way it serves as a foundation for emotional resilience, allowing people to cope with complex feelings of betrayal, vulnerability and eventual reconciliation that occur after medical errors.

Trust was developed for James from the compassionate actions of the nurses that took care of his daughter with dedicated service, *"These nurses loved my little girl and took care of her like she was their own, and not just because we were watching them so closely either."*

This statement highlights two major aspects that can build trust: genuine care, as well as perceived authenticity. James states that the nurses' concern was not a performance or the result of external review but was genuinely rooted in an intention to do good by his daughter. His phrase, '*loved my little girl,'* conveys James' perception of the level of compassion extending beyond a professional obligatory level. For James this was critical as it provided reassurance that the nurses were invested in his child's wellbeing. This belief may have softened any subsequent feelings of anger or betrayal that may have been caused by mistakes due to the understanding that it was not intentional or due to lack of care. In turn this may have helped him more readily grant forgiveness.

Similarly, Amber's account shows how trust can mitigate negative feelings after medical errors:

> I stayed because he had been treating me for two decades and had given me more quality of life in the earlier years that I ever dreamed of having and so his diligence is my case, and in doing everything possible was enough to push me and to continue to trust, even though I had every reason not to trust.

She reflects on how she decided to stay with her healthcare provider despite having reasons not to trust. Here, Amber emphasizes how her provider's prior hard work and dedication built a foundation

of trust that exceeded any present errors. By saying, *"I stayed because he had been treating me for two decades…"* she implies that trust is developed gradually through persistent effort to do the best for her and her health over time. For Amber, this long-term trust acted as a buffer to resentment and facilitated her healing process.

Subordinate Theme 3.2: The Value of Interpersonal Relationships

For many of the individuals in the study, their interpersonal relationships served as an anchor to help them navigate the emotional impact caused by medical error. Claire's account underscores this:

> He's my protector. He's an angel, you know. And watching him every day and groaning is a beautiful boy that he is. He is so caring and loving. And you know, he says to me every single day, Mom, you're beautiful, even in days when I don't feel it, he'll say, Mom, you're beautiful, you know. He's the reason for me being here now.

Claire's description illustrates how her son's constant expressions of love from telling her she is beautiful every day, is a source of strength for her. The sense of emotional safety allows her to feel valued through love and care, implying that it allows her to be more resilient to adversity.

Similarly, Mary reflects on how her family gives her a meaning and a purpose despite hard circumstances:

> I am making meaning out of this experience, because I know that my kids, they need to see that. You know, there is some happiness, even if you're dealing with different things and it's rough. I have a lot of bad days. I do, but I don't know what I do without my kids, my husband, my family and our animals.

Here, Mary acknowledges her family motivates her to persist through hardships. She describes how having loved ones around her fosters an environment that facilitates both physical and emotional

healing. She also illustrates how she perseveres with strength through modelling resilience for her children.

The narratives also show how interpersonal relationships play an important role in mitigating the feeling of isolation during crises. Amber's account illustrates:

> I don't know what I would have done if my family wasn't there at the hospital as much as they were and for six weeks, my mother was with me, 24 and didn't leave. I felt less alone and less violated, because I knew that if I didn't catch something else, she was there to catch it.

During a vulnerable time, Amber's mother's constant presence gave comfort as portrayed in her narrative. Amber's narrative is another example of how the presence of loved ones acts as a buffer against feelings of isolation during traumatic healthcare experiences. Amber also explains that having someone she trusted by her side helped her feel *"less violated,"* and "*if I didn't catch something else, she was there to catch it,"* which implies that interpersonal relationships act as a resource and can help repair some dignity when harm has been done.

Superordinate Theme 4: Attribution of Responsibility

Superordinate theme 4, 'attribution of responsibility,' highlights the perception of blame after a medical error. Within this superordinate theme emerged two subordinate themes, 'systemic issues versus individual responsibility,' and 'understanding human fallibility,' as described below. This theme captures the complex ways in which patients and families assign responsibility by weighing systemic failures against individual actions. It underscores the importance of understanding systemic issues rather than focusing solely on individual accountability, and understanding that healthcare professionals are human and therefore likely to make mistakes.

Subordinate Theme 4.1: Systemic Issues versus Individual Responsibility

The podcast guests highlighted how a rigid hierarchy within healthcare systems create barriers to communication among healthcare providers. Sally addresses this issue:

> I understand that systems can be the systems improvement could be the solution. Now I don't want to ignore that there are doctors that maybe should not be practicing. We need systems in place to identify that with the nurses, they could have been more proactive. I think, however, they were really prevented. In this hierarchical system, which I've witnessed, the nurse was trying to inform the doctor.

Her statement brings together a number of important points pertaining to how systemic failures intersect with an individual's responsibility and their impact on patients' and families' understanding of medical errors and the potential for forgiveness. Sally's phrase, "*the nurse was trying to inform the doctor,"* but was, "*prevented,"* illustrates how a hierarchical system prevented to nurse from providing the attending doctor with critical information which could have avoided medical error. Sally admits that *"nurses could have been more proactive,"* implying individual responsibility. She however quickly puts things into context by stating that nurses were *"really prevented"* from doing so by systemic factors that were outside their control. This dual viewpoint represents a complex notion of responsibility. Although people may be somewhat to blame for their actions, or inactions, bigger institutional factors frequently affect and control human conduct. Sally places emphasis on structural reform rather than asserting blame solely on individuals.

James expands on this and highlights the broader implications of flawed systems on patient safety:

> These are the most empathetic, compassionate people I know. And when something bad like this happens, it's a result of the systems, the flawed systems, then imagine how devastated they are. And I mean, they're, they're in the business of saving lives.

James describes healthcare professionals as empathetic and compassionate. He points out the fact that it is intrinsically what motivates healthcare professionals to do no harm. His assertion that

'flawed systems' rather than personal carelessness are the true cause of most medical errors, shifts the emphasis from individuals to systemic flaws. James's quote suggests that empathy for healthcare providers may be a bridge towards forgiveness because it takes away responsibility from them and shifts the focus onto systemic issues. James further states:

> I wanted to be part of the solution, and uncover where the systems, processes, and protocols broke down that horrible day to set these amazing clinician caregivers up to fail.

James here emphasizes his motivation not only to understand what went wrong but also to tackle systemic issues that led to the error. His recognition that healthcare providers were '*set up to fail'* implies an empathetic stance that can lead to forgiveness by removing responsibility from the individual providers and placing it on systemic failure.

Lisa also acknowledges that focussing solely on individual responsibility does not address the root cause of medical errors. Lisa supports a change to systemic solutions that put learning and development ahead of punitive actions:

> So it's not plucking out one doctor saying they were the problem. It was, here's the solution. And I think most patients now in the patient safety movement, really embrace the systems based approach for improvement. All of a sudden, the issue escalated from the two of us to this is just wrong. We decided that we're gonna take this on.

Where errors are often attributed to individual incompetence or negligence, Lisa underscores the issues with this approach. When Lisa says, "*the issue escalated from two of us to this is just wrong,"* she is referring to her and her doctor. Lisa illustrates this as an inadequate response by oversimplifying complex situations and not addressing systemic causes that allow such errors to happen. Lisa's statement also implies that this approach may be unproductive and harmful because it risks scapegoating individuals rather than addressing broader structural deficiencies. When she says, '*It was, here's the solution,'* the attention is shifted toward problem-solving and systemic reform. This

perception emphasizes solutions instead of blame and looking to prevent, rather than punish. She implies that medical error is rarely the outcome of action alone, but rather these errors are produced from a collection of factors within health care systems.

Subordinate Theme 4.2: Understanding Human Fallibility

One of the most prevalent comments amongst the narratives are that doctors are not infallible creatures but rather everyday humans with responsibility and enormous pressure. Sally illustrates the importance of differentiating between malicious intent and unintentional error, *"We forgave his surgeon. We forgave because we knew it was not intentional. The doctors weren't bad, they could have been better doctors, but they weren't bad people, and they made mistakes."* Her use of phrases like, "*they weren't bad people,"* indicates that understanding intent allows patients and families to disconnect the action or harm done from the person who made the mistake. Knowing that her loved one's surgeon did not intentionally harm gave Sally room to be compassionate rather than harbour resentment and blame.

Kayla's further encapsulates this perspective on human fallibility:

> Doctors are human. They're going to make mistakes. We asked them to be gods. We asked them to act like gods. But the reality is they're human, and we need to move away from that mode of thinking.

Here, Kayla demonstrates a change in perspective from seeking perfection to acknowledging that human imperfection is a natural part of life. Kayla addresses the emotional load imposed on healthcare providers by societal expectations. Kayla suggests that if patients and families recognise this pressure there is potential for empathy to be fostered.

James presents medical errors as statistically inevitable, providing a practical perspective on human fallibility:

> God made us all fallible. We're all capable of making a very human error… Chances are pretty good that you being this hypothetical rock star cardiac surgeon… you're still… going to have a significant error that results in and/or is lethal to a patient.

His words reveal a recognition of the fact that despite a physician's training and expertise, errors will inevitably be made. This way of thinking allows James to see errors as a normal part of life rather than extraordinary failures. James' perception further highlights the importance of understanding that perfection is unattainable, even within the healthcare industry. This understanding helps James reframe mistakes or errors as inevitable rather than avoidable.

By focusing on the fact that mistakes are inevitable during the learning process, Sarah points on the need of recognition and accepting human limits to be a major part of professional development:

> I didn't want punishment for the resident who was also working on the case that didn't seem fair to me, and is also a large part of residency, I hope that residents feel like they can make, you know, within reason, mistakes that can then be caught by attendings. It's a learning experience.

From her perspective, there is a learning curve that comes with any medical training, in which errors are not only possible but are more or less expected. However, Sarah does not consider these errors to be indicative of incompetence or negligence but rather as opportunities to learn and improve. Her perception suggests that she sees fallibility as inherently human as opposed to a problem that needs to be punished. She also acknowledges that residents are working within a safety net meant to mitigate the effects of their errors, but to learn from them. Sarah's statement also displays empathy towards the human and vulnerable elements of healthcare providers. Her refusal to insist on punishment to the resident is an understanding that even highly trained professionals are not free from error under certain circumstances. Understanding that errors are just reflections of the fundamental limitations of all people, especially those still learning their skill, has facilitated her willingness to forgive.

Superordinate Theme 5: Advocating for Change

The superordinate theme, 'advocating for change,' represents a transformation in individuals who have suffered from medical error. This theme demonstrates the interplay between the individual's acknowledgement of systemic issues and their commitment to creating positive change. The podcast guests discuss how they redirect their pain and trauma into advocating for change while building support networks for individuals going through similar experiences. Within this theme, no subordinate themes emerged. However, this absence does not mean the theme is lacking in complexity, but rather, that there is a symbiosis among the various aspects of advocacy that focus on one mission of driving systemic improvement and personal healing.

Across podcast guests there was a tendency for them to turn their own suffering into purposeful action. Sally's statement illustrates this process, *"And I decided that I couldn't, I couldn't not go forward and try to make change, because what I saw was wrong, and I needed it personally to heal."* Sally's words show an intrinsic motivation to remedy perceived injustices in the healthcare system. She opts to act because she wants to recover personally, suggesting that taking action may alleviate the feelings such as anger or helplessness following medical error. By responding to what happened in a prosocial way as opposed to vengeance, Sally points toward a movement towards forgiveness.

Amy's statement is an example of the way advocacy can arise from a personal experience of medical error. Amy's narrative highlights how community support plays a crucial role in shaping individuals' perceptions of harm, fostering accountability, and promoting healing:

> I'm doing quite a few things, a couple of things. I work for the CDC with revamping some of their myalgic encephalitis documentation for providers and caregivers. And then I also do some volunteer work for a very active state organization. I do all their social media work to help raise awareness of their events that they have related to this illness to help support people In Minnesota that have it, because so many people are so isolated with this disease.

Her words highlight her commitment to improving healthcare practice at an organisational level. Her advocacy is also focussed on combating isolation by creating a supportive environment for individuals in similar circumstances. Amy's work not only aims to prevent future harm but also aims to ensure that those who have suffered from myalgic encephalitis are understood d supported within healthcare system.

Lisa's narrative highlights the need for establishing support networks as part of the advocacy efforts:

> I told him I wanted to start an organization that focused on the effects of medical error, and we decided that both patients and clinicians needed more support after similar experiences. Soon we were making the rounds at hospitals doing presentations. I remember older doctors lining up to talk to me, telling me medical error stories they had kept to themselves for years. Patients and clinicians alike were calling us for help.

