Commentary: **Narrative Lessons From a Nigerian Novelist: Implications for Medical Education and Care**

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Abstract

In her TED Talk entitled "The danger of a single story," Nigerian novelist Chimamanda Adichie shares stories about her life that illustrate the natural human tendency to interpret the lives of others in the context of what she describes as narrowly constructed and often stereotypical "single stories." These single-story views often portray others as wholly different from those constructing the stories, thereby diminishing the possibilities for genuine human connection. Referencing Adichie's talk, the author describes the narrative dissonance that so often distances patients from their physicians. He illustrates the dangers to patients that can result from single-story caregiving by physicians, sharing an example from his own experience in which unnecessary harm came to his patient because of his own single-story thinking. The author argues that these single-story dangers must be openly and consciously addressed in the training of doctors to counteract the tendency for their clinical and educational experiences to inculcate single stories by which physicians come to interpret their patients. He offers suggestions as to why single-story thinking arises in clinical practice and how to mitigate these forces in medical education. The author concludes by contending that the education of physicians, and caring for the sick, should be aimed at preserving the dignity of those being served, and he argues for an "equal humanity" model of the patient–physician relationship that engages patients in all dimensions of their multiple stories.

> Stories matter. Many stories matter. Stories have been used to dispossess and to malign, but stories can also be used to empower and to humanize. Stories can break the dignity of a people, but stories can also repair that broken dignity.
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> —Chimamanda Ngozi Adichie[1]

A medical resident first exposed me to TED, a nonprofit that arose from a 1984 conference of innovators in the fields of technology, entertainment, and design (hence the acronym). TED describes itself as "a nonprofit devoted to Ideas Worth Spreading,"[2] and among its offerings are TED Talks, a vast and ever-growing array of online talks and performances presented by "the world's most fascinating thinkers and doers,"[2] generally 20 minutes or less in duration, and available for free. A poignant and powerful TED Talk that I now use in my narrative medicine teaching with medical students, and one that I would suggest should be required viewing for all medical students, residents, and clinical faculty, was given in 2009 by Chimamanda Ngozi Adichie, a prize-winning and highly regarded Nigerian novelist. Her presentation is entitled "The danger of a single story,"[1] and has broad and important implications for how doctors are trained and how they care for the sick.

An engaging storyteller, Adichie begins by describing her earliest experiences as a child reading British and American books and stories. She began to write her own stories and illustrate them with crayons at a young age. All of those stories—the ones that she read and the ones that she then wrote—included blue-eyed, white-skinned individuals whose characteristics and lived experiences bore no resemblance to, and had no connection with, her own experiences, her family or friends, or her homeland. In retrospect, and only after exposure to African novels, she realized that she had come to have a "single story of what books are," observing "how impressionable and vulnerable we are in the face of a story, particularly as children."[1]

Adichie next describes a boy who served as in-house domestic help in her middle-class Nigerian family's home. She learned from her mother how poor the boy and his family were. Later, when she encountered a beautiful colorful basket woven by the boy's brother, her surprise that something so beautiful could have been created by people of poverty taught her that her views of the boy and his family had been constructed from a single story: "All I had heard about them was how poor they were, so that it had become impossible for me to see them as anything else but poor. Their poverty was my single story of them."[1]

At the age of 19, Adichie came to America to attend Drexel University in Philadelphia. Her American roommate showed a degree of astonishment when she discovered that Adichie spoke fluent English—in fact, that she had been exposed to English as Nigeria's official language. Her roommate was also quite surprised to learn that Adichie enjoyed familiarity with popular American music and could use a stove. Adichie sensed that her roommate, in advance of their meeting, had already felt sorry for her. Her roommate "had a single story of Africa: a single story of catastrophe. In this single story there was no possibility of Africans being similar to her in any way, no possibility of feelings more complex than pity, no possibility of connection as human equals."[1]

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After having been in the United States for some time, Adichie had occasion to travel to Guadalajara, Mexico. Her visit occurred at a time when considerable U.S. political attention and media coverage had been focused on the problem of immigration, with illegal Mexican immigrants frequently portrayed as a cause for concern. When she arrived and experienced the richness and joy of the Mexican culture and people, she realized that she, too, had been "just as guilty in the question of the single story…. I realized I had been so immersed in the media coverage of Mexicans that they had become one thing in my mind, the abject immigrant. I had bought into the single story of Mexicans and I could not have been more ashamed of myself."[1] She concludes her talk quite powerfully with the idea that the way to create such a single story is simply to "show a people as one thing, as only one thing, over and over again, and that is what they become."[1]

