REFLECTION

Nasruddin and the Coin

Peter A. de Schweinitz, MD, MSPH

Department of Family and Preventive Medicine, University of Utah, Salt Lake City, Utah

ABSTRACT

Many problems can be solved through following clinical guidelines and algorithms. In this essay, however, I explore the importance of narrative by connecting an ancient Middle Eastern teaching fable to a contemporary story of healing. A middle-aged Latina, Magdalena, comes to my residency clinic with chronic hypertension, cerebrovascular disease, and depression. Using standard biomedical approaches, I attempt to manage and cure these chronic conditions. After several months of failure, I seek the guidance of an eccentric mentor, who points me toward broader and deeper interactions with my patient. Ultimately, Magdalena heals herself through revisiting her past. Her story suggests that the cause of illness may sometimes be found outside the usual biomedical framework of explanation.

Ann Fam Med 2011;9:268-270. doi:10.1370/afm.1230.

When I was a boy, my dad, an electrical engineer of solid European stock, told me Middle Eastern stories, most often about Nasruddin, a wise fool and wanderer. One dark night Nasruddin arrived in a village to find a man searching about under a street lamp. He approached the man and asked what he was looking for. "A gold coin," came the reply. After searching with the man for a few minutes, Nasruddin asked the man where he had lost it.

The man pointed across the street. "Over there," he said.

"Well why are we looking for it here?" Nasruddin replied.

The man looked at Nasruddin in disbelief. "There's no light over there."

Many problems can be understood and treated by the light of diagnostic and therapeutic algorithms and common biomedical knowledge. There are other problems and situations in which rubrics, biochemical markers, images, consultants, and medicines fail to help the patient. As physicians, what do we do with our patients when the answers are not forthcoming? At times, both physician and patient must crawl around in the dark.

During the autumn of my family medicine internship, a 38-year-old Latina transferred care from the community health center to my clinic. A social wallflower with a bowl-cut hairdo, white tennis shoes, and unshapely slacks, Magdalena looked to me with a respect I'd hardly yet earned. "I have insurance now," she explained, "so I can come to a better clinic." I felt a twinge of guilt; her former physicians were some of my best teachers.

Born with a "bad kidney," Magdalena had been diagnosed in her Caribbean homeland with hypertension when she was just 13 years old. Ten years later, after immigrating with her family to Florida, her bad kidney was identified and removed. Sometime in the interim she met missionaries and left Catholicism for a Protestant denomination, then moved westward to the Rocky Mountains to be close to fellow believers. While studying family science at the local university, she suffered a cerebrovascular accident. The stroke did not take her ability to reason and speak, but did leave her with mild weakness and a slight limp. She now lived alone and depressed, in a small apartment just outside of the university campus.

AJC *Annals* Journal Club selection; see inside back cover or http://www.annfammed.org/AJC/.

Conflicts of interest: author reports none.

CORRESPONDING AUTHOR

Peter de Schweinitz, MD, MSPH
375 Chipeta Way
Salt Lake City, UT 84108
peter.deschweinitz@utah.edu

For the next 2 and one-half years I tried to help Magdalena. First, there was her recalcitrant blood pressure. I spent the initial 6 months ruling out secondary causes of hypertension and searching for the ideal medical regimen. I examined her single remaining renal artery with magnetic resonance imaging and checked her urine catecholamine levels. I titrated her medications, and I added and switched classes of medicine. Despite my best efforts (and the guidance of the faculty physicians), by her 6th visit to the clinic, her blood pressure had decreased only slightly, from 156/95 mm Hg to 148/90 mm Hg.

For her depression, I tried paroxetine, sertraline, and venlafaxine. At times Magdalena seemed encouraged, imagining that she was healed. But her improvements never lasted. Most likely the medicines never rendered an effect beyond the temporary placebo response, which seemed to correlate with Magdalena's hopeful and pleasing attitude toward her inexperienced doctor.