Lisa started an organization to deal with the aftermath of medical errors along with creating open dialogue between patients and healthcare providers. In her words, advocacy exemplifies a way for breaking walls of silence and stigma within the healthcare community. She demonstrates how advocacy can foster empathy and understanding between groups that are often positioned as adversaries in the aftermath of medical errors. Lisa's advocacy work recognises that both parties are affected by medical error in different ways. Lisa promotes support systems that cater for the needs of both groups by advocating for opportunities for reconciliation and collaboration. Lisa points out also that storytelling is a powerful tool for advocacy. Her memory of doctors *"lining up"* to share their stories implies that both patients and providers carry unspoken difficulties associated with medical errors. Lisa creates a space to have these narratives out in the open and which can help to dismantle the culture of silence around medical errors.

Kayla implies how advocacy becomes a way to channel emotions and provides a sense of collective influence, *"So we band together, and we said, No, we if we can do something, we need to do something, and we need to create a collective voice."* Kayla underscores the importance of unity

among those affected by medical error. The words *‘banding together’* reflects that advocacy is both a group and an individual effort to raise the voices that may not otherwise be heard.

For some, advocacy is a means to hold healthcare institutions accountable for their actions, or lack thereof. This is highlighted by Mary:

> Trans vaginal meshes, at least from the way I'm understanding it, have been 100% banned in every country around the world, which is amazing, and it took all of us, you know, just trying to let the FDA know, hey, this is dangerous, and it's killing people.

The successful scenario which she describes, a global ban on transvaginal meshes, is an example of how collective action can result in tangible results that are meaningful to patients’ concerns. Again, we see the importance of systemic accountability. By emphasizing a worldwide ban was due to collective advocacy, Mary highlights the importance of acknowledgement of harm. The global ban on transvaginal meshes is not only a recognition of patients’ experiences, but also a demonstration of commitment on behalf of the institution to prevent future harm.

Chapter 7: Discussion

In this chapter, the findings are critically discussed as they emerged from the superordinate themes in the thematic analysis. Each is discussed as it is situated with the literature to increase the understanding of how patients and families perceive forgiveness and the factors influencing their willingness to forgive healthcare providers after medical error. The first superordinate theme, 'emotional responses of victims,' revealed grief to be a common response to medical error with emotional processes closely aligning with the Kübler-Ross model of grief. The second superordinate theme, 'desired communication from offender,' highlights the importance of communication following an error by discussing the communicative issues experienced by individuals in the study and the responses they expected or preferred. Superordinate theme 3, 'the influence of connection,' shows the impact of trust and long-term relationships with healthcare providers, and the importance of interpersonal connections and support networks. Superordinate theme 4, 'attribution of responsibility,' reveals the interplay between systemic issues and human fallibility, and how the perception of blame influences willingness to forgive. The final superordinate theme 5, 'advocating for change,' shows a powerful pathway to forgiveness when individuals in the study channelled their pain into confronting systemic issues and advocating for change. Following the critical discussion of the themes, this chapter further describes the strengths, limitations, theoretical implications, and directions for future research.

7.1 Emotional Responses of Victims

The emotional responses of the victims revealed complex journeys through grief, acceptance and emotional adaptation. The subordinate themes, *navigating grief, acceptance and letting go,* and *navigating through challenges,* reflected the interconnected phases that the individuals experienced as they processed their trauma, gradually worked through their pain, and reorientated their lives. Individuals in the study described overwhelming feelings of grief and despair initially after the error occurred, accompanied with anger and self-blame. However, the narratives showed that the

individuals were able to transition towards acceptance through cognitive reframing and realigning their values. Finally, the individuals in the study described ongoing efforts to navigate through continuing challenges, characterised by resilience, purpose, and spiritual growth.

The findings reveal that the emotional responses of victims to medical error change and develop over time. The responses of grief, acceptance and emotional adaptation reflect a transformation of identity, values and purpose which in turn facilitated emotional recovery and forgiveness. The findings showed this process to be unique to the individual and shaped by factors that emerged across the themes in the analysis, such as familial roles, support systems, beliefs, and perceived accountability of healthcare providers. For example, the individuals in the study who had strong support networks described greater resilience and increased capacity to shift from anger to acceptance. Similarly, the individuals who felt that healthcare providers took responsibility through apology and transparency, were more likely to frame their experience in a way that facilitated forgiveness. This will be further discussed in the following subsection. However, these connections underscore the interplay between emotional processing and external factors shaping the way forgiveness is perceived following an error.

Research consistently identifies grief as a common first response and coping mechanism to medical error (Wu, Huang, Stokes, & Pronovost, 2009). Scott et al., (2009) state that grief provides individuals with an opportunity to process their pain by acting as a foundation for the emotional process toward forgiveness. This recognition may lead individuals to confront the need for healing and therefore creating a space where forgiveness can eventually be attained. However, if people don’t have the appropriate support or resources to help them move through this stage, then, unresolved grief can hinder progress (Murtagh, Gallagher, & Andrew, 2012).

The findings align closely with the Kübler-Ross model of grief which outlines five stages: denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1970). It is reasonably argued that the grieving process is not linear and therefore, grief is no longer emphasized as stages (Tyrrell,

Harberger, Schoo, & Siddiqui, 2023). Much like the experience of grief, forgiveness is not a single one-off decision but happens over time, both consciously and unconsciously, with non-linear progress (Browne, 2009). The comparison between grief and forgiveness highlights how forgiveness following medical errors is an emotionally complex non-linear phenomenon. In the same way that grieving individuals may move through denial, anger, and acceptance at various bereavement phases, they may also move through feelings of hurt or empathy several times before allowing a space for forgiveness. The comparison sheds light on the fact that forgiveness cannot be expected to follow a consistent course among patients and families after experiencing medical errors.

More recently studies are exploring the connection between the Kübler-Ross model of grief and the process of forgiveness as both involve emotional responses to loss such as death, separation or betrayal. Kessler (2014) highlighted that grief can be experienced in many ways and forgiveness plays a role in the healing process. He notes that grief manifests in a variety of emotional forms, with anger being a common part of the process. Forgiveness often involves confronting and gradually moving away from negative emotions, such as anger, to prevent the development of resentment and facilitate emotional healing (Kubler-Ross & Kessler, 2014). This is particularly relevant for patients and family members victim to medical error as forgiveness can facilitate emotional healing and help navigate grief more effectively. Anger is essential in facilitating forgiveness as a natural expression of pain as well as an emotional step towards healing. Additionally, Farley and Sweeten-Shults (2021) discuss how mourning and forgiving follow the same process of acknowledging grievances and how this is essential for healing. The researchers point out that the Kübler-Ross model helps individuals understand their emotional responses while processing anger and moving towards forgiveness can facilitate healing from grief (Farley & Sweeten-Shults, 2021).

Denial, as noted in the Kübler-Ross model, usually acts like a defence mechanism to protect people from overwhelming emotions (Kubler-Ross, 1970). The findings showed how the individuals in the study were initially hesitant to confront their feelings which is consistent with the view of

denial as a way to create emotional distance from the initial shock of the error. This stage can delay willingness to forgive because the literature shows that acknowledgment of harm is important for forgiveness in the context of medical error (Gallagher, Waterman, Ebers, Fraser, & Levisnson, 2003). In both Enright's process model and Worthington's REACH model the first step toward forgiveness is to acknowledge the offense and its emotional impact (Enright & Fitzgibbons, 2000; Worthington, 2006). If individuals are hesitant to confront the reality of the harm through denial, they may be effectively hindering the forgiveness process.

According to the literature, anger is considered to be a natural response to adverse events (Kubler-Ross, 2005). As noted, anger and rage were commonly discussed among the narratives. However, its role in forgiveness seems to vary between individuals. As seen in the narratives, some individuals made a decision to skip the anger phase. This corresponds with Worthington et al. (2016) who suggested that some individuals may avoid or supress anger based on their personal beliefs or coping mechanisms. In contrast, some of the individuals channelled their anger into purposeful action, such as advocating for change. This supports research showing that when acknowledged and expressed constructively, anger can contribute to healing by prompting individuals to seek justice or engage in meaningful coping strategies (Exline et al., 2003). This further aligns with findings by Dekel et al. (2021) who reported that constructive responses to anger may help nurture resilience and healing in the aftermath of traumatic events, thereby facilitating forgiveness. The contrast in responses demonstrate how individuals process anger differently following medical error. Processing feelings of anger is important because unresolved feelings of anger can hinder willingness to forgive (Kim, Payne, & Tracy, 2023).

The narratives also suggest that the individuals in the study experienced a period of emotional heaviness manifested through sadness, hopelessness, and reflecting on what their lives might have been like had the error not occurred. This aligns with the depression stage of the Kübler-Ross model and was illustrated in the narratives with the emotional turmoil experienced by the

individuals. The individuals in the study described struggling to come to terms with the implications of the error and the effects it had their lives. Wu et al. (2020) also stated that such emotions are common in individuals who are victims of medical error. This stage is a pivotal point where individuals process their pain more deeply but may still feel consumed by it (Kubler-Ross, 2005).

The narratives show a gradual shift in perspectives around how the individuals in the study come to terms with their reality and adjust to a new way of living. This process was characterised by the emergence of emotional resilience, personal growth, and eventually acceptance. In the context of medical error, acceptance often serves as a foundation for forgiveness by enabling individuals to acknowledge what has occurred, and channel their emotions into healing (Gallagher et al, 2003). Rather than remaining fixated on blame, the individuals in the study described how reframing their experience allowed them to find meaning in their pain. In their 2007 study, Worthington et al. found that forgiveness was more likely for those who reframed adverse events as opportunities for growth. Once the individuals in the study came to terms with acceptance, we see how they navigated through challenges to find a way forward. Across the narratives there is an interplay between resilience, acceptance and forgiveness. Individuals in the study who reframed the medical error as an opportunity for growth and understanding human imperfection were more willing to forgive.

7.2 Desired communication from offender

The findings showed that communication was the most desired response by patients and families following a medical error. The individuals in the study expressed a strong desire for timely, honest and transparent explanations from healthcare providers that would help them make sense of what had happened. This is supported by Mazor et al. (2004) who pointed out that patients who were given explicit explanations as to what happened and why specific decisions were made were more likely to forgive. However, instead most individuals in the study were met with communication failures which manifested as isolation, lack of timely explanation, and avoidance of responsibility. A key contribution of the current study is that communication following a medical error should not

only be present but should also emphasize quality and continuity. The individuals in the study reported feeling further victimised when the communication was delayed, vague or unempathetic. This suggests that communication following an error should not only be factually informative but emotionally responsive to patient and families' needs.

The literature consistently shows that communication following an error is an important part of mitigating negative emotional responses and fostering forgiveness (Gallagher, 2003). Furthermore, research by Ledema et al. (2011) indicated that timely disclosure following adverse events is essential to preserve trust. If healthcare providers do not provide timely explanations and corrective actions to patients, they could feel that they are being neglected and that the providers are being negligent (Bari, Khan, & Rathore, 2016).

Apology also emerged as an important aspect of desired communication from offenders. This is consistent with prior literature that suggests explanations with a sincere apology accompanied with acknowledgement of responsibility, encourages patients and families to forgive healthcare providers (Robbenholt, 2009). These responses were found to support emotional healing and facilitate willingness to forgive in the current study. However, the narratives also demonstrated that the absence, delay or vague apologies left individuals in the study feeling dismissed or devalued. However, in contrast to existing literature that tends to treat communication or disclosure as a one-off discrete event, the current study highlights a need for longitudinal, emotionally sensitive communication as the findings showed that forgiveness was hindered not only due to absence or delay of initial disclosure, but by a lack of ongoing engagement. Additionally, the findings of the current study suggest that an apology alone is not always sufficient. An effective apology showed to be less dependent on whether one is offered and more on how it is communicated in terms of timing, honesty, transparency, empathy, responsibility, and ongoing efforts. Ultimately, patients and families expect communication that is part of a sustained relational process in which healthcare providers remain accessible and responsive to emotional needs.

By taking responsibility, healthcare providers express respect for the patient's experience, acknowledge their pain, and may help counter feelings of betrayal or anger (Harrison, Lemaire & Morrow, 2020). This act of accountability can rebuild damaged relationships between patients and providers (Witman, Park, & Hardin, 1996). However, the findings in the analysis also suggest that responsibility and accountability need to go further than just acknowledging the incident, it also has to be about taking steps to handle the effect of the error and avoid future failures. This is consistent with the work of Boothman et al. (2012) on disclosure programs where it is expected that errors are not only admitted, but also commitment to systemic improvements is demonstrated.