Adichie's instructive life stories and observations serve to illuminate the concept of what I will call *narrative dissonance*, a substantive lack of harmony between a particular person's actual narrative and another person's more narrowly constructed and often overgeneralized version of what he or she interprets as that particular person's narrative. Such dissonance manifests frequently in patient–physician relationships, and, more importantly, I would argue, it is taught—both explicitly and in the hidden curriculum—to medical students and residents throughout their training. Physicians learn single-story approaches to many types of patients, and these approaches can fail us as caregivers and can harm those who seek our care. Adichie's "danger" causes me to recall a patient from my early practice to whom I delivered care for which I have never forgiven myself. My patient was a victim of the danger of which she speaks, and it was my single-story caregiving that created his suffering.

In the first few years of my practice, fresh out of a nephrology fellowship program and newly board certified, I cared for a 58-year-old African American man who was experiencing progressively worsening kidney function resulting from long-standing and poorly controlled hypertension. His low socioeconomic status had made it difficult for him to take the best care of himself, I had concluded. When he reached stage 4 chronic kidney disease, I referred him to a vascular surgeon for the creation of an arteriovenous fistula in his left, nondominant arm because he would soon need dialysis. After the surgery, he began to complain of clumsiness in his left hand. I suspected that the slight interruption in blood flow to his hand may have exacerbated some minor, and heretofore subclinical, neuropathy in his left arm and hand. His concerns seemed overstated. The fistula had been created in his nondominant hand, all objective neurologic testing revealed no dysfunction in the hand, and I was offering him lifesaving treatment for a fatal disease, after all.

Yet, my patient continued to complain about his clumsy hand. I grew weary of his complaints. He appeared to become obsessed with this concern. During a brief hospitalization for pneumonia, the house staff and medical students became party to his incessant complaining. The patient became the subject of frequent, lighthearted joking on our daily rounds. "Perhaps we should consider nursing home placement" and "How will he ever be able to care for himself again?" were some of the comments we laughed about to mitigate our frustration over his complaining. On the morning of his discharge from the hospital, the medical student assigned to his case came from the patient's bedside to join our team rounding in the hallway. When the discussion again turned to the patient's "horrible disability," the student asked me a question that continues to haunt me now, decades later. "Did you know," the student inquired, "that this guy is a pianist?"

Reflecting back on this gentleman's case, I am inclined to believe that had I been aware of his piano playing, and how important it was to him, I would have encouraged him to consider methods of dialysis that would have allowed him to avoid such a disabling operation on his arm. I had made assumptions about him, undoubtedly fueled by my single story of African American men. In my single story, such people didn't play pianos. In my single-story approach, I had offered him a compromised life, and it was a compromise that didn't have to be.

Caring for the sick is, at its essence, a narrative enterprise. It requires that a caregiver be equipped with a clear understanding of his or her own narratives—biases, values, and perspectives—to be fully conscious of what he or she brings to the patient encounter. It also requires competence in receiving, honoring, and broadly understanding the particular narrative of a particular patient. It requires *moral imagination*, as colleagues and I have described elsewhere,[3] as a strategy of sustaining hope for patients—all patients—no matter their circumstances.

The single-story dangers of which Adichie warns must be openly and consciously addressed in the education and training of doctors. Too often, students and residents are explicitly taught to concoct single stories of certain patient types and then to operate in those single stories in caring for such patients. A recidivistic alcoholic is easily dismissed as "a hopeless drunk in for the umpteenth time on his way to the grave," despite the fact that some alcoholics successfully achieve long-term sobriety. Morbidly obese patients are quickly recognized as unable to control their own impulses to eat, making them become more obese, despite many examples of patients who have overcome their obesity. Assumptions get made regarding the literacy of poor patients, and such assumptions may lead us to fail to offer useful education to poor patients who may benefit substantially from it. Presently, I care for an African American gentleman at the local free clinic who is a scholar, a retired college professor, and who, as a result of myriad circumstances, is simply without financial resources. He is poor. Yet he teaches me things during our encounters. And he continues to benefit from our efforts to educate him about his health issues. This man is at risk for suffering greatly under the care of single-story caregivers.

