AMA Journal of Ethics®
March 2022, Volume 24, Number 3: E212-217

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Narrative, Compassion, and Counter Stories

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Abstract

Critical race theory (CRT) tools of evaluating stock stories and counter stories can help clinicians and researchers illuminate experiences of those at the margins in order to gain insights into the normalized injustices that are hidden from view in a dominant narrative. To do this work requires vigilance and intentionality. Here, CRT is applied to a patient case involving overevaluation for nonaccidental trauma (NAT) to describe the impact on patient care and experience of competing perspectives. CRT is also applied to assess the literature on the harms of inequities in NAT evaluations.

Start by Seeking Compassion

In *The Unbearable Lightness of Being*, Milan Kundera writes:

> All languages that derive from Latin form the word "compassion" by combining the prefix meaning "with" (com-) and the root meaning "suffering" .... In other languages ... this word is translated by a noun formed of an equivalent prefix combined with the word that means "feeling." ... In languages that derive from Latin ... [a]nother word with approximately the same meaning, "pity" ..., connotes a certain condescension towards the sufferer. "To take pity on a woman" means that we are better off than she, that we stoop to her level, lower ourselves.... In languages that form the word "compassion" not from the root "suffering" but from the root "feeling".... [t]he secret strength of its etymology floods the word with another light and gives it a broader meaning: to have compassion (co-feeling) means not only to be able to live with the other's misfortune but also to feel with him any emotion—joy, anxiety, happiness, pain. This kind of compassion signifies ... the maximal capacity of affective imagination, the art of emotional telepathy.[1]

In Kundera's definition of compassion that is "pity" rather than "co-feeling," the feeler, a man, "stoop[s]" to the level of a woman. For many in medicine, the goal is to achieve compassionate care that is co-feeling, or "feeling with," patients and families. However, the systems, hierarchies, practices, and policies in medicine may contribute to the perpetuation of stock stories that can cause unintentional harm to patient families while leading clinicians away from true co-feeling compassion. Thus, in order for clinicians to achieve Kundera's definition of co-feeling compassion for all patients and families, intentional and systematic approaches are necessary. For example, applying critical race theory (CRT) to stock stories in the form of counter stories can help clinicians and researchers reframe their care approaches to center patient and family perspectives. Here, I use the power of counter storytelling to analyze abstract forces, such as racism

and anti-Blackness, and to consider when and how to use counter story in clinical care and research.

Definitions

The concepts of a dominant narrative, or stock story, and a counter narrative, or counter story, have been explored in CRT and narrative ethics.[2,3,4] Stock stories and stories about stock characters are shared and shaped by people in power.[1] Such stories present perspectives that support existing power structures as the neutral and given reality, while skirting responsibility for injustice.[2,3,4] Counter story is a tool that contradicts and exposes the oppression in the stock narrative by giving voice to the silenced, ignored, or oppressed.[2,5] Counter story centers in the margins, bringing forward perspectives of socially marginalized groups.[5] As Martinez notes, counter story "recognizes that the experiential and embodied knowledge of people of color is legitimate and critical to understanding racism that is often well disguised in the rhetoric of normalized structural values and practices."[5] When applied in medicine, counter story can help to expose injustices and highlight the voices and experiences of patients and families that might otherwise be missed or ignored. In doing so, this tool can help clinicians both recognize racism and other systems of oppression in their work and explore a patient's or family's unique experience or perspective in order to provide individualized, co-feeling care.

Narrative Abolition in Clinical Care

Example of a stock story and characters. A 9-year-old boy was found to have severe hypocalcemia after presenting to a hospital with a new seizure and multiple leg fractures. When he transferred to another hospital, the emergency department (ED) doctors asked his mother about the fractures. She wondered why the 2 hospital teams had not communicated and refused to answer questions. The ED doctors became suspicious that the child's injuries were due to nonaccidental trauma (NAT) and described the patient's mother as "escalated," and "uncooperative." They reported her experience with child protective services (CPS) to further justify their suspicion about her character and motivations. A CPS report was filed, and law enforcement was contacted.

Reframing the stock story as a counter story. Upon meeting the patient and his mother, the admitting team learned that the patient's mother felt that the ED team was immediately suspicious of her and that she was treated differently because she was Black. The admitting team also learned that her CPS experience was as a foster and adoptive parent of relatives' children. Her son presented to care 4 times that year for severe leg pain after falling during sport activities. Repeatedly, he was diagnosed with "growing pains" without work-up. The night he was brought to the first hospital for a seizure, his mother learned her son's previous injuries were undiagnosed leg fractures from severe calcium deficiency and a subsequent seizure. During chart review, the admitting team learned that the first hospital's report described NAT as unlikely, given the etiology of severe hypocalcemia.

If the ED team members had approached the case with co-feeling and curiosity, they might have learned about important clinical, social, and relational context that could have guided their care and approach. The counter story from the perspective of the patient's mother exposed how the ED team might have jumped to conclusions about the case history, diagnosis, and management (for example, by assuming that the mother's prior CPS involvement might implicate abuse in this case or by failing to learn about the family's painful prior experience with the health care system, which might have informed

the mother's mistrust and behavior on presentation). Learning these critical contextual features helps to expose the role of racism in clinical care. Thus, approaching all patient cases with co-feeling curiosity—and doing so systematically and intentionally—not only might help clinicians provide more compassionate care to individual patients and families but also might set the stage for identifying important systemic changes that could address racism in clinical practice.