The analysis found transparency to be a fundamental element of communication. Individuals in the study recognized the importance of transparent communication which provided details about what caused errors as well as provider honesty regarding uncertainty and system limitations. This resonates with research that consistently shows that full disclosure and honest communication improves the patient-provider relationship after adverse events like medical errors (Kachalia et al., 2018). The individuals in the study also importantly noted that transparency should be an ongoing process rather than a onetime act. The narratives highlighted that patients and family members may need some time process emotionally, but transparency positively impacts this process. This insight confirms Bell et al.'s (2018) observation that such responses to medical error change over time and that providers must continue to be available and communicative as the healing journey continues, thereby facilitating willingness to forgive.

Importantly, this study highlights that emotional healing and forgiveness are most likely when transparency and responsibility are experienced together. For example, the individuals often mentioned episodes when providers not only accepted fault but also explained in detail what went wrong and what they had done to prevent things from happening again. This distinguishes the difference between responsibility and transparency but underlines how both are important. This

finding is consistent with Mazor et al.'s (2004) conclusion that there is a positive interaction between sincerity in apologies and competence in addressing underlying issues when patients forgive. Nevertheless, it is important to note that even when providers do exhibit responsibility and transparency, literature shows that forgiveness is not always guaranteed.

7.3 The Influence of Connection

Another important finding in the study is the role of long-term relationships in shaping trust and influencing forgiveness. The individuals who had long-term positive relationships with their healthcare providers were able to foster forgiveness more easily. This finding is consistent with Durand et al (2015) who point out that sustained positive experiences with healthcare providers generate goodwill that can protect against adversity, like medical errors. By creating an emotional connection between patients, families, and healthcare providers, trust makes it simpler for individuals to forgive errors when they occur (Mazor et al, 2006). Trust and consistency over a long period of time enables patients to explain errors in the context of a wider narrative of competence and dedication (Durand et al., 2015). For example, James and Amber had a long history of high-quality care which allowed them to maintain trust and were less likely to see an error as a generic reflection of systemic incompetence and more likely an isolated incident. Patients who are trusting and emotionally connected to their providers report less intentional errors and less evidence of provider incompetence (Gallagher et al., 2003). This emphasizes the need for health care settings to provide an atmosphere for prior proof of competence and quality relationships as a channel to forgiveness.

The findings also shed light on the importance of interpersonal relationships providing emotional resilience and mitigating feelings of isolation. A key finding in the narratives was that familial relationships serve as a foundation for emotional support following medical error. The narratives consistently illustrated how their loved ones were a significant source of comfort, strength and purpose during the challenging times following medical error. Research shows that having a

strong social support system leads to better psychological outcomes in those who are victim to medical error (Mazor, Simon, & Gurwitz, 2004). According to Ledema et al. (2011), these connections foster emotional resilience which helps individuals process their feelings constructively, reducing the likelihood of prolonged anger or resentment toward healthcare providers.

The analysis also found that physical presence of loved ones supported emotional recovery. Individuals in the study reported feeling more secure and less alone when their loved ones were physically present during their adverse experiences following medical error. This is supported by research that found perceived physical support to act as a buffer against the psychological impact of traumatic events such as medical errors (Edwards, Evans, & Elwyn, 2017). Mazor et al. (2006) also found that physical support following medical error allowed patients to feel more validated in their experiences. The analysis depicts how trust and relationships can mediate patients' and families' perception of harm as well as their willingness to forgive healthcare providers.

7.4 Attribution of Responsibility

The findings revealed that attribution of responsibility interplayed between systemic issues and human fallibility. The narratives highlight how attribution of responsibility can be complicated and hinder forgiveness if not properly understood. Systemic flaws like hierarchical structures, poor communication, insufficient safety procedures were frequently considered to be major causes of medical errors in the current study. This framing may be influenced by the nature of the sample where individuals may be more comfortable discussing systemic shortcomings rather than assigning individual blame. It is also possible that that the narratives reflect a level of emotional processing or reframing that occurred over time, or a conscious decision to narrate their experiences in a way that they were willing to share publicly.

However, the findings of this study are consistent with the systems-based approach advocated by researchers such as Kohn et al. (1999) who argue that most errors result from complex systemic failures rather than individual negligence. The consistency between findings by researchers,

such as Gallagher (2003) and Leape (2002), and the current study suggest a growing consensus within healthcare research regarding the fundamental systemic causes of medical error heavily influenced by the environment and systems rather than just individual negligence. However, while previous research has been mostly centred around clinician reports, incident reviews, or organisational statistics, the current study introduces an additional dimension by exploring lived experiences and capturing how individuals personally interpret and attribute responsibility.

The structural issues within healthcare systems were described by the individuals in the study as often inadequate for healthcare professionals to act proactively or effectively deal with potential risks. In organizations with rigid hierarchies, nurses may feel disempowered to challenge the physicians and as such preventable harm may occur (Edwards, Evans, & Elwyn, 2017). According to studies, patients may feel betrayed or misled by the organization if they believe that errors were avoidable because of systematic deficiencies (Gallagher, et al., 2006). For example, the findings of the current study showed that if a patient knows that an error occurred because their nurse was unable to escalate concerns because of hierarchical barriers, then their willingness to forgive may be diminished. This emphasizes how important it is that health care organizations confront these fundamental deficiencies.

Individuals in the study recognized the significance of systemic problems, but they also understood the necessity of safeguards to identify practitioners who may pose risks. This integrated strategy shows a sophisticated knowledge that patient safety outcomes are influenced by both individuals and systems, hence the interplay between systemic issues and human fallibility. Human fallibility proved to be an important consideration in patients and families' responses to forgiveness in the aftermath of medical errors. The attribution of responsibility in the current was influenced by podcast guests' awareness of limitations inherent in healthcare providers, knowing that errors are generally unintentional and occur within the systems attribution of a pressure filled and complex working environment. By gaining this understanding, they were able to come to terms with how their

emotional reactions to those adverse events were reconcilable with a broader perspective on human imperfection, thereby facilitating forgiveness. This is consistent with existing literature in that patients are more likely to forgive when they know that errors are not intentional, reinforcing the awareness of human fallibility within a systems context (Gallagher et al., 2003). For example, a study has demonstrated that when patients learn about the reasons for an error, for instance fatigue, resource constraints, the complexity of decision making, they become more compassionate to healthcare providers (Mazor et al., 2004). This was also shown in the findings of the current study as forgiveness was also found to be influenced through empathy and compassion. Podcast guests who practiced empathy by putting themselves in the shoes of healthcare providers, acknowledged the stresses they endure. This aligns with Enright's (2001) forgiveness framework that emphasizes empathy as one of the main mechanisms for overcoming anger and resentment. The podcast guests who understood the difficulty of healthcare providers being subject to cognitive overload, systemic inefficiency and other stressors were more likely to attribute responsibility with empathy and compassion rather than blame. Considering healthcare practitioners as fallible individuals rather than perfect entities is reflected in the podcast guests' capacity to explain errors within these frameworks.

The necessity of questioning societal norms around healthcare providers infallibility was also discussed by the podcast guests as they acknowledge the pressure of unrealistic ideals put on healthcare providers, setting patients and families up for disappointment if these ideals are not met. This finding is consistent with Bosk's (2003) work that shows that societal narratives of 'heroic' physicians encourage unattainable expectations of patients and practitioners. By acknowledging healthcare providers as fallible individuals, the individuals in the study were able to gain a perception that fosters mutual understanding and respect. For example, if patients and families have reasonable expectations established from the outset, then they typically will not have feelings of betrayal or anger when an error occurs, thereby facilitating forgiveness.

7.5 Advocating for Change

One of the most prominent findings across all narratives was the relationship between emotional healing and advocacy. Advocacy in the current study encompassed active engagement in accountability seeking, promoting systemic improvements and future harm prevention. For some of the individuals in the study, advocacy was a catalyst for emotional healing, including forgiveness, and for others a degree of emotional resolution was necessary before they could participate in advocacy. This implies that the relationship is cyclical where emotional healing, including forgiveness, not only facilitates but is also facilitated by advocacy.

The individuals in the study described how advocacy helped them regain a sense of control of their experience which was largely non retributive in nature as they were not seeking to punish those involved but rather to ensure accountability, raise awareness and promote change. This reflects a shift from personal suffering toward purposeful action. As studies have shown, people who experience trauma often find meaning and purpose by contributing to broader societal change (Tedeschi & Calhoun, 2004). Mazor et al. (2013) also states that advocacy provides individuals with a sense of agency over their experience in which they once felt powerless. Advocacy in the current study served as an avenue to restoring a sense of justice without seeking retaliation or blame, which supported the emotional processing of the error, including the possibility of forgiveness.

The findings in the current study emphasized advocacy's therapeutic value and aligns with research stating that advocacy can serve as a coping mechanism for individuals dealing with trauma and loss (Gallagher et al., 2013). Podcast guests illustrated how they were able to reconcile their feelings of mistrust and betrayal, which influences forgiveness, by addressing systemic issues within the healthcare system and advocating for change. This aligns with previously mentioned findings regarding moving beyond individual responsibility and confronting broader systemic issues by reconciling feelings of betrayal and mistrust through active engagement and empowerment. As a result, advocacy does not only become a personal recovery tool but also a means of restoring

people's trust in healthcare systems. The podcast guests highlighted the importance of meaningful responses to their advocacy from healthcare organisations, such as policy or regulatory changes, in fostering reconciliation. For example, knowing tangible outcomes associated with their advocacy efforts, like bans of harmful medical devices and enhanced safety protocols, increased willingness for forgiveness for individuals in the study. This finding is consistent with existing literature on how institutional accountability can encourage forgiveness after medical error (Berlinger, 2014). The participants' experiences show how systemic change can also be a validation of the participants' concerns and influence willingness to forgive.

7.6. Thematic Integration and Contributions

Thematic analysis revealed five superordinate themes which interact with one another to create an integrated picture of forgiveness as being dynamic, relational, and contextual. The implications of these findings present several new contributions which challenge and develop the existing theoretical view of forgiveness as applied in healthcare settings.

The findings demonstrated a profound interaction between emotional processing, trust, and agency as reinforcing factors of the forgiveness process. The theme, 'emotional responses of victims,' highlights how individuals must first navigate their emotional responses of grief, anger and disappointment before forgiveness becomes a possibility. However, emotional healing proved to be influenced by the way the response was delivered, such as transparency and open communication, as well as by the content that was delivered in terms of apology and responsibility. The themes 'emotional responses of victims' and 'desired communication from offender' demonstrate that without open communication or acknowledgement from providers, emotional healing becomes challenging which hinders movement towards acceptance, reconciliation or forgiveness. This challenges existing forgiveness models, such as Enright and Worthington's models as discussed in the following subsection, that predominantly view forgiveness as an internal and dispositional process. Instead, the current study revealed that willingness to forgive is relational and dependent on external

factors, which reflects a demand for further attention to be paid to institutional and interpersonal processes.

The third theme, 'the influence of connection,' served as a moderation factor between emotional processing and communication. The individuals in the study who had long-term relationships with healthcare providers were more willing to attribute the error within the broader context of systemic issues and human fallibility, which minimized the sense of betrayal and increased the likelihood of forgiveness. This theme demonstrated the important but underexplored role of relational continuity in influencing the perception of situational harm. Conversely, where no such prior relationships were present, the individuals were more reliant on provider communication and behaviours following the error. These findings indicate a new contrast between dispositional and situational forgiveness revealing that while dispositional forgiveness predisposed some of the individuals to be more empathic and perceptive, situational forgiveness was dependent on the providers immediate responses and behaviours. Therefore, the current study shows that the combination of dispositional and situational factors creates a need for a more holistic model of forgiveness which highlights the interdependence of both the personal and situational aspects of forgiveness.

This is further complicated by the theme, 'attribution of responsibility,' where the findings do not conform with traditional blame orientated frameworks and instead suggest that forgiveness was more likely when the individuals could attribute fallibility to providers within the broader context of systemic failures. This theme shows an interconnection with 'the influence of connection', as the individuals who trusted their providers were more likely to attribute the error to systemic issues rather than individual negligence.

Additionally, the individuals in the study who had supportive networks among family and community were more likely to be empathetic and able to practice cognitive reframing, facilitating their willingness to forgive. These emotional resources reduced negative emotions, such as anger,

and enabled individuals to progress through the emotional aftermath of the error and be more willing to forgive. Willingness to forgive was not solely shaped by the events in the aftermath of the error, but also how responsibility was conceptualised and attributed among individuals, providers, and organisations. These findings move beyond current literature which views attribution of an error as an isolated fixed cognitive appraisal and instead shows that it is dynamically influenced by relationships, previous trust, and the availability of emotional support resources.

