Abstract

Chimamanda Adichie is a Nigerian author of great success. With a Master’s degree in creative writing from the Johns Hopkins University and Yale School of Arts, she wrote *Americanah*, which sold over half a million books during her scholarship period at Harvard. She received several literary awards, including the National Book Critics, in 2013. She attended 2 years of medical school, and her sister is a doctor in the United States. She presented two of the most viewed TED talks (non-profit organization dedicated to the dissemination of ideas, usually in the form of short lectures, with free internet access, with more than 1 billion views). *The danger of a single story* is one of Chimamanda’s TED talks, which has many possible interfaces with Medicine, some of which are presented in this article, emphasizing narrative medicine as a possible antidote to the danger of a single story.

Beyond the single story

Writer Chimamanda Adichie is the author of successful books, such as *Americanah, Half of a Yellow Sun* and *Purple Hibiscus*, published in Brazil by Companhia das Letras Publisher. Born into a middle-class family in Nigeria, the daughter of a teacher and an administrator, she is now 39 years old and lives in the United States and her country. She is the author of two of the most renowned TED (Technology, Entertainment, Design) talks carried out in the USA: “We Should All Be Feminists” and “The Danger of a Single Story”. The first became a book of great success after singer Beyoncé used it in her song “Flawless”. Here we are interested in her second TED talk, in which she addresses what it called the risk of a single story and that has already been discussed from the viewpoint of cultural identities.

*The danger of a single story* allows multiple reflections in medical practice. Chimamanda starts by saying that as most of the Nigerian middle-class families, her family had domestic workers who were very poor. One of them, Fide, was an 8-year-old child. Her mother always mentioned Fide as a poor person; when the children of the house did not eat everything on their plates, she would say, “don’t you know that people like Fide have nothing to eat?” Thus, the ultimate catchword for Fide was his poverty and his helplessness.

When during a party, Chimamanda and her family were visiting the boy’s home, they found a poor environment, yes, but a cheerful one, and his mother showed them with pride a beautiful basket made by one of her sons. Chimamanda was astonished because it had never occurred to her that anyone in Fide’s family could actually create something. She had a single story about Fide: poverty was his single history. Are we, in medical practice, in a country with the level of social inequality such as ours (75th position in the Human Development Index, behind Costa Rica, Venezuela, Argentina, Uruguay and Chile, for instance), at some point connecting with our patients only through this single story of poverty?

When Chimamanda arrived at the United States, she was placed at the other side of this very uneven balance: her roommate, an American girl, was amazed at her English (unaware that Nigeria was an English colony and that English was its official language) and quite disappointed when, after asking the Nigerian girl to show her some “tribal” music, she showed her a recording of Mariah Carey. There were other surprises, when the American girl realized that the Nigerian girl knew how to use the stove.

The American girl, even before she met Chimamanda, had already felt sorry for her because she had a single...
African story: the story of catastrophe. And considering this single story, there was no possibility for Africans to be equal to her, which prevented her from more complex feelings rather than pity. A pity that, deep inside, can explain a well-intentioned arrogance. How many times, in the presence of our patients, we know only that they have a serious health problem, a serious heart condition, for instance. Are we, as we dedicate ourselves to treat a patient and recognize the severity of a clinical picture, failing to recognize other possible relationships with him or her?

In another situation mentioned by the writer, a teacher, when assessing one of her literary texts, pointed out a major flaw: the lack of a legitimate “Africanity”, because the characters were too much like him: this teacher had a single story of Africa, the story of the differences that made them apart. And how can one create a single story? With power. In the case of people, showing only one of the person’s characteristics: her color, her disease, her poverty, thus crystallizing the identities. By reinforcing only one characteristic, the person turns out to be just that – very often even to herself.