By the spring of my intern year I had neither succeeded in reducing her blood pressure nor in alleviating her depression. Moreover, she suffered a first seizure. An attending physician blamed the seizure on her prior stroke. I suspected my failure to control her blood pressure was more likely responsible. Magdalena, however, heaped blame on herself, on her fate. "Yo suffro mucho [I suffer much]," she said.

"Maybe she should see a counselor," I said.

Our faculty behavioral medicine director didn't see the point. George rocked back in his chair, elevating his Green Bay Packers tie to the brim of his ample paunch. "What is it that she would talk to them about?"

"I don't know. Maybe they could help her to see things differently."

But George must have lost faith in psychotherapy as a magic bullet. "Does she *want* to see a counselor?"

"No, I don't think so," I said.

"What I like to do is start with the primary arenas," he said. "Work, religion, and family."

The next few months were filled with strenuous encounters. As I broadened the scope of our interviews, I learned about Magdalena's father, the diligent electrician; her mother, the loyal homemaker; and of Magdalena's devotion to her new religious community. At times Magdalena's eyes welled with tears, especially when talking of her parents, both now dead. Often catharsis seemed to bring Magdalena peace, but in the end this seeming peace would quickly fade, as had any benefit of the antidepressants. I wondered whether self-discovery and emotional expression were of any permanent value.

"How do we change people, George?"

George's tie inched a button or so up his green sweater. "I figure we give 'em what we have, and they take what they want. We know we're done when they stop showing up."

Although in general I admired George, I couldn't quickly absorb his wisdom. To my young mind, his shotgun approach seemed overly passive (even blasé). As a professional, wasn't I supposed to precisely diagnose and choose from my doctor's bag the one best remedy for the circumstance? George made medicine sound like a Sunday morning buffet.

Despite my skepticism, I attempted to incorporate the advice of my mentor by opening up a separate and more personal bag of remedies, those which had worked in my own life. Thich Nhat Hanh had written about "mindful" walking; I skipped the Buddhist references and simply suggested a walk to clear the head. At church I'd learned that prayer can release emotional tension and yield divine guidance; I made the suggestion. (We shared a religion.) Viktor Frankl and Rachel Remen had written of the therapeutic importance of discovering life's meaning; I suggested journaling. Sometimes George's advice seemed to make sense. Magdalena walked out with hope. She always returned, however, with the same limp and the same pleasing smile that would ultimately give way to her downturned gaze and slumped shoulders.

With time I learned more about Magdalena and her loneliness. A single woman in a familial community, Magdalena saw marriage as an essential element of existence, mandatory, in fact, for both true happiness and "eternal progression." Around her, students one-half her age were dating, proposing, and projecting themselves into the future through their offspring. Magdalena's parents had long since died, and her fertile years were coming to a close.

"Do you ever go out, Magdalena?"

"Claro que si [Yes, of course], Doctor. I go to church parties sometimes." Magdalena answered my hesitant question with a superficial answer. "On Friday we played a game of Frisbee at the park." At the time I couldn't imagine Magdalena attracting a mate. I looked at her and saw a stroke victim and spinster, a soul with little hope of happiness, in terms both American culture and her religion prescribed.

Then, 2 months before I graduated from residency, something unusual happened: Magdalena missed her monthly appointment. By this point, Magdalena had begun to blend into the crowd of chronic patients—the type who trigger the smile of habit, the professional nod, and the rote medication renewal. Thoughts of her no longer pestered me on the bike ride home from the clinic or entered dinner conversations with my wife and young son. In short, I had lost hope (nearly) for a cure. And George's philosophy—"give 'em what we have and they take what they want"—

seemed less blasé and more realistic, perhaps even wise, if only as a method of lowering one's expectations.

It was only after my medical assistant handed me her chart that I realized that I hadn't seen Magdalena in 2 months. I looked at the yellow sticky note on her chart. Then I looked again. I practically scowled at my assistant. "Are these right?" Her blood pressure was 125/82 mm Hg! The young woman nodded. Frowning not so much at the assistant as at this deviation from the expected—this normal pressure in a recalcitrant hypertensive—I opened the door.