The final theme, 'advocating for change,' revealed advocacy as both a coping mechanism and a transformative tool linking the emotional, relational and systemic aspects of forgiveness. Advocacy allowed the individuals in the study to feel empowered as it restored a sense of agency after feeling betrayed. This theme demonstrates that forgiveness is more than just a form of emotional resolution, but a proactive effort to seek accountability and improvement within the healthcare system. This differs to current literature which predominantly views advocacy and forgiveness and separate responses to harm. The current findings reveal that they can reinforce each other as advocacy enables individuals to make sense of their experience and restore trust in the system, ultimately influencing their willingness to forgive. This interconnection is absent in current forgiveness literature and models, therefore representing an innovative contribution to the theoretical and practical knowledge of recovery post error.

7.7 Study Implications

The study explored how patients and families perceive forgiveness in response to medical errors and identified various factors that influence their willingness to forgive healthcare providers. The findings of the current study reinforce forgiveness as a complex, relational and context-dependent process that extends beyond simple conceptions. Forgiveness in the context of medical error is not a single emotional act or decision, but rather shaped by an interplay of individual traits, relationship history, support networks, systemic responses, and broader sociocultural frameworks. This section discusses the summary of key findings, thematic integration and contributions,

theoretical implications, clinical implications, strengths and limitations, directions for future research, and concluding remarks.

7.7.1 Summary of Key Findings

The findings revealed that the emotional aftermath of medical errors deeply shapes how individual's made sense of their experiences, which influenced willingness to forgive. While the term, 'forgiveness,' was not always explicitly used by the individuals in the study, their narratives reflected process associated with it such as, letting of resentment, seeking understanding, or finding peace. The individuals in the study demonstrated a persistent need for straightforward explanations, sincere apologies, accountability, and tangible steps to avoid similar error in the future. The absence of communication through avoidance and silence proved to undermine trust while forming significant barriers to forgiveness. In contrast, open disclosure, responsibility, transparency, and ongoing communication fostered a sense of respect and validation, which patients and families identified as key precursors to forgiveness. For example, several individuals described a process of emotional healing after receiving transparent communication or sincere apologies, suggesting that these actions played a role in shifting their perception towards healthcare providers. In contrast, patients and families frequently reported that grief and anger linger long after the error has occurred if they feel isolated or dismissed by healthcare providers which demonstrates the essential requirement for both individuals and institutions to provide empathetic care.

The individuals who had long-term relationships with their healthcare providers were more trusting and more likely to attribute errors to isolated events rather than incompetence or ill intent. This highlights the importance of relational continuity and emotional connection with healthcare providers as it allows patients to feel respected and more willing to forgive. On the contrary, where such relationships did not exist, forgiveness proved more difficult to obtain. In these cases, patients and families were more likely to attribute the error to individual negligence rather than systemic issues or human fallibility. While some of the individuals recognised systemic factors expressed a

greater understanding and pathway to forgiveness, this attribution was often facilitated by prior trust and communication with healthcare providers. Significantly, the individuals who could incorporate empathy for the healthcare provider's circumstances within a comprehension of systemic issues were more capable of reframing the error as an unfortunate outcome of a complex system rather than an unforgiveable moral failure.

Finally, the practice of advocating for change proved to be impactful in transforming the emotional experience of medical error and paved a pathway towards forgiveness. All individuals in the study engaged in advocacy after the error which gave them a sense of purpose, allowing them to redirect their grief and anger into meaningful action because it helped them understand the limitations of the system. Given that podcast guests are likely to be individuals who share their stories publicly, this may reflect a unique characteristic of the current study's sample. However, the findings highlight the potential therapeutic value of advocacy. The individuals found advocating for change a way of restoring trust in the system, including providers, when they were met with responsiveness and tangible change by organisations. This shows that forgiveness can also be closely tied to justice, recognition and systemic change. Promoting the possibility of advocacy in other patients and families that have experienced medical error can be promising as a tool to promote emotional healing, including forgiveness.

7.7.2 Theoretical Implications

Forgiveness theory is typically focused on the interpersonal setting in which the responsible parties are relatively easy to identify, and emotional healing usually occurs through personal processes of empathy, reasoning, or transformation. This study places forgiveness in a more dispersed and institutional setting where responsibility may be distributed across systems rather than resting solely with an individual. In this context, willingness to forgive extended beyond the emotional process of the individual but also shaped by the relational and organisational responses that followed the error. This challenges dispositional forgiveness assumptions and suggests that

forgiveness following medical error is significantly influenced by external situational factors. For example, the presence of absence of communication, trust, and systemic understanding. The current study therefore contributes to forgiveness theory by demonstrating that, following a medical error, it cannot fully be understood without acknowledging the broader organisational and relationship processes within which it transpires.

Enright and Worthington's models are both built on the emotional transformation of the individual. Enright's model focuses on cognition and affective change such as reframing the offense by means of empathy and emotional resolution (Enright & Fitzgibbons, 2019). Worthington's REACH model similarly defines mechanisms of forgiveness through empathy, altruism and commitment (Worthington, 2006). The findings of the current study align with these models by demonstrating how empathy can facilitate forgiveness. However, in the context of healthcare, this empathy was not only directed towards individual offenders, but also towards an understanding of broader systemic factors and human fallibility.

The current study also demonstrates that patients and families' willingness to forgive is strongly determined by organisational responses, transparency, support networks, pre-existing trust and relationships with healthcare providers. These contextual variables represent an expansion of the current models as they show that forgiveness, especially in healthcare setting, is highly reliant on the emotional and ethical tone set by the healthcare providers and organisations.

This study supports the notion that forgiveness is more easily facilitated when the offense is viewed as an accident as opposed to malicious intent to cause harm. The individuals who were able to reframe their experiences, viewing healthcare providers as fallible humans acting within the limits of the system, were more willing to forgive. This cognitive reframing, core to both Enright and Worthington's models, was supported by previous positive interactions and long-term relationships with healthcare providers, open disclosure practices, and the willingness to acknowledge fallibility.

These findings suggest that the theory of forgiveness could benefit from understanding the ways in which systemic and relational contexts promote or hinder empathetic understanding.

While stress and coping theory has previously recognised forgiveness as a form of emotional regulation (Worthington & Sherer, 2004), the current study contributes to this model by demonstrating how forgiveness operates as a coping mechanism in the context of medical error. Lazarus and Folkman (1984) defined coping as a cognitive and behavioural effort to deal with stressful situations. The findings of the current study indicate that forgiveness served as both an emotion-focused and a meaning-focused coping mechanism as it enabled the individuals to minimise psychological distress, restore a sense of justice, and restoration of emotional balance. The individuals practiced forgiveness as a way to work through grief, anger, moral disappointment, and to find meaning from their trauma.

The findings also show that emotional healing, including forgiveness, was both facilitated by and contributed to advocacy. Advocacy gave the individuals in the study an outlet to redirect the emotional responses and sense of injustice into purposeful action, which resulted in greater emotional healing. Some of the individuals showed that forgiveness enabled them to engage in advocacy without becoming consumed by resentment. This reciprocal relationship suggests that, in the context of medical error, forgiveness and advocacy may operate as interdependent forms of coping. This broadens the conceptualisations of the coping theory to incorporate strategies that are focused on emotional healing and transformative change within a system.

The findings suggest the necessity of a more integrated theoretical conceptualisation of forgiveness following medical error that moves beyond interpersonal frameworks. Forgiveness, in the context of medical error, should be viewed not only as a subject of individual emotional processing, but as a dynamic process that is influenced by organizational behaviour, support networks, and perceived integrity of the healthcare system. Although traditional models of forgiveness provide powerful paradigms for individual reconciliation, they fail to appreciate the complexity of forgiveness

in hierarchical settings like the healthcare system. Forgiveness theory models should therefore attempt to include aspects of relational trust, systemic justice, and organizational accountability into frameworks. Such a model could be more indicative of the lived experiences of patients and families and improve the concept of forgiveness theory in practical healthcare settings.

7.7.3 Clinical Implications

The findings of the current study provide valuable implications on clinical practice, especially the way in which healthcare providers respond to patients and families following medical errors. A major contribution of the current study is the understanding that forgiveness following medical errors is not only an emotional process but is shaped by factors such as communication and organizational culture. Forgiveness was often contingent on how healthcare providers engaged with patients and families after an error. Clinically, the findings support the importance of timely, transparent, and emotional approach to open disclosure practices. As the narratives revealed, communication that lacks empathy or is delayed may intensify emotional trauma, while transparency and responsibility can restore trust and healing. Clinical training should therefore incorporate strategies that extend beyond technical protocols and include meaningful communication components such as sincere apologies, acknowledging responsibility, expressing genuine empathy, offering clear approaches to avoid similar events in the future, and ongoing engagement. Such clinical interventions are not only ethical but directly support emotional healing, as shown in the current study.

The patients in the current study who reported a long-term history of relationships with healthcare providers who made the mistake were more likely to perceive the error as an isolated incident due to previously established trust through capability and care. These patients were more likely to emotionally heal and willing to forgive. It is therefore important for clinical settings to prioritise models that facilitate stable, consistent relationships between patients and healthcare providers as the findings show that trust and longevity are essential to emotional recovery. The

findings further demonstrated that patients and families expect evidence that healthcare organizations are improving their processes and committed to making systemic changes that avoid similar events in the future. These findings imply integrated clinical forms of feedback which ensure that patients and families have an opportunity to express concerns and to have a role in the quality improvement process, as well as remain informed on how their cases have led to change within the organization.

In the context of New Zealand, concepts such as *whanaungatanga* (connection), *mana* (dignity), and *utu* (restoring balance) offer important guidance for how healing is navigated. Forgiveness in this sense is not only about emotional healing but also restoring harmony with the collective. In multicultural settings, clinical care should integrate practices that allow space for dialogue, collective reflection, and culturally meaningful acts of restoration (Durie, 2001). This may include facilitating *hui* (gatherings) with whānau, enabling narrative-based healing (such as storytelling or oral testimony), and recognising the cultural and spiritual dimensions of justice and reconciliation (Mead, 2003). A culturally safe approach is therefore critical for promoting forgiveness and upholding values within the healthcare system.

7.8 Strengths and Limitations

This section outlines the key strengths and limitations of the current study. Acknowledging both strengths and limitations offers a balanced appraisal of the research design and outcomes and clarifies the scope and credibility of the study's contributions to existing literature. The strengths of the study are presented across conceptual and theoretical contributions, methodological rigor, and practical relevance. The limitations of the study are discussed as secondary data limitations, demographics, generalisability and transferability. By reflecting on these aspects, this section provides important context for assessing the strengths and implications of the current study's conclusions.

7.8.1 Strengths

Conceptual and Theoretical Contributions

A key strength in the current study is its ability to reframe forgiveness as an evolving process shaped by emotional experience, situational context, and how individuals make sense of what happened. Although prior research on medical misadventure tends to view forgiveness as a psychological trait or a single event, the current study expands on this by showing that patients and families experience forgiveness as a nonlinear, multifaceted, and context dependent process. This challenges existing models and emphasizes the need for dynamic frameworks that recognise the emotional, moral and systemic aspects of medical error.

Methodological Rigor

The use of reflexive thematic analysis informed by hermeneutic phenomenology enabled a multifaceted way of exploring lived experiences. Forgiveness is a multidimensional concept and thematic analysis allowed for its complexities to be captured. Furthermore, thematic analysis allows for the exploration of additional factors regarding forgiveness or systematic problems within the healthcare system that could influence patient attitudes (Hall & Fincham, 2005). This method was critical to the current study in exploring how individuals narrate their experience with medical error, their responses, and the factors that influence their willingness to forgive.

What sets the current study apart is its use of podcast narratives as a source of naturalistic qualitative data. Unlike structured interviews or surveys, podcasts offer organically unfolding, participant driven narratives that are often recorded in informal and emotionally expressive settings (Markham & Harris, 2021). This naturalistic format can attain the semantics and expression of lived experiences that fits into the hermeneutic phenomenological premises that form the basis of the study. By using podcast narratives as a data source, it provides access to numerous healthcare patient perspectives who might not participate in conventional scientific research procedures (Markham & Harris, 2021). Individuals who contribute to podcasts maintain freedom to share their

stories naturally without restrictions from preestablished research goals. As a result, discussions of forgiveness emerged organically from the broader narrative, rather than being elicited through direct questioning, allowing for more authentic insights. The unique characteristics of podcasts such as accessibility, storytelling capabilities, educational value, opportunity for reflection, and authenticity prove especially beneficial when studying delicate matters such as medical error-related forgiveness.