Within the so-called hidden curriculum of the clinical educational environment, single-story epithets abound. Students hear their patients described as "crocks," "drug seekers," "frequent flyers," "house cases," "crackheads," or worse. Perhaps the most ubiquitous of such descriptors is the "noncompliant." "To comply" literally

means "to bend," and in the clinical setting, the use of such a term arises from the paternalistic and physician-centric perspective of wanting the patient to "do as I say," that is, to "bend to my will," often with little or no regard for the implications of such bending in the actual lived experience of a particular patient. And, just as Adichie has described "how impressionable and vulnerable we are in the face of a story, particularly as children,"[1] medical educators must remain mindful of how impressionable and vulnerable young trainees are to absorbing and embracing these single stories of their patients.

A physician's tendency to operate in single stories may be in part a manifestation of the power differential that exists in patient–physician relationships. Physicians wield great power in caring for patients, and such power arises from the highly specialized knowledge and training we acquire, knowledge and training that we are expected to use to serve the suffering. And the patient presents as vulnerable, creating further inequality in the relationship. Adichie[1] makes reference to this point as she notes:

> It is impossible to talk about a single story without talking about power. There is a word, an Igbo word, that I think about whenever I think about the power structures of our world, and it is "nkali." It's a noun that loosely translates to "to be greater than another." Like our economic and political worlds, stories too are defined by the principle of nkali: How they are told, who tells them, when they're told, how many stories are told, are really dependent on power.

I would argue that the consequences of single-story thinking in health care are revealed in the health disparities of minorities and the growth of the cultural competency movement in medical education. The medical literature is replete with evidence that members of certain minority groups receive inferior care. This alarm was perhaps most notably sounded in the Institute of Medicine's 2003 landmark report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.[4] It is entirely conceivable that some of these care discrepancies arise from single-story thinking. Members of some minorities may not be invited to participate in cancer treatment trials, for example, because physicians may operate under the assumption, even if subconsciously, that they aren't capable of interpreting the complexities of informed consent. And despite a higher prevalence of coronary heart disease among African Americans, physicians may be less likely to offer these individuals diagnostic cardiac catheterization because the physician's single story describes them as more distrustful of their Caucasian physicians and, hence, more litigious.

The cultural competency movement in medical education has been a laudable attempt to mitigate such discrepancies in health care and to promote the highest-quality care for all people. Its principles suggest that if we better understand people of other cultures, we are better equipped to help them when they are in need. And although these approaches should remain an important part of medical training, a cautionary flag must be waved regarding the extent to which traditional cultural competency teaching can actually propagate stereotypical thinking. If one aims to describe for learners how members of a given culture behave, how they feel about their physicians, and how they value certain treatment options, for example, one may be creating single stories about all members of that culture. As Adichie[1] points out, "The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but they are incomplete. They make one story become the only story."

If the ends of medicine are fundamentally focused on the well-being of those we serve, whether it be through the diagnosis and management of disease, the relief of suffering, or simply mindful presence with the dying, it follows that we must have hope that they have the capability to overcome their challenges. Such hope comes from a broader knowing of who they are, what matters to them, and how they derive meaning in their lives. Chimamanda Adichie's 19-minute TED Talk is elegant storytelling, offering invaluable lessons that can make us better healers. To become so, physicians must be offered many opportunities to engage patients in all dimensions of their multiple stories. Students and residents must be repeatedly exposed to the stories of others, the accomplishment of which can be substantially augmented by exposure to the humanities in their training. Conversations in clinical educational environments must be broadened to focus attention on why we behave as we do, why our patients do, and how we can come to better understand our differences. More time in medical care must be spent in storytelling. And trainees must be taught to exercise their moral imaginations and to develop their narrative competence, as effective antidotes to single-story medical practice.

"The consequence of the single story," Adichie[1] teaches us, "is this: It robs people of dignity. It makes our recognition of our equal humanity difficult. It emphasizes how we are different rather than how we are similar." And if physicians are indeed to be what Anne Sexton[5] so eloquently described in her poem "Doctors" as "only a human/trying to fix up a human," then a model of care that emphasizes "our equal humanity" should continue to guide us. I have harmed patients through single-story thinking, and I have witnessed the single-story training of a generation of medical students and residents. Medical care and medical education can be better, and the rich, varied, and morally instructive narratives of our patients can lead us in that direction, for all of our sakes.

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