



Fred J. Schiffrman Humanism in Medicine: Reflections

A Curious Eye

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Abstract

In this paper, the author describes a case in which being curious pushed the medical team to help a patient in an unexpected way. A multidimensional model of curiosity is presented as a roadmap to enhance distinct curiosity skills as a hospitalist.

The late Faith Fitzgerald wrote in her seminal essay, *Curiosity*, that teaching physicians should “identify [learners] with a gift for curiosity and take infinite pains not to suppress but to encourage that gift.”¹ Storytelling provides fertile ground for an exploration of curiosity, as together the pair “converts strangers...into people we can empathize with.”¹ As a hospitalist, busy and buried in the minutiae of daily clinical work, the importance of keeping curiosity at the forefront cannot be overstated.

Working with medical residents one morning, my team cared for a patient in his late 60s who had briefly lost consciousness and was admitted to the hospital for investigation. The patient’s vital signs, physical examination, laboratory data, and electrocardiogram were deemed unremarkable. Apparently, he didn’t look sick.

I’ve made a habit of combing through the electronic pile of my patients’ emergency department documentation, the initial intake note, and nursing updates. Interesting tidbits inevitably crop up, and, in this case, I learned that the patient had endorsed forceful coughing fits and that one nurse thought his pupils were of different sizes. Other notes simply stated PERRL, the clinical shorthand for “pupils equal, round, and reactive to light”.

Walking to meet the patient, the residents and I reviewed common causes of syncope, making a point to consider laryngeal ictus (i.e., cough syncope) as a fitting explanation for his presentation. I usually wouldn’t have pressed the team to closely examine the pupils of a patient presenting with syncope, but in this case, I did. His pupils were identically sized. They were also completely tonic, failing to constrict even the slightest to the bright flash of a penlight or accommodation maneuvers. Try as we

might, we couldn’t connect the patient’s syncope to his tonic pupils, and I had never encountered the latter before. It seemed possible they were not connected. The patient denied any visual symptoms, and his other work-up soon concluded without any compelling reason for ongoing hospitalization. The tonic pupils could have become an incidental finding, passed over without further thought, but my curiosity got the better of me. I pushed the residents to pause and think creatively.

We considered autonomic dysfunction as a cause of increased cough sensitivity, syncope, and tonic pupils. Alternatively, we wondered whether an infiltrative pathology or vasculitis might present with isolated neurologic symptoms. We then remembered that syphilis could present with pupillary abnormalities. Although not the classically described Argyll Robertson pupils (which fail to constrict to light, but respond briskly to accommodation), perhaps the patient’s ophthalmologic oddity hinted at an occult syphilis infection. We learned that Adie’s pupil (which constricts sluggishly or not at all to both light and accommodation) can be bilateral in 20% of cases and has been associated with syphilis infection.^{2,3} Denying any concern for sexually transmitted diseases, the patient consented to syphilis testing, which was pending at the time of discharge.

The Fluorescent Treponemal Antibody Absorption test soon returned positive, and the Rapid Plasma Reagin titer was >1:100. We called the patient, who was in disbelief. We explained that his tonic pupils and bloodwork were consistent with neurosyphilis. Although such a diagnosis is associated with morbid neurologic complications and significant social stigma, we assured him that we

could help. He sounded understandably worried. How could we have uncovered such a thing incidentally?

The patient returned to the hospital and underwent a lumbar puncture. Our initial history taking had failed to reach far enough into his past. He described unprotected sexual encounters during his 20s, and it seemed likely that he had contracted the infection decades ago. The cerebrospinal fluid Venereal Disease Research Lab test ultimately returned positive, confirming a diagnosis of neurosyphilis. After initiating IV aqueous penicillin G, I shook hands warmly with the patient, both of us grateful to have learned from one another. He completed his antibiotic course in the outpatient setting without any further neurologic complications.

Never before had I seen a case of neurosyphilis, let alone helped to make the diagnosis myself. Convinced it was curiosity that gave rise to such a discovery, I've since felt compelled to echo Faith Fitzgerald's call. If we are inspired to find deeper meaning in our work, we will help our patients in unexpected ways.

One study evaluating the personality traits of 150 physicians in training found that curiosity facilitated learning via conscientiousness and an openness to new experiences.⁴ High-curiosity states put us in the right mindset to pick up on what we might otherwise have missed, as evidenced by another study, which showed an association between being curious and enhanced memory for incidental information.⁵

Some hospitalists, however, might view curiosity as a double-edged sword. Newly unearthed information can appear as a looming threat, and we might feel unprepared to face certain consequences of curiosity if what we encounter is painful (either for our patients or ourselves). On the other hand, there are concerns that the fast-paced environment of medicine might stifle curiosity, as evidenced by a study of more than 300 medical students reporting that intellectual medical curiosity decreased significantly throughout their training.⁶ This should be particularly worrisome for hospitalists who might find their job satisfaction waning, straining to remember the last time they experienced wonder at work.

How might we intervene at such a critical inflection point? One useful strategy is to understand that curiosity isn't one-dimensional. Thankfully, there are multiple avenues of attack. Todd Kashdan, a psychologist and contemporary curiosity expert, has contributed to a model of curiosity that consists of five dimensions: 1. joyous exploration, 2. deprivation sensitivity, 3. stress tolerance, 4. social curiosity, and 5. thrill seeking.⁷ Each dimension is versatile, and such a conceptual framework allows hospitalists to target distinct curiosity skills in a manageable fashion.

1. JOYOUS EXPLORATION

Joyous exploration is a mindset. If, as hospitalists, we approach the seemingly mundane with openness instead of complacency, we will be more apt to make discoveries, and, as Kashdan has written, "catch serendipity."⁸

2. DEPRIVATION SENSITIVITY

Deprivation sensitivity, or recognizing knowledge gaps, couldn't be more important to hospitalists. Being sensitive to what you don't know yet or need to learn more about is essential to knowledge acquisition. Failing to do so leads down a path of stagnation and rigid thinking, away from diagnostic creativity.

3. STRESS TOLERANCE

Exploring the unknown is a necessary part of being curious, but the inevitable uncertainty can be stressful. If we intentionally employ strategies to tolerate and manage the stress of hospital medicine (including mindfulness exercises, adequate sleep/healthful eating, and finding support in a community), we can push toward solutions rather than falling prey to indecision.

4. SOCIAL CURIOSITY

Hospitalists have a unique opportunity to work with a diverse group of individuals throughout every hospitalization — so long as we are willing to escape the often siloed world of orders and documentation hidden behind the computer screen. Engaging more in person and acting with *social curiosity* on the wards invites rich collaboration among patients and members of the medical team.

5. THRILL SEEKING

Thrill seeking is all about novelty. For hospitalists, this can start with learning a unique clinical skill, reaching out to a mentor for advice, or applying for a new role. Such action catalyzes change and forward momentum, unlocking our potential to build autonomy. Taking a leap into the unknown is daunting, but it is the first step toward progress.

Kashdan's multidimensional model provides me with a roadmap to enhance my curiosity skills as a hospitalist. Taking notice of what has been there all along requires intentional observation and an open mindset. I encourage all of us in hospital medicine to share this approach with learners and colleagues. In doing so, we will be sure to encounter countless surprises because whenever we are curious, routine discovery becomes possible.

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