Additionally, the reflexive position adopted throughout the research process, supported by ongoing supervisor feedback and input, contributed to the analysis credibility and insightfulness. Regular reflection further allowed for a conscious engagement with interpretations and ensuring that the findings remained grounded in the experiences and perceptions of the individuals in the study.

Practical Relevance

The study contributes practical insight for healthcare organizations by identifying key communication practices that facilitate or hinder forgiveness and emotional healing following an error. The current study provides strong evidence that apology, transparency, responsibility, timely, and ongoing communication are essential to emotional healing and forgiveness. By documenting how apology, taking responsibility, and systemic change influence forgiveness, the study offers clear implications for organisational training, disclosure protocols, and patient support initiatives. It further responds to an ethical mandate in healthcare to address more than just the clinical outcomes, but to also engage with the emotional vulnerability of patients and families following errors (O'Connor, Coates, Yardley, & Wu, 2010).

7.8.2 Limitations

Secondary data limitations

As a secondary data source, podcasts present issues with content control. It should be noted that the podcasts were not originally created for research purposes. As the researcher is not involved in the interview process, the content is limited to the questions asked by the podcast host.

Therefore, the depth and general direction of the narratives are not guided by specific research questions, but rather by the conversational flow dictated by the podcast host. The podcast guests may not have explicitly addressed forgiveness, which limits consistency across the episodes. As a result, there may be relevant aspects of forgiveness, such as subtle emotional processing or cross-cultural conceptions, that remain unexplored across the podcast episodes. Some of the narratives also focused more on the medical error events itself with limited discussion on forgiveness and emotional recovery which restricted the possibility of considering perceptions extensively.

Limited Context and Demographics

Podcast narratives do not usually provide much demographic data or background context regarding the guests being interviewed, unlike traditional qualitative methods. As a result, it was not possible to examine how individual characteristics, such as age, socioeconomic status, cultural background, and how these factors influence forgiveness perceptions. However, it should also be noted that such analysis would not have been reliable for the current study due to the limited number of cases. Pseudonyms and brief case descriptions were adopted to preserve anonymity in the current study, although they were also developed from limited available information. Therefore, the analysis is limited in its abilities to explore the broader identity context in which forgiveness was experienced.

Generalisability and Transferability

Since this research was conducted using a sample of individuals who opted to share their experiences publicly, there is a risk of selection bias. Such individuals may differ from those who are not ready yet, may never feel ready, or choose not to speak publicly about medical error due to trauma, stigma, or fear. Due to the small sample size, and specific medium used, the findings are not generalisable to the general population, and transferability to other populations, such as cultural contexts, may not be applicable. However, generalisability is not the primary objective of the current study, but rather the deeper comprehension of lived experiences (Creswell & Poth, 2018).

7.9 Directions for Future Research

This study contributes to a growing body of literature on understanding the psychosocial and relational aspects of medical error as it relates to forgiveness. The findings highlight the complex and contextual dynamic of forgiveness as they reveal the interdependence between individual, interpersonal, and systemic factors. However, the current study also provokes several questions and areas to be developed, warranting further empirical investigation to improve understanding of the variables that facilitate or hinder forgiveness following medical error.

Future research should employ longitudinal studies to explore how forgiveness in the context of medical error unfolds over time and the way it is influenced through continuous interactions with healthcare organizations. If we can understand how forgiveness grows or shifts over time, we can create better support systems that continue to help individuals well beyond the initial shock and emotional trauma caused by the error.

The sample in the current study included individuals who were comfortable sharing their stories publicly through podcast channels. This could be an indication of personal traits such as assertiveness, access to resources, or a sense of responsibility to help others, which may affect perceptions of forgiveness. Future research should be carried out on the perception of forgiveness on a larger scale of cultural, socioeconomic, and spiritual backgrounds. These studies might be able to enlighten the process of different worldviews and belief systems regarding concepts of apology, responsibility, emotional healing, and forgiveness.

The findings highlighted the significant role of prior long-term relationships with healthcare providers shaping forgiveness. The individuals in the current study who reported positive long-term relationships with their providers were more likely to understand the error as an isolated incident rather than incompetence, thereby facilitating their willingness to forgive. In future research, the dynamics of rapport, continuity of care, and interpersonal trust should be explored as a promoting factor in the process of forgiveness. This is especially relevant due to the contemporary move

towards fragmented care models in which patients are experiencing more decreased continuity with healthcare providers (Starfield, Shi, & Macinko, 2005). Such studies could be used to guide relational patient safety and harm resolution.

The responses from healthcare organizations were essential in influencing the emotional outcome of patients and families, as well as shaping perception of forgiveness. Future research should explore the influence of different organisational disclosure practices on levels of empathy, accountability, likelihood of formal complaint, and ongoing engagement. The comparison of data collected in organizations with developed open disclosure policies and those without may provide insightful data on structural and communicative factors facilitating or hindering forgiveness. Additionally, the importance of apology content, timing, and sincerity should also be explored to further enlighten channels through which organizational behaviour can lead to emotional resolution.

The findings showed that advocacy was used as a coping mechanism and a strategy for restoring emotions by most of the individuals in the study. However, very little is empirically known about the way in which advocacy functions as a means of meaning-making, empowerment, and eventually forgiveness. Future research should focus on examining how patients and families are affected psychologically and emotionally when they advocate for change following a medical error These insights could inform how healthcare organizations respond in the aftermath of error and create systems that truly support healing and improvement.

To truly understand forgiveness following a medical error, future research should consider a multidisciplinary lens of emotional, social, cultural, ethical and systemic factors. Such an approach would move beyond a psychological lens to also account for the broader contexts in which forgiveness is experienced. Additionally, it is important for future research to consider individual demographics to determine how they experience and respond to errors. This would enable findings to be more representative and applicable across diverse populations and healthcare contexts. Expanding the scope and methodology of forgiveness research will allow future research to play a

pivotal role in the development of healthcare systems that not only aim to avoid error but are willing to respond and remedy the likely event in a humane and restorative way.

7.8 Concluding Remarks

In conclusion, the study contributes to a growing body of research that views forgiveness as a relational, dynamic and context-sensitive process. The findings of the current study not only support preexisting theoretical assumptions of forgiveness but also challenges them. Instead, it could be argued that such theories don't fully encapsulate how individuals experience and process forgiveness following events such as medical errors. Forgiveness after a medical error unfolds gradually, shaped by how individuals manage their emotions, who they trust, how the healthcare system responds, and their need to make sense of what happened. The findings suggest that forgiveness in the context of medical error is not simply an act of releasing anger and resentment, it is about rebuilding trust, regaining a sense of control, and facing the complicated relationships and power dynamics involved when errors occur in healthcare. Such insight has significant implications on healthcare providers and organizations seeking to create an atmosphere that encourages healing and reconciliation. If forgiveness is attained, it is often a reflection of restored trust, not only due to apology or disclosure, but also because of sincere recognition, organizational and individual accountability, and human connection.

Finally, this thesis highlights the importance of incorporating emotional and relational aspects to medical error and patient safety discussions. It supports a patient-centred approach that acknowledges that complexity of harm, recognises the burden of emotional recovery, and facilitates forgiveness as a possibility rather than an expectation. The insights from this study suggest the need for ongoing interdisciplinary research and structural changes with a higher emphasis on empathy, communication, and justice and in the aftermath of medical error.

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Appendices

Appendix A: Letter to Podcast Hosts

Dear (name of host),

I hope this message finds you well. My name is Lauren Lorimer, and I am a master's research student at Massey University in New Zealand. As part of my master's qualification, I am conducting a thesis project exploring how patients and families perceive forgiveness following a medical error, and what factors may influence their ability to forgive. This study aims to investigate the complex relationships between patient forgiveness and medical errors by considering the systemic, psychological, and emotional elements that encourage or discourage forgiveness. I intend to obtain important insights on how these ideas are discussed in real-life discussions by examining conversations on this subject in public spaces like podcasts.

Your podcast offers a unique forum for in-depth, multifaceted discussions on important healthcare issues related to medical error. In particular, your episodes that cover topics like medical errors, patient safety, and the accountability culture in healthcare are highly relevant to the research I am conducting. The interchange of dialogue between you and your guests provides new perspectives that can enhance the thematic analysis utilized in this study.

I would like to kindly request your permission to include selected episodes of your podcast as part of the thematic analysis dataset. The analysis will be focussed on the content in terms of themes of forgiveness and accountability within healthcare settings. This research will anonymize all findings where appropriate. I will not be using any identifiable information such as names, age, demographic information or location. I will also not be including quotes that could lead to the identification of your guests. This research strictly follows the ethical standards for academic research.

Thank you very much for taking the time to consider my proposal. Your podcast is an invaluable resource for key discussions about healthcare issues and I appreciate the work you do to facilitate such conversations.

I would be happy to consider any particular terms or conditions under which you might prefer your content be used.

If you have any concerns or questions regarding further details, please feel free to contact me at any time.

I look forward to hearing from you.

Kind Regards,

Lauren Lorimer

Appendix B: Initial Coding

Podcast 1: James

Initial Theme	Descriptive notes	Quotes
Skipping the “anger stage of grief”	James’ comment was that he ‘skipped’ the ‘second stage of grieving’ which is anger and rage. He credits this to the grace of God and his good experience with the people who treated Lola. Reasons: his faith, and the way they cared for his daughter.	"I skipped over the natural second stage of grieving, which is anger and rage. Everybody tells me, James, I don't know how you did that, because if that was my baby girl… How did that happen? How can you stand how can you sit there and say, No, I believe it's for two profound reasons."
The dedication of the healthcare workers	James sees all the nurses and clinicians who dedicated their time treating his daughter like they were looking after their own. It occurred to him that the caregivers didn’t want the error to occur.	"These nurses loved my little girl up and took care of her like she was their own, and not just because we were watching them so closely either."
Focussing on systemic issues rather than individual responsibility	Demonizing the individuals rather than focusing on systemic issues: One of James’ goals of the article was to not demonize the individuals that were involved and to instead discover the systemic failures and the process failures that led to the error. There was no way he wanted responsibility put on one person, or to prevent a focus on improving the whole system.	"I wanted to be part of the solution, and uncover where the systems, processes and protocols broke down that horrible day to set these amazing clinician caregivers up to fail."
Publicly forgiving those involved in the error	James was given the opportunity later to publicly forgive the pharmacist involved in the error it. James could now set the record straight and focus on repair of the systemic issues.	"I was given that opportunity to publicly forgive [him] and set the record straight." “[Him] and I were actually brought together on camera in May of 2011 and I was given that opportunity to publicly forgive [him] and set the record straight." And then shortly thereafter, [him] and I, again, it may sound odd, but I don't care, [him] and I actually became friends and we made a promise to one another to try and make something come from all of this. And we did probably about a dozen or so lectures and presentations all over the United States that following year or two."
A focus on being part of the solution/Desire for change	A desire to help make sure this doesn’t happen to someone else. James’ desire was to be part of the solution. He was able to redirect his energy toward advocacy and systemic	"I knew [daughter] was with the Lord. I knew that I was here again one day, but shortly thereafter, I became obsessed with I didn't know quite you know immediately how I was going to do this, but I wanted to make certain that I was doing everything to

	improvements by learning to forgive and cooperate with it.	uncover Where did, where did the systems, processes and protocols break down that horrible day to set these amazing clinician caregivers up to fail."

Podcast 2: Sally

Initial Theme	**Descriptive Notes**	**Quotes**
Understanding human fallibility	Sally and her family recognised that the surgeon's involved in both her son and husbands' cases did not intentionally harm them.	"We forgave his surgeon. We forgave because we knew it was not intentional." "The doctors weren't bad they could have been better doctors, but they weren't bad people, and they made mistakes."
Focus on systemic issues rather than individual responsibility	Using a systemic approach to safety, Sally did not blame individual providers but rather a system of policies, education and accountability.	"I understand that the systems improvement could be the solution. Now I don't want to ignore that there are doctors that maybe should not be practicing. We need systems in place to identify that with the nurses, they could have been more proactive. I think, however, they were really prevented. In this hierarchical system, which I've witnessed, the nurse was trying to inform the doctor." "So it's not plucking out one doctor saying this was a problem. It was, here's the solution. And I think most patients now in the patient safety movement, really embrace the systems-based approach for improvement."
Personal journey of grieving and channelling tragedy	Initially, sally went through a grieving process and then decided to 'come out swinging' and take action. This meant she was able to take something personal and make it something positive for a movement toward change.	"I grieved profoundly. I don't talk about that much. It's I know what it's like to hit rock bottom, and I did, but I was a mom and a wife, and we had another baby, and I had to be present for that, and so I really had to visit my soul." "And I asked myself, What was I going to do? Was I going to curl up and mourn and grieve angry the rest of my life, or was I going to come out swinging? And I decided that I couldn't, I couldn't not go forward and try to make change, because what I saw was wrong, and I needed it personally to heal." "So when I got to speak at HRQ for the first time, I sense this. There's really good people out there that would want to do something about this."

