VOL. 47 ■ NUMBER 1 ■ JAN 24
SGIM Forum
Society of General Internal Medicine

IMPROVING CARE

WHAT HAPPENS IN BETWEEN: A PILOT INTERVISIT CURRICULUM FOR INTERNAL MEDICINE RESIDENTS

Matthew J. Mulligan, MD; Karen E. Stenehjem, MD; Anne C. Cioletti, MD

Dr. Mulligan (matthew.mulligan@hsc.utah.edu) is an assistant professor in the Division of General Internal Medicine at the Spencer Fox Eccles School of Medicine at the University of Utah. Dr. Stenehjem (Karen.Stenehjem@cuanschutz.edu) is an assistant professor of medicine in the Division of General Internal Medicine at the University of Colorado Anschutz Medical Campus and Rocky Mountain Regional VA Medical Center. Dr. Cioletti (anne.cioletti@hsc.utah.edu) is an associate professor and the Associate Chief of Ambulatory Operations in the Division of General Internal Medicine at the Spencer Fox Eccles School of Medicine at the University of Utah.

Intervisit care, the asynchronous care provided between visits, is essential to the provision of all medical care, especially ambulatory care. It encompasses a wide range of tasks that include follow-up of diagnostic testing, care team collaboration, medication management, and responding to patient messages. In recent years, intervisit care has received attention from physicians and health systems nationwide due to increases in the use of patient messaging and the association of this increased volume of messages with burnout.[1,2,3] While the uptake of patient portals has significant opportunity for improved patient-physician communication, it is crucial for physicians to have strong intervisit management skills to balance effective intervisit patient communication with increasing intervisit care workload and its associated burnout.

Even though intervisit care is a fundamental aspect of patient care and a core aspect of several Internal Medicine Accreditation Council for Graduate Medical Education (ACGME) 2.0 milestones, many residents do not get formalized training in intervisit care.[4] In addition, literature regarding teaching methods for intervisit care remains scarce.

We developed a pilot intervisit curriculum during the 2022-23 academic year in our large academic internal medicine residency program at the University of Utah with an aim to improve knowledge and comfort of intervisit care for internal medicine residents. The objectives of our intervisit curriculum included:

1. recognizing intervisit care as a clinical skill set distinct from traditional face-to-face care;
2. determining appropriate use of resources and care team members; and
3. employing a novel medical decision-making framework for applying intervisit care.

We delivered our intervisit care educational sessions via a 3-part noon conference series for all internal medicine residents and gave more in-depth workshops to a small sub-set of ambulatory focused residents. Our sessions included case-based discussions of common intervisit care scenarios with a focus on developing actionable care plans and next steps. These sessions employed multiple educational techniques including cased-based discussion, real-time polling, and gamification.

To evaluate our intervisit curricular intervention, residents completed electronic pre- and post-surveys. These surveys asked residents if they were confident in managing intervisit care and if they felt intervisit care was important using a Likert scale from strongly disagree (1) to strongly agree (5). We received 51 pre- and 63 post-didactic responses to the survey. We found that residents' median confidence in managing intervisit care was low prior to the curriculum for both the small- and large-group settings (median 2, IQR 1 and median 3, IQR 2, respectively). However, their confidence improved after

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RESOLUTIONS 2024: UNDERSTANDING WHAT IS IMPORTANT TO OUR PATIENTS

Michael Landry, MD, MSc, FACP,
Editor in Chief, SGIM *Forum*

"Resolution (noun): a promise to yourself to do or not do something."[1]

January 2024 signals the start of a new year. With each New Year comes New Year's resolutions. We often make personal resolutions on changes we will choose to add to our daily routines or actions to omit over the next 365 days. As you read this January issue of the SGIM *Forum*, reflect on 2023. What are the changes you resolved to make in 2024? Do your resolutions include some of these common choices?

- I resolve to eat healthier;
- I resolve to read more;
- I resolve to quit smoking;
- I resolve to lose weight;
- I resolve to drink less;
- I resolve to exercise more;
- I resolve to save more money;
- I resolve to reduce stress;
- I resolve to spend more time with family; or
- I resolve to have better sleep habits.

Just as we make personal resolutions, our patients also make resolutions. How often have you asked your patients about their New Year's resolutions?

We attempt to motivate our patients throughout the year to change their habits and behaviors. We find it challenging to get them to initiate and follow through on these changes. Resolutions are made under the premise of achieving success. We don't resolve to eat more fast food, smoke more cigarettes, drink more alcohol, or to be more stressed. We should discuss with our patients the resolutions that they made to start 2024. If they are so interested in making a particular change that they make it a 2024 resolution, as physicians, we should capitalize on their newfound motivation.

New Year's resolutions are set due to traditions and expectations. Research shows that New Year's resolutions often falter and fail over time. "Researchers suggest that only 9% of Americans that make resolutions complete them. In fact, research goes on to show that 23% of people quit their resolution by the end of the first week, and

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WORDS AND CONTEXT MATTER

Martha S. Gerrity, MD, MPH, PhD, FACP, President, SGIM

"How we talk with each other about the 2025 Annual Meeting will matter. Effective communication facilitates meaningful dialogue, encourages empathy, and lays the groundwork for finding commonalities that can unite and move us forward despite different viewpoints."