I've only twice in my medical career seen a patient so abruptly changed—once when I halved the dose of long-acting methylphenidate on a 10-year-old-turned-zombie, and the other time when a smoker gave up cigarettes and began to oxygenate.

Magdalena had never been assertive, but now she came after me like an old pal. "How have you been, Doctor?" I sat down on my stool. "The weather has been so nice these days, you know, not too hot."

I cut in: "Where have you been, Magdalena?"

"Florida." For the first time in many years Magdalena had visited her only remaining close family member, an aunt.

"Look at that," I said, pointing at the sticky note.

Magdalena smiled. "I know, Doctor. I had to stop one of my medicines. I was getting dizzy."

"Dizzy, like the room was spinning, or light headed, like you were going to faint?"

"Light headed," she replied.

"What happened?"

Magdalena recounted her visit to the Florida hospital, where the emergency department doctor had ordered her to stop 1 of her 2 blood pressure medicines. Magdalena was not intrigued with her sudden drop in blood pressure, but I was. Even success—a patient's improvement—is not enough. We need an explanation. "Is that all you did in Florida, Magdalena…see your aunt?"

Magdalena's eyes flicked low and oblique. She paused briefly, as if allowing any distracting inhibition to pass. "While I was there, I saw a man I used to know."

Drawing on my images of Florida—a state I'd never visited—and on our many conversations about her early family experiences, I imagined her at a dingy apartment complex, speaking with an elderly friend of her deceased father. Dusty toys littered the floor of the stairwell.

"What did you talk about, Magdalena?"

Magdalena's eyes dropped once again to the floor. This time they returned solemn with authority. "Doctor, 20 years ago I was engaged to be married." With one sentence my image of Magdalena had shattered. Wasn't she a 41-year-old spinster with a limp? For the first time I recognized the attractive radiance of her dark brown eyes.

"In the winter you told me to write in my journal. You remember?"

I didn't. "Oh, yeah. Uh huh."

"I wrote in my journal, Doctor. Every day, like you said. I hadn't even remembered him until I started writing. When I was in Florida I decided to go find him. I looked him up in the telephone book. I asked him why he did that to me, why he broke off the engagement. You know what he told me, Doctor?" I shook my head. "He said it wasn't about me. He said it was because of his own problems. All this time I thought I was too ugly or not good enough."

For 20 years Magdalena had lived with an assumption. That assumption had lived in her hesitant smile and formless clothing. It reflected back at her through the words, actions, and subtle gestures of her social world. Even her doctor, someone who had wanted badly to make her world better, could not see her differently. Perhaps for a time Magdalena tried to wear a smile over her assumption. She covered it over with a new life out West, with Frisbee in the park, with a new apartment or new part-time job. Then somehow she forgot it altogether. But it did not forget her. A fragment of Magdalena's life remained where she had dropped it.

Like the men in the old tale, Magdalena and I began our relationship by searching for the coin under the safety of the street lamp by using the standard algorithms of care. Sometimes, however, what lies at the root of uncontrolled disease is outside the obvious medical causes. Unique and personal factors may underlie, anchor, or interact with the patient's chronic problem or behavior. (This may be true even when the antihypertensive drug works.) What do we do when the textbook fails to heal the patient? Do we continue to invite the patient back month after month? When she comes, how do we spend our time? Sometimes we must leave the easy certainty of the lamp. We trip across the road, get down on our hands and knees, and search.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/cgi/content/full/9/3/268.

Key words: Physician-patient relationship, psychophysiology, mind-body relations, narrative medicine, medical education

Submitted August 26, 2010; submitted, revised, December 2, 2010; accepted December 23, 2010.

Acknowledgment: I wish to thank my dad, Alan de Schweinitz II, and the many writing mentors who have read this paper: David Morris, Julie Reichert, Rebecca de Schweinitz, Alistair Bahar, Chase Peterson, Rachel Remen, Dianne Duchesne, and the 2 anonymous reviewers.