Support from patient advocacy community	Sally’s involvement in Patients for Patient Safety gave her an opportunity to work with others who had come across similar experiences within the framework of a supportive community and with a collective approach to resolve the fundamental systemic problems.	"So we band together, and we said, No, we if we can do something, we need to do something, and we need to create a collective voice.” “And at this time that we've known each other, but once we decided to all meet the mountains of [location] and sit around my kitchen table and say, How can we be the catalyst at United States was ramp." “We have strategic partnerships, of [organisation names]. We're working with all of our government agencies, and to everybody's credit, everybody has said, Yes, let's work together." "So we are seeing a remarkable momentum. And we can't take all the credit, because I think that all of our partners collectively are creating this engine that's moving forward."

Podcast 3: Lisa

Initial Theme	Descriptive Notes	Quotes
Overcoming isolation and lack of communication	Both Lisa and the doctor who committed the error felt isolated and lacked communication from the hospital which contributed to their emotional turmoil. Eventually they reconnected with each other and were able to understand each other’s experience and perspective. The doctor was shut out from communication from the institution due to fear of being subpoenaed which implies a wider institutional culture involved in lack of support and accountability.	“I felt cut off from hospital communication, how no one would talk to me.” “No one would talk to [doctor] about what happened either, partly from fear of being subpoenaed, so he hid his emotions. We had both been isolated.”
Empathy and compassion	Lisa empathised with her attending doctor after understanding his side, demonstrating her capacity for compassion.	“My friends were encouraging me to sue but my mind was elsewhere. I was thinking ‘how must he be feeling?’”

	The doctor himself went through a transformation of compassion where was also able to empathise with Lisa and saw her as a human being, not just a patient.	"When he moved back to [town] we got a coffee and I explained my side of the story, how I felt cut off from hospital communication, and how no one would talk to me. No one would talk to [doctor] about what happened either, partly from fear of being subpoenaed, so he hid his emotions. We had both been isolated. All of a sudden the issue escalated from the two of us to this is just wrong."
Responsibility and accountability	The doctor took initiative, despite advice against it, and wrote Lisa an apology letter, showing a willingness to take accountability for the error. His accountability and Lisa's ability to understand the broader systemic issues allowed them to move away from individual responsibility.	"Against all advice he wrote me a letter that said he was sorry, that he didn't expect a response, but he was there if I wanted to talk."
Focus on systemic issues rather than individual responsibility	Lisa and the doctor realised that the error was bigger than just the two of them. It was not only a personal failure but a much broader systemic issue that needed to be addressed.	"All of a sudden, the issue escalated from the two of us to this is just wrong. We decided that we're gonna take this on."
A focus on being part of the solution/Desire for change	Lisa and her doctor worked together to start the Medically Induced Trauma Support Services organization which represents a shared goal for desired change. This shows a forward looking approach which is focussed on preventing similar situations happening in the future, while supporting others who may be affected by similar incidents.	"I told him I wanted to start an organization that focused on the effects of medical error and we decided that both patients and clinicians needed more support after similar experiences." "Soon we were making the rounds at hospitals doing presentations. I remember older doctors lining up to talk to me, telling me medical error stories they had kept to themselves for years. Patients and clinicians alike were calling us for help." "Over the past 15 years we have piloted patient therapy groups and convinced hospitals across the country to develop peer support programs."
Time and reflection	Lisa notes that her emotional recovery took quite some time which suggest that her process of forgiveness was gradual rather than immediate. This allowed for a period of reflection and healing which resulted in Lisa gaining the necessary perspective to forgive.	"It took quite some time to recover from the surgery, but the emotional toll was even greater." "When I opened my eyes, I didn't have brain damage. I did have a scar, broken ribs, and a terrified family. My husband was crying. I couldn't even comprehend what was going on." "I was in this state of mental chaos. You know, I had this knot in my stomach that I was constantly walking around with."

Podcast 4: Amy

Initial Theme	Descriptive Notes	Quotes
Gaining understanding	Amy did her own research into her illness to gain a deeper understanding of the appropriate treatments compared to the harmful treatments she had been receiving. The increased understanding helped her move past the initial resentment and frustration towards healthcare providers.	"But then I did further research, looked at some more authoritative resources, and realized that some of the protocols that they were telling me that I should do, such as exercising more, which initially I love the thought of that, or cognitive behavioural therapy were actually doing me more harm than good, and it actually caused a setback in my health."
Shift in perspective	Amy mentions that in some ways she felt her illness made her a better person as it enabled her to shift her focus more on helping others through advocacy. This mindset shift allowed her to find meaning beyond her own negative experiences and contributed to her ability to forgive.	"I feel like in some ways, and this may sound really weird to say to some people, but getting this chronic illness, in some ways, has made me a better person, because I think my pre life, I was very motivated and focused and had all these goals, but they were really like my own personal goals to move myself forward, and now my goals are more focused on things that affect a broader group of people beyond me, especially through my work with our nonprofit and my writing, our goals To create awareness in the public, is to help people beyond me and spat just goals that are, you know, I certainly have goals for Well, a lot of my goals now are more overly focused."
Acceptance and adaptation	Amy had to learn how to pace herself and prioritise taking care of herself, even though this meant being less productive. This took time, and an important part of her healing and forgiving the providers was to accept these limitations instead of pushing herself as she had in the past.	"I really didn't know. I mean, I I thought all I had was a sleeping disorder, because at the beginning, that's really mostly what it was, was just exhaustion. So I went to the sleep clinic, and they gave me medications, and they said, We're gonna help you sleep. And I really just thought it was some sort of sleep condition that I had, but in 2016 more symptoms started coming up, as far as memory loss, vision loss, swollen lymph nodes, I was getting, if I get sick with one thing, I'd get sick with multiple it would make me susceptible to other things very quickly."
Finding community through advocacy	By being involved in advocacy work and supporting others with the same illness, Amy was able to find a purpose and connection which helped her move forward rather than dwell on errors of the past.	"I'm doing quite a few things, a couple of things. So I work for the CDC with revamp being some of their magic encephalitis documentation for providers and caregivers. And then I also do some volunteer work for a very active state organization, not my current not the state I live in, but another

		state. I do all their social media work to help raise awareness of their events that they have related to this illness, and then me as Mallory, people here in Minnesota formed a nonprofit called the Minnesota MECFS, or myopic encephalitis flush chronic fatigue syndrome Alliance, to help support people In Minnesota that have it, because so many people are so isolated with this disease."

Podcast 5: Kayla

Initial Theme	**Descriptive Notes**	**Quotes**
Acceptance and letting go	Kayla discussed her acceptance of the path she was on as she explored valuable lessons during her cancer experience. This acceptance and change in perspective are important in the forgiveness process because it frees her from the bitterness and resentment.	"I just accepted that this is how my life was meant to unfold. And when you embrace that and you allow it to make you better instead of bitter, you know, there's not much I can't deal with."
Spiritual growth and healing	Kayla says her cancer 'became a spiritual journey' and she used the experience to start working on healing her 'soul' and her issues which happened as a child. This inner work and personal growth are necessary to actually get to the point of able to give forgiveness.	"I embarked beyond this whole healing journey that was, that's been amazing. It's been tough, but it's amazing." "I truly believe that when your soul, when you're when you carry around these emotional, spiritual wounds, it really does affect your physical body."
Letting go of ego	Kayla tells us that she had to give up societal understanding of what her 'life should be' and become more comfortable with herself.	"You realize that you know, you can't take any of this stuff with you, and all you really want is to have the people who love you around you. All this stuff that we put so much importance on, like the house, the car, clothes, hair, makeup, you know, that you learn that, you know, you know, see things personal, everybody's, you know, everybody has wounds, that everybody's struggling in normal way"
Understanding human fallibility	Kayla sympathises with the human aspect of her doctor (and of 'doctors being human' and making mistakes). The forgiveness process is supported by this ability to see	"Doctors are human. They're going to make mistakes. We asked them to be Gods. We asked them to act like gods. But the reality is they're human, and we need to move away from that mode of thinking."

	the other perspective rather than demonizing them.	
Focussing on positive impact through advocacy	Kayla's experience inspired her educate others and focus on a positive impact through advocacy. A forgiving mindset is directed towards constructive energy instead of revenge or punishment.	"I need to do something. You need to, I need to do something, you know. And I hooked up with survivors teaching students, so we go in to the medical school again."

Podcast 6: Claire

Initial Theme	**Descriptive Notes**	**Quotes**
Importance of relationships	Her son gave her meaning and acceptance and through him she found a source of strength and protection. She was able to move towards acceptance as opposed to bitterness because she saw her son grow, and how he never showed any wavering in his love and support for her.	"he's, my protector. He's an angel, you know. And watching him every day and groaning is a beautiful boy that he is. He is so caring and loving. And you know, he says to me every single day, Mom, you're beautiful, even in days when I don't feel it, he'll say, Mom, you're beautiful, you know." "he's the reason for me being here now."
Resilience and growth	Despite the trauma and challenges, and yet Claire did still have a will to carry on and to advocate change. She was able to find purpose and meaning despite the suffering showing a journey of resilience.	"I try to get some change it most for the heart failure, I set up a petition about eight years ago and got signatures and took it through to the parliament in Edinburgh for them to discover, through again, reading and looking at things, that there's A there's a blood test that can be taken that would indicate that enzymes are raised when you are possibly in the process of heart failure, and I tried to get them to include that in all maternity care." "Me, as I said, it's too late for me now, you know, I was another thing. Can't have any more kids, you know. And that was a that's kind of heartbreaking to beautiful nieces, one who's going to be a mum very soon, and another one, and I don't want them or anybody else to go through if I have the ability to see no hold on. That shouldn't be happening, you know."
Empowerment and Advocacy	Claire's work to spread awareness and promote policy change demonstrates her empowerment and her will to stop other's from experiencing the same tragedy.	"I try to get some change it most for the heart failure, I set up a petition about eight years ago and got signatures and took it through to the parliament in Edinburgh for them to discover, through again, reading and looking at things, that there's A there's

		a blood test that can be taken that would indicate that enzymes are raised when you are possibly in the process of heart failure, and I tried to get them to include that in all maternity care." "I'm also on Facebook and under Carol summons, anybody at all. I've had a few people my stories kind of been in a couple of newspapers, and what to do with the heart thing because of the petition, you know, more than willing to speak to anybody or share my story again, whatever, whatever helps."
Lack of communication and accountability	Claire was denied any explanations or compensation from the medical system.	"No, I've been let down by legal and medical professionals, meaning medical professionals who were involved getting expert reports for like the NHS. You know, I had a sent me to London to see specialist colonoscopy doctor, a bio doctor, and it was in tears. Want me to quantify how much faecal matter I would lose in a day. You know, having to adjust that. How do you how do you justify that even having a slight accident can be traumatic." "And the thing about SAP checked at the time, if you take the time to do a prompt examination and carry out the repair at the time, there's a huge chance that I would not have suffered anything, you know, so it was, the opportunity was there. It just wasn't taken, and there's been no explanation as to why he didn't do that."