In the case of countries and continents, the economic power has globalized values that seemed unique. Power comes, almost inevitably, accompanied by a sense of superiority. This power allows the telling of only one of the stories of a person, a patient, a country, a continent, and makes it the definitive story of that person, that country, that continent. These are stereotypes that are not exactly lies in some cases, but constitute incomplete truths. In Brazil, samba, soccer and beaches (and now, corruption, Zika virus); in Africa, beautiful landscapes, AIDS, animals, catastrophe. In the case of Medicine, very often the disease and single definer of a person (e.g., “the patient with an aortic stenosis”, “the patient with a diastolic dysfunction” etc.).

Another example mentioned by the author: a student asks her how it is to live in a place where men are violent and attack women (referring to her “Purple Hibiscus” book). She answers, with irony, that is the same feeling of living in a country in which all men are serial killers, as she read “American Psycho”. Because we know a lot of stories and several narratives of the United States, none of us would ever think that all American men are serial killers. The higher the place of power, the greater the number of acknowledged stories. Perhaps our patients, when they see us, perceive several stories: a picture in the office with the family, another in the papers, in the case of the more famous ones, an imaginary one that allows them to think we travel on vacation. And what about us, do we know how our patients have fun, what gives them pleasure? How their families are? How do they perceive their lives?

In the health scenario, narrative medicine, developed by the American physician Rita Charon, appears as a possibility of creating spaces for the appreciation of the patient’s stories. The narrative or narrative-based medicine aims to help physicians to improve their human skills that are necessary for its practice, such as listening, empathy, compassion, as well as assisting in the development of moral values. For this purpose, it uses literature and stimulating the production of narratives as resources, through projects that can be developed among professionals or students of undergraduate medical courses.

According to Charon, physicians enter their patients’ lives at moments of great weakness. These are extremely complex narrative situations with subjective tones and, according to the author, for a better understanding of the patient’s history, it is necessary for the professional to have good fluency as a reader. That is, the habit of reading stories allows you to listen to the many stories that constitute the patient’s life. Considering the technoscientific focus of medical courses, we believe that this proposal, by introducing the appreciation of the patient’s biographical stories, represents a significant transformation in medical training, with a direct impact on the improvement of the doctor-patient relationship quality.

Doctors work based on the stories they are told. Is it allowed to have a space to create other stories of a patient? For that to occur, the professional needs, first of all, to be available to listen. Doctors, during an examination, listen to their patients on average for 16 seconds, before they interrupt their free accounts and start the standard questioning. During this standard questioning, which uses direct questions, we obtain only answers, but not the patient’s story. Not even the story of the patient’s illness experience: only the story of the disease. And if not even the narrative of this illness is being allowed, imagine what happens with the other stories.

Chimamanda Adichie is accurate when she observes that “it is very difficult for us to properly associate with a person without being engaged with the multiple stories of that person.” By neglecting the construction space of these several stories, we deny a connection as equal
human beings. We all are the fruit of different stories. Single stories create stereotypes, steal the dignity, prevent the acknowledgement of our equality and emphasize our differences, rather than our similarities. And, as the Nigerian says, “just like stories have been used to expropriate, stories can also be used to empower, develop, humanize, rebuild a broken dignity.” And we, as health professionals, we experience this possibility every day. This is no small reward.

**Author contributions**

Conception and design of the research: Mallet AMR, Andrade L, Geovanini F, Carvalho SB. Writing of the manuscript: Mallet AMR, Andrade L, Geovanini F, Carvalho SB. Critical revision of the manuscript for intellectual content: Mallet AMR, Andrade L, Geovanini F, Carvalho SB.

**Potential Conflict of Interest**

No potential conflict of interest relevant to this article was reported.

**Sources of Funding**

This study was partially funded by Universidade Estácio de Sá, Programa de Produtividade.

**Study Association**

This article is part of Post-doctoral work of Ana Luisa Rocha Mallet by Universidade do Estado do Rio de Janeiro (UERJ) in Comparative Literature.

**References**

1. Beyoncé-Flawless ft Chimamanda Ngozi Adichie. [Internet]. [Citado em 2016 Jan 10]. Disponível em: https://www.youtube.com/watch?v=JFFK6_q3M