When narratives are written, centered, and manipulated by those in power, and when these narratives shape medical and legal decisions, individuals and institutions can harm patients and families. Research on NAT evaluations shows that patients of color are overevaluated (or evaluated for NAT more often than indicated), while White patients are underevaluated, with the largest disparities being between Black patients and White patients.[6,7] Although multiple factors contribute to inequities in NAT evaluations, one is the unquestioned perpetuation of stock stories and the selective—conscious or unconscious—ignoring of counter stories. This selective emphasis on stock stories occurs in the language used by clinical teams when discussing patients and families, both verbally and in the electronic medical record, and in the way that policies and procedures are disparately applied to patients and families. For example, in the above story, several tropes are utilized, including the angry Black woman, the "difficult" or "uncooperative" parent, and the history of CPS involvement as a red flag. These stock story tropes are shared and manipulated among those in power, resulting in overevaluation.

One reason that stock stories go unquestioned is the influence of cognitive biases on decision making. As an example, when clinicians anchor on a diagnosis, they shape a narrative around data that supports a diagnosis or decision and ignore counter narratives that contradict the suspicion. Especially when clinicians must act quickly, they are at risk of relying heavily on cognitive biases and of centering stock stories while ignoring counter stories.[8,9] Cognitive biases can lead to incorrect diagnoses and inappropriate interventions. As a result, biases contribute to disparities in patient care and outcomes. One well-studied example is the underrecognized and undertreated pain in adult and pediatric Black patients across different presentations and diseases.[8,9]

Cognitive biases are evident in this case. The ED team used new data (like prior CPS involvement) to support the stock narrative of NAT. "Prior CPS involvement" conjures an image of and nurtures assumptions about abuse, especially when we ignore the counter story (eg, that the involvement was as a foster parent). As with anchoring on a diagnosis, it is valuable to examine stock stories and to recognize counter stories in providing co-feeling care. Analyzing abstract forces, such as social injustice, through the more concrete and accessible form of a story helps us understand and address them.[10] In medicine, doing so can prompt us to unpack racism and other oppressive forces at individual and systemic levels.

However, clinicians might be reluctant to look inwards to examine biased narratives when they contribute to oppressive forces such as racism rather than a missed diagnosis. Doing so requires intentionality and recognition of their own defensiveness when faced with stock stories to which they contribute. The admitting team in this case heard the stock story during handoff from the ED team, then learned the counter story upon meeting the patient. The patient's mother readily shared her counter story to educate the admitting team and to offer feedback so that another family might receive different care. The stock and counter stories were presented plainly and starkly, and it

was easy to recognize the harm caused by their dissonance. However, it is not a family member's or patient's duty to inform and educate clinicians about a counter story affecting clinical care. This case helped me to consider the many other stock stories I had perpetuated and the many counter stories I had missed because I had not systematically sought them out. In order to provide equitable, co-feeling care that centers justice, it is the clinician's duty to vigilantly seek out counter stories in every patient case.

Narrative Research

To conduct research that reduces the harms caused by racism in health care, we must critically examine the paradigms and hypotheses that shape such work. In addition, the direction and focus of such work ought to be determined and shaped by those we aim to serve. In a *Health Affairs* blog article on this topic, Boyd et al discuss how the current academic publishing process promotes research that "undertheorizes racism as a clinically relevant cause of poor health and underelaborates solutions to racism as a health intervention" and how researchers focus on documenting inequities without addressing them.[11] While there is literature on disparities in diagnoses, evaluations, and decision making for cases of NAT,[6,7,12,13,14] there is little literature on strategies to address these disparities.[6,13,14]

Existing research seeking to improve disparities in NAT evaluations implements standardized tools to help clinicians.[6,7,13,14] These tools are framed as a way to increase rates of evaluation among White patients, thereby decreasing missed diagnoses of NAT.[6,7,13] This approach assumes that missed diagnoses of child abuse among White patients is the primary harm of our inequitable system. This narrative of missed NAT diagnoses in White families ignores the critical counter story: overevaluation of families of color harms patients and families of color. For example, important harms of underevaluation, which existing research captures, include further child injury and trauma.[6,7,12,13] Important harms of overevaluation, which are less explored in existing research, include parent-child separation and parental stress and distrust in the health care system.[13,14]

In order to learn more about the potential harms of and solutions to overevaluation of families of color, researchers can apply tools like counter storytelling and community engagement in their work. CRT concepts, such as counter story telling, have been applied to public health research on the impact of racism on health disparities.[15] Authentic community engagement means sharing power and control while listening to and attending to the interests and concerns of communities. Community-based participatory research, focused on perspective-gathering from the communities we harm with overevaluation, is an important starting point.[10,15]

End Seeking Compassion

Research and clinical work ought to be shaped by the diverse perspectives of the people both endeavors seek to serve. As standpoint theorists argue, through the outsider-within phenomenon, individuals who faced marginalization are in a unique position to expose the normalized injustices that are hidden from view in a dominant narrative.[16] Thus, bringing forward the experiences of those at the margins is the duty of clinicians and researchers seeking to center justice in their work. As we strive to provide compassionate care and create compassionate systems, a critical first step is recognizing that "knowledge" about a situation is fundamentally shaped by perspective, which is informed by social position. Next, we can recognize that there are likely

contrasting stock and counter stories that are informed by different perspectives, particularly when there is a conflict between clinical teams and patients or families. Beyond recognizing this fact, we ought to systematically and intentionally seek out counter stories and critically examine the stock narrative in every clinical case and in the research we design and conduct. Ultimately, providing equitable, co-feeling care requires seeking out, listening to, and centering the stories of patients and families.

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Editor's Note

Identifying information in the case, retold with permission, has been modified.

Citation

AMA J Ethics. 2022;24(3):E212-217.

DOI

10.1001/amajethics.2022.212.

Acknowledgements

Thank you to Dr Aaron Wightman and Dr Douglas Diekema for their thoughtful mentorship and review of this manuscript.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980