Podcast 7: Mary

Initial Theme	**Descriptive Notes**	**Quotes**
Acceptance	Mary talks about accepting her limitations and how it has helped her build resilience.	"I got, I got a blanket on me right now, like eating blanket covered with pillows behind me. It's like, if you sit down, I have to have it. I have to have it really soft and comfortable. I can't sit down on a hard surface anymore."
Self-compassion	Mary's emphasis on the need for mental health support for patients with chronic pain and medical problems suggests she is understanding and is	**Acknowledging mental health challenges:** "And that's why mental illness and mental you know, help needs to be stressed to those patients, because you're going through all these things, it's a domino thing. The minute

	compassionate beyond just her case. The fact that she is willing to continue to work at her own healing and quality of life in the face of the setbacks suggests an underlying resilience, and self-forgiveness for any perceived failures or limitations.	you lose that part of your life, it dominoes all the way down, because then you have to fight for how are you going to hurt your folks? How are you going to pay to go to the doctor?" **Acknowledging emotional toll:** "I went through a period of feeling sorry for myself. I still do. You know I hate being a burden to my family, and I can't go out and do the things that I used to be able to do."
Empathy and understanding	Sharing her story and connecting with a more widespread community of advocates may reveal a legacy of trust and openness that is supported by forgiveness, both of herself and the circumstances she was in. She seems to approach the world compassionately, and as a result is able to offer forgiveness and understanding to others without placing it solely on her own experience.	"I want to make sure that I'm not bringing a spotlight to my family, you know, and making sure that the reasons why I do it is for the patients. A lot of patrons feel like they don't have anyone out and they just need somebody to help them, depending on their circumstances, there's a lot of us that are doing wrong, but when we lost Chrissy, the world felt it."
Focussing on positive impact through advocacy	Her continued work on advocacy and a desire to help other mesh patients implies being able to move forward rather than holding onto resentment.	**Connecting globally and providing resources:** "I met somebody in South Africa. One lady in South Africa, and it was really neat to be able to connect like that and just let them know. You know what, we have tons of resources here. What can we do to help this person? Try to get them some help, even if it's emotional, because we get a lot of that too, you know, they're venting online. They don't know what to do their husband or their kid, you know, something, and we, we all have the same thing, you know, families that are impacted by it, and we just try to give them support." "I want to be able to get the help to everybody, regardless of where they live." **Advocating for policy changes:** "Trans vaginal meshes, at least from the way I'm understanding it, have been 100% banned in every country around the world,

		which is amazing, and it took all of us, you know, just trying to let the FDA know, hey, this is dangerous, and it's killing people."
Importance of relationships	Maintaining close relationships in the face of adversity suggests resilience and acceptance through support networks.	"I am making meaning out of this experience, because I know that my kids, they need to see that. You know, there is some happiness, even if you're dealing with different things and it's rough. I have a lot of bad days. I do, but I don't know what I do without my kids, my husband, my family and our animals."

Podcast 8: Amber

Initial Theme	**Descriptive Notes**	**Quotes**
Transparency and accountability	Amber felt that there was no accountability when the initial provider who made the first mistake did not take responsibility. This is contrasted by her relationship with her long – time doctor who also made errors but was quick to admit and apologise.	"I felt betrayed because I wasn't feeling like my doctor was honest about the situation. And in this case, there were two of them. I felt that the person who had the scalpel at the time of the mistake should have come into my room, got to it, I apologize to me face to face, which was something that he chose not to do over six weeks."
Trust and relationship	Amber maintained and trusting relationship with her due to the positive care he provided over the years. This pre – existing relationship helped Amber move towards forgiveness.	"I stayed because he had been treating me for two decades and had given me more quality of life in the earlier years than I ever dreamed of having and so his diligence is my case, and in doing everything possible was enough to push me and to continue to trust, even though I had every reason not to trust."
Shift in perspective	Her family encouraged her to focus on gratitude and moving forward rather than focus on legal action.	"I have come to understand that. And I think that just by showing some compassion, my family and I maybe would have been able to deal with the situation a little bit better if that doctor were here right now." "My grandfather once told me that life is like a game of poker. You are given this life, and you play it to the best of your ability. And whenever I am faced with a new card or a new hand or new situation that comes up, I can only move forward and deal with it the best that I'm able to."
Importance of relationships	Her family is a constant presence of support and has	"I don't know what I would have done if my family wasn't there at the hospital as much

	been crucial in helping her focus on recovery.	as they were and for six weeks, my mother was with me, 24 and didn't leave. I felt less alone and less violated, because I knew that if I didn't catch something else, she was there to catch it."

Podcast 9: Layla

Initial Theme	**Descriptive Notes**	**Quotes**
Transparency and accountability	Layla emphasizes the importance of explaining to patients exactly what happened. She notes that while people may not be able to forgive in the moment, transparency allows them to process and find a sense a closure. She also discusses the importance of responsibility through apology.	"I recognize that a lot of healing and work and grief is up to the individual, and I can't make that happen. I can tell them the truth. I can apologize. We can take responsibility, but we cannot. We can't force people to accept it." "I also think about how people hear something in the moment is not how they will feel most likely, not how they will feel about it after months or years later. And these are not events that people write off, right? Like these are. These are life changing events. And as people change and grow and learn, and they may reflect on it differently than the way they did that day, and that's okay."
Empathy and understanding	Layla's approach of transparency and open communication enables better mutual understanding between patients/families and healthcare providers. Such an empathetic connection, where both sides can exchange their experiences and point of view, facilitates forgiveness. Layla tells of a powerful story of a physician who had her side of the story heard which allowed her to get the forgiveness of a grieving family.	"And then the physician who was involved walked in as well, and she her body language was the same. And through the course of this meeting, the father talked about how this position was the face of everything that went wrong, and she she listened, she looked them in the eyes, and just silently, had tears running down her cheeks the entire time." "And the father, the one who said you were the face of everything that had gone wrong, said to her, I had no idea that you were fighting so hard for her."
Shared healing and humanity	Layla talks about the recognition that and the belief that no one wants these errors/outcomes to happen. She acknowledges a shared vulnerability between patients	"I've had, I've had meetings where the attorneys I'm walking into the meetings with will maybe say, I'm afraid that I'm going to cry in this meeting. And I just say, I hope you do, because why didn't we acknowledge this event, not only from a hospital standpoint,

	and doctors which helps facilitate healing.	but also from a very human standpoint of I am connecting with you. I recognize how hard this was, and this matters to me in every way and, and I am feeling this with you as much as I can." "So the healing, the healing is not one sided with this kind of work."

Podcast 10: Sarah

Initial Theme	**Descriptive Notes**	**Quotes**
Accountability and apology	Sarah emphasizes the importance of providing genuine apologies to patients following a medical error. She described the apology she received from the practitioner who caused the error to be one of accountability and a focus on preventing future errors.	"He really took accountability, explained that it was an AI error, explained how it was going to be prevented in the future, and also ultimately asked about my health care and how I was doing, which is really all I was asking for, but I was sceptical in that health program."
Empathy and understanding	Sarah displays empathy and understanding of medical errors; doctors' burnout and systemic problems that might cause them. Sarah's balanced perspective enables Sarah to be more forgiving and deal with people collaboratively, not adversarially.	"I also think a lot of this sometimes just goes off of and this is very, This isn't science, right? This is just five space. But I would like to think that if there was a patient that a physician was seeing for five plus years had a really good relationship with them, that that conversation would be less intimidating, and maybe doesn't have to go through legal at all, because they feel like this relationship is built on trust versus there is a phenomenal article by Dr Daniela Lamas in the New York Times that she wrote in 2022 about a near miss that she had that was caught by another physician in the emergency department, And that was not a physician that she had ever seen before, to my knowledge, and she talks about the issues with burnout, and in this case, the patient didn't know."
Closure and validation	Sarah said the apology meant a lot and that receiving it and having the error corrected in her medical record was good enough closure and validation around the event. It made her feel heard and respected as a patient, therefore enabling forgiveness.	"I achieved closure because it was a genuine apology. There was no ego in this conversation. He really took accountability, explained that it was an AI error, explained how it was going to be prevented in the future, and also ultimately asked about my health care and how I was doing, which is really all I was asking for, but I was sceptical in that health program."

Human fallibility	Sarah wanted no punitive action taken against the resident responsible, believing such an environment allowed for some mistakes to be made and corrected.	"I didn't want punishment for the resident who was also working on the case that didn't seem fair to me, and is also a large part of residency, I hope that residents feel like they can make, you know, within reason, mistakes that can then be caught by attendings. It's a learning experience."
Collaborative approach	Sarah believes that in medical errors, patients and doctors should do the best they can to work together, and she does not support adversarial legal battle. Such a collaborative spirit allows for forgiveness and a common purpose to improve patient care.	"I think the closer we get to advocating for all these systems, working together on the patient and the human rights end, and then also within legal compliance, the closer we're going to get to truly equitable care."

Appendix C: Master Table of Themes

Superordinate theme	Subordinate theme	Podcast Guests	Notes	Quotes
Emotional Responses of Victims	**Navigating Grief**	James, Sally, Lisa, Michelle	James' comment was that he 'skipped' the 'second stage of grieving' which is anger and rage. He credits this to the grace of God and his good experience with the people who treated his daughter. Initially, Sally went through a grieving process and then decided to 'come out swinging' and take action. This meant she was able to take something personal and make it positive. Lisa notes that her emotional recovery took quite some time which suggests that her process of forgiveness was gradual rather than immediate. Mary acknowledges the emotional toll medical error can have. She emphasizes the need for mental health support for patients suffering from chronic pain demonstrating her compassion for others.	James: "I skipped over the natural second stage of grieving, which is anger and rage. Everybody tells me, Chris, I don't know how you did that, because if that was my baby girl, I How did that happen? How can you stand how can you sit there and say, No, I believe it's for two profound reasons." Sally: "I grieved profoundly. I don't talk about that much. It's I know what it's like to hit rock bottom, and I did, but I was a mom and a wife, and we had another baby, and I had to be present for that, and so I really had to visit my soul." Sally: "And I asked myself, What was I going to do? Was I going to curl up and mourn and grieve angry the rest of my life, or was I going to come out swinging? "And I decided that I couldn't, I couldn't not go forward and try to make change, because what I saw was wrong, and I needed it personally to heal." Lisa: "It took quite some time to recover from the surgery, but the

				emotional toll was even greater. I was in this state of mental chaos. You know, I had this knot in my stomach that I was constantly walking around with.” Mary: "I went through a period of feeling sorry for myself. I still do. You know I hate being a burden to my family, and I can't go out and do the things that I used to be able to do." Mary: “And that's why mental illness and mental you know, help needs to be stressed to those patients, because you're going through all these things, it's a domino thing. The minute you lose that part of your life, it dominoes all the way down.”
	Acceptance and letting go	Amy, Kayla, Mary, Amber	Amy mentions that in some ways she felt her illness made her a better person as it enabled her to shift her focus more on helping others through advocacy. This mindset shift allowed her to find meaning beyond her own negative experiences and contributed to her ability to forgive. Kayla discussed her acceptance of the path she was on as she explored valuable lessons during her cancer experience.	Amy: "I feel like in some ways, and this may sound really weird to say to some people, but getting this chronic illness, in some ways, has made me a better person, because I think my pre life, I was very motivated and focused and had all these goals, but they were really like my own personal goals to move myself forward, and now my goals are more focused on things that affect a broader group of people beyond me, especially through my work with our nonprofit and my writing, our goals To create awareness in the public, is to

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			This acceptance and change in perspective is important in the forgiveness process because it frees her from the bitterness and resentment. Mary tells us that she had to give up societal understanding of what her 'life should be' and become more comfortable with herself. Amber's family encouraged her to focus on gratitude and moving forward rather than focus on legal action.	help people beyond me and spat just goals that are, you know, I certainly have goals for Well, a lot of my goals now are more overly focused." Kayla: "I just accepted that this is how my life was meant to unfold. And when you embrace that and you allow it to make you better instead of bitter, you know, there's not much I cant deal with." Mary: "you realize that you know, you can't take any of this stuff with you, and all you really want is to have the people who love you around you." "all this stuff that we put so much importance on, like the house, the car, clothes, hair, makeup, you know, that you learn that, you know, you know, See things personal, everybody's, you know, everybody has wounds, that everybody's struggling in normal way" Amber: "My grandfather once told me that life is like a game of poker. You are given this life, and you play it to the best of your ability. And whenever I am faced with a new card or a new hand or new situation that comes up, I can only move forward and deal with it the best that I'm able to."

	Navigating through challenges	Amy, Kayla, Claire	Amy did her own research into her illness to gain a deeper understanding of the appropriate treatments compared to the harmful treatments she had been receiving. The increased understanding helped her move past the initial resentment and frustration towards healthcare providers. Kayla says her cancer 'became a spiritual journey' and she used the experience to start working on healing her 'soul' and her issues which happened as a child. This inner work and personal growth are necessary to actually get to the point of able to give forgiveness. Despite the trauma and challenges, and yet Claire did still have a will to carry on and to advocate change. She was able to find purpose and meaning despite the suffering showing a journey of resilience.	Amy: "But then I did further research, looked at some more authoritative resources, and realized that some of the protocols that they were telling me that I should do, such as exercising more, which initially I love the thought of that, or cognitive behavioural therapy were actually doing me more harm than good, and it actually caused a setback in my health." Kayla: "I embarked beyond this whole healing journey that was, that's been amazing. It's been tough, but it's amazing." "I truly believe that when your soul, when you're when you carry around these emotional, spiritual wounds, it really does affect your physical body." Claire: "I try to get some change it most for the heart failure, I set up a petition about eight years ago and got signatures and took it through to the parliament in Edinburgh for them to discover, through again, reading and looking at things, that there's A there's a blood test that can be taken that would indicate that enzymes are raised when you are possibly in the process of heart failure, and I tried to get them to include that in all maternity care."

Desired communication from offenders	**Communication Issues**	Lisa, Claire, Amber	Both Lisa and the doctor who committed the error felt isolated and lacked communication from the hospital which contributed to their emotional turmoil. Eventually they reconnected with each other and were able to understand each other's experience and perspective. The doctor was shut out from communication from the institution due to fear of being subpoenaed which implies a wider institutional culture involved in lack of support and accountability. Claire was denied any explanations or compensation from the medical system. Amber felt that there was no accountability when the initial provider who made the first mistake did not take responsibility. This is contrasted by her relationship with her long – time doctor who also	Lisa: "I felt cut off from hospital communication, how no one would talk to me. No one would talk to [doctor] about what happened either, partly from fear of being subpoenaed, so he hid his emotions. We had both been isolated." Lisa: ""When he moved back to [town] we got a coffee and I explained my side of the story, how I felt cut off from hospital communication, and how no one would talk to me. "No one would talk to [doctor] about what happened either, partly from fear of being subpoenaed, so he hid his emotions. We had both been isolated. All of a sudden the issue escalated from the two of us to this is just wrong." Claire: "No, I've been let down by legal and medical professionals, meaning medical professionals who were involved getting expert reports for like the NHS. You know, I had a sent me to London to see specialist colonoscopy doctor, a bio doctor, and it was in tears. Want me to quantify how much fecal matter I would lose in a day. You know,

			made errors but was quick to admit and apologise.	having to adjust that. How do you how do you justify that even having a slight accident is can be traumatic." Claire: "And the thing about SAP checked at the time, if you take the time to do a prompt examination and carry out the repair at the time, there's a huge chance that I would not have suffered anything, you know, so it was, the opportunity was there. It just wasn't taken, and there's been no explanation as to why he didn't do that." Amber: "I felt betrayed because I wasn't feeling like my doctor was honest about the situation. And in this case, there were two of them. I felt that the person who had the scalpel at the time of the mistake should have into my room, got to it, and apologise to me face to face, which was something that he chose not to do over six weeks."
	Responsibility and Apology	Lisa, Layla, Sarah	The doctor took initiative, despite advice against it, and wrote Lisa an apology letter, showing a willingness to take accountability for the error. His accountability and Lisa's ability to understand the broader systemic	Lisa: "Against all advice he wrote me a letter that said he was sorry, that he didn't expect a response, but he was there if I wanted to talk."

			issues allowed them to move away from individual responsbility . Layla emphasizes the importance of explaining to patients exactly what happened. She notes that while people may not be able to forgive in the moment, transparency allows them to process and find a sense a closure. She also discusses the importance of responsibility through apology. Sarah emphasizes the importance of providing genuine apologies to patients following a medical error. She described the apology received from the practitioner who caused the error to be one of accountability and a focus on preventing future errors.	Layla: "I recognize that a lot of healing and work and grief is up to the individual, and I can't make that happen. I can tell them the truth. I can apologize. We can take responsibility, but we cannot. We can't force people to accept it." Layla: "I also think about how people hear something in the moment is not how they will feel most likely, not how they will feel about it after months or years later. And these are not events that people write off, right? Like these are. These are life changing events. And as people change and grow and learn, and they may reflect on it differently than the way they did that day, and that's okay." Sarah: “I achieved closure because it He really took accountability, explained that it was an AI error, explained how it was going to be prevented in the future, and also ultimately asked about my health care and how I was doing, which is really all I was asking for, but I was sceptical in that health program.”

The Influence of Connection	**The Importance of Trust in the Patient-provider Relationship**	James, Amber	James sees all the nurses and clinicians who dedicated their time to Lola treating her like they were looking after their own. It occurred to him that the caregivers didn't want the error to occur. Amber maintained and trusting relationship with her due to the positive care he provided over the years. This pre – existing relationship helped Amber move towards forgiveness.	James: "these nurses loved my little girl up and took care of her like she was their own, and not just because we were watching them so closely either." Amber: "I stayed because he had been treating me for two decades and had given me more quality of life in the earlier years that I ever dreamed of having and so his diligence is my case, and in doing everything possible was enough to push me and to continue to trust, even though I had every not to trust."
	The Value of Interpersonal Connection	Claire, Mary, Amber	Claire's son gave her meaning and acceptance and through him she found a source of strength and protection. She was able to move towards acceptance as opposed to bitterness because she saw her son grow, and how he never showed any wavering in his love and support for her. Mary found that maintaining close relationships in the face of adversity	Claire: "he's my protector. He's an angel, you know. And watching him every day and groaning is a beautiful boy that he is. He is so caring and loving. And you know, he says to me every single day, Mom, you're beautiful, even in days when I don't feel it, he'll say, Mom, you're beautiful, you know." "he's the reason for me being here now."

			suggests resilience and acceptance through support networks. Amber’s family is a constant presence of support and has been crucial in helping her focus on recovery. Sarah believes that in medical errors, patients and doctors should do the best they can to work together. She does support adversarial legal battle. Such a collaborative spirit allows for forgiveness and a common purpose to improve patient care.	Mary: “I am making meaning out of this experience, because I know that my kids, they need to see that. You know, there is some happiness, even if you're dealing with different things and it's rough. I have a lot of bad days. I do, but I don't know what I do without my kids, my husband, my family and our animals." Amber: "I don't know what I would have done if my family wasn't there at the hospital as much as they were and for six weeks, my mother was with me, 24 and didn't leave. I felt less alone and less violated, because I knew that if I didn't catch something else, she was there to catch it." Sarah: "I think the closer we get to advocating for all these systems, working together on the patient and the human rights end, and then also within legal compliance, the closer we're going to get to truly equitable care."
Attribution of Responsibility	**Systemic Issues Versus Individual responsbility**	James, Sally, Lisa	Demonizing the individuals rather than focusing on systemic issues: One of James’ goals of the article was to not demonize the individuals	James: "These are the most empathetic, compassionate people I know. And when something bad like this happens, it's a result of the

			that were involved and to instead discover the systemic failures and the process failures that led to the error. There was no way he wanted responsibility put on one person, or to prevent a focus on improving the whole system. Using a systemic approach to safety, Sally did not blame individual providers but rather implemented a system of policies, education and accountability. Lisa and the doctor realised that the error was bigger than just the two of them. It was not only a personal failure but a much broader systemic issue that needed to be addressed.	systems, the flawed systems, then imagine how devastated they are. And I mean, they're, they're in the business of saving lives." James: "I wanted to be part of the solution, and uncover where the systems, processes and protocols broke down that horrible day to set these amazing clinician caregivers up to fail." Sally: "I understand that systems can be the systems improvement could be the solution. Now I don't want to ignore that there are doctors that maybe should not be practicing. We need systems in place to identify that with the nurses, they could have been more proactive. I think, however, they were really prevented. In this hierarchical system, which I've witnessed, the nurse was trying to inform the doctor." "So it's not plucking out one doctor saying this was a problem. It was, here's the solution. And I think most patients now in the patient safety movement, really embrace the systems based approach for improvement." Lisa: "All of a sudden, the issue escalated from the two of us to this is

				just wrong. We decided that we're gonna take this on."
	Understanding Human Fallibility	Sally, James, Kayla, Sarah, Lisa	Sally and her family recognised that the surgeon's involved in both her son and husbands' cases did not intentionally harm them. James' faith helps him recognise that we are all capable of making mistakes. Kayla sympathises with the human aspect of her doctor (and of 'doctors being human' and making mistakes). The forgiveness process is supported by this ability to see the other perspective rather than demonizing them. Sarah wanted no punitive action taken against the resident responsible, believing such an environment allowed for some mistakes to be made and corrected. Lisa empathised with her attending doctor after understanding his side, demonstrating her capacity for compassion.	Sally: "We forgave his surgeon. We forgave because we knew it was not intentional. The doctors weren't bad they could have been better doctors, but they weren't bad people, and they made mistakes." James: "God made us all fallible. We're all capable making a very human error, having an oversight. There's only you know so much any human mind can can endure, and statistically, chances are pretty good that you being this hypothetical rock star cardiac surgeon, you know, chances are, you're still, no matter how many lives you save. Chances are, during the course of your career, your statistics and objective analysis is probably going to say that you're going to have a significant error that reaches for and or lethal to a patient of yours." Kayla: "Doctors are human. They're going to make mistakes. We asked them to be Gods. We asked them to act like gods. But the reality is they're

				human, and we need to move away from that mode of thinking." Sarah: "I didn't want punishment for the resident who was also working on the case that didn't seem fair to me, and is also a large part of residency, I hope that residents feel like they can make, you know, within reason, mistakes that can then be caught by attendings. It's a learning experience."
Advocating for Change	**Being part of the solution**	James, Sally, Lisa, Amy , Kayla, Claire, Mary	Sally was motivated to be part of the solution rather than dwelling on the trauma in order to help her heal. She was determined to take action and drive change. Lisa and her doctor worked together to start the Medically Induced Trauma Support Services organization which represents a shared goal for desired change. This shows a forward looking approach which is focussed on preventing similar situations happening in the future, while supporting others who may be affected by similar incidents.	Sally: "And I decided that I couldn't, I couldn't not go forward and try to make change, because what I saw was wrong, and I needed it personally to heal." Lisa: " I told him I wanted to start an organization that focused on the effects of medical error and we decided that both patients and clinicians needed more support after similar experiences." "Soon we were making the rounds at hospitals doing presentations. I remember older doctors lining up to talk to me, telling me medical error stories they had kept to themselves for

			By being involved in advocacy work and supporting others with the same illness, Amy was able to find a purpose and connection which helped her move forward rather than dwell on errors of the past. Kayla's experience inspired her educate others and focus on a positive impact through advocacy. A forgiving mindset is directed towards constructive energy instead of revenge or punishment. Claire's work to spread awareness and promote policy change demonstrates her empowerment and her will to stop other's from experiencing the same tragedy. Mary's continued work on advocacy and a desire to help other mesh patients implies being able to move forward rather than holding onto resentment.	years. Patients and clinicians alike were calling us for help." Amy: "I'm doing quite a few things, a couple of things. So I work for the CDC with revamp being some of their magic encephalitis documentation for providers and caregivers. And then I also do some volunteer work for a very active state organization. I do all their social media work to help raise awareness of their events that they have related to this illness to help support people In Minnesota that have it, because so many people are so isolated with this disease." Kayla: "I need to do something. You need to, I need to do something, you know. And I hooked up with survivors teaching students, so we go in to the medical school again." Claire: I try to get some change it most for the heart failure, I set up a petition about eight years ago and got signatures and took it through to the parliament in Edinburgh for them to discover, through again, reading and looking at things, that there's A there's

				a blood test that can be taken that would indicate that enzymes are raised when you are possibly in the process of heart failure, and I tried to get them to include that in all maternity care." Mary: "Trans vaginal meshes, at least from the way I'm understanding it, have been 100% banned in every country around the world, which is amazing, and it took all of us, you know, just trying to let the FDA know, hey, this is dangerous, and it's killing people."
	Building Supportive Communities	Sally, Lisa, Claire	Sally's involvement in Patients for Patient Safety gave her an opportunity to work with others who had come across similar experiences within the framework of a supportive community and with a collective approach to resolve the fundamental systemic problems. Lisa and her doctor drove initiatives for patient therapy groups and peer support programs within hospitals which showed real progress and had a personal impact on both of them. Claire's efforts to build a supportive community and provide emotional	Sally: "So we band together, and we said, No, we if we can do something, we need to do something, and we need to create a collective voice." Sally: "We have strategic partnerships, of which IHI and Bucha Institute or are both. We're working with all of our government agencies, and to everybody's credit, everybody has said, Yes, let's work together." "So we are seeing a remarkable momentum. And we can't take all the credit, because I think that all of our partners collectively are creating this engine that's moving forward."

			support contributed to a sense of shared experience and compassion through the mesh advocate community. These connections can enable a mindset of moving forward and forgiveness.	Lisa: "Over the past 15 years, [him] and I have piloted patient therapy groups and convinced hospitals across the country to develop peer support. We've seen real progress, but for us, the biggest change was personal." Claire: "I met somebody in South Africa. One lady in South Africa, and it was really neat to be able to connect like that and just let them know. You know what, we have tons of resources here. What can we do to help this person? Try to get them some help, even if it's emotional, because we get a lot of that too, you know, they're venting online. They don't know what to do their husband or their kid, you know, something, and we, we all have the same thing, you know, families that are impacted by it, and we just try to give them support."