Words can shape our perceptions and influence emotions. They can connect us with others or separate us. While words have definitions, their impact is influenced by the context in which they are used and the context of the listener. I had several recent experiences that remind me of the importance of words and context—and how easily our words can be misunderstood or evoke different feelings depending on the listener and their context.

During one of our planning calls for the 2024 Annual Meeting, we discussed strategies for involving our past presidents and other prominent leaders from SGIM and ACLGIM. Every time someone said, "senior leaders" or "senior members," they would look at me and quickly correct themselves to say, "later career." I was never offended, especially in the context of SGIM and our leaders who have done so much for us and had significant impact on clinical care, education, and research. It also doesn't bother me to be referred to as *senior*, but I have friends who bristle when someone alludes to their age. I also mistakenly used the term *abrasive* to describe a communication style when I should have used other descriptors. I did not realize that in the context of the individual's background that abrasive had negative personality connotations, which was not the message I wanted to communicate. I am thankful they felt comfortable pointing this out and helping me understand their context.

This month, SGIM announces the Council's decision to hold the 2025 Annual Meeting in Hollywood, Florida, as planned several years ago. (See the CEO Q&A column in this issue of the *Forum* for a description of their work.[1]) My recent experiences, as well as national and international events, caused me to reflect

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Q & A WITH SGIM'S CEO AND THE CHAIR OF SGIM'S MEETING SITE SELECTION WORKGROUP: THE DECISION TO HOST THE 2025 ANNUAL MEETING IN FLORIDA

Eric B. Bass, MD, MPH; Brita Roy, MD, MPH, MHS; Francine Jetton, MA, CAE

Dr. Bass (basse@sgim.org) is the CEO of SGIM. Dr. Roy is the Chair of SGIM's Meeting Site Selection Workgroup (Brita.Roy@nyulangone.org). Ms. Jetton is SGIM's Senior Director of Communications and Publications.

SGIM's vision is "A just system of care in which all people can achieve optimal health." But what does our Society do when legislation passed in specific states is at odds with the views of many members about a "just system of care"? How can we support our members and their patients in these states? Should SGIM contribute to the economy of locations where physicians are restricted from providing what they consider to be evidence-based care? How do we decide where to host our annual meetings, given the serious concerns from members about recent legislation and travel bans? These are all questions that the Meeting Site Selection Workgroup sought to answer.

The SGIM Council convened this workgroup to assess the implications of whether to continue plans to meet in Hollywood, Florida, in 2025 or pull out of the contract and relocate the meeting to a less politically charged location. I recently talked with Council member Dr. Brita Roy (Chair of the Meeting Site Selection Workgroup and Chair of the 2019 Annual Meeting) about how the workgroup made the recommendation to maintain our current contract and host the SGIM25 annual meeting in Florida.

EB: What was the Council's charge to the Meeting Site Selection Workgroup and who are its members?

BR: Council asked the workgroup to make recommendations on how to address concerns about the location of the SGIM25 annual meeting, review and consider revising and weighing selection criteria for future meeting sites, and prepare a rank-ordered list of recommended sites for annual meetings in 2027, 2028, and 2029. The workgroup includes SGIM's immediate Past-President, Treasurer, Treasurer-Elect, Chair of the Board of Regional Leaders, another Past-Chair of the Annual Meeting Program Committee, and three at-large members representing constituent groups affected by recent legislation, including the Women and Medicine Commission and Minorities in Medicine Interest Group. The composition of the group was balanced across career stage, gender, and region. We met with SGIM staff to review the terms of the current contract for the SGIM25 meeting and recommend sites for future meetings based on newly revised and weighted selection criteria.

EB: What criteria are used to select sites for annual meetings?

BR: SGIM selects sites for annual meetings 4-5 years before the meeting itself. The best advice in the meeting industry is to describe the nature of the experience that we want attendees to have, establish criteria for selecting an appropriate site consistent with the desired experience and our core values, and ensure careful vetting by our site selection partners. Decisions are made with the best possible information available at the time, considering a number of criteria. Once a site has been selected, SGIM signs a contract with large penalties (several hundred thousand dollars) for breaking the agreement. The selection criteria approved by Council in October 2022[1] included:

- Geographic rotation to facilitate equitable access of members;
- Venue cost;
- Direct flight access;
- Available dates, avoiding conflicts with meetings of other organizations;
- Condition of meeting space;
- Attendee experience in the city (e.g., accessible restaurants and activities);
- Attendee safety and security;
- Prior experience with the location;
- Environmental sustainability; and
- Political considerations.

The guidance policy emphasizes the importance of transparency with members about the selection process.

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ASYNCHRONOUS CARE: THE RISING THREAT TO PRIMARY CARE SUSTAINABILITY

Nathaniel Gleason, MD; R. Jeffrey Kohlwes, MD, MPH

Dr. Gleason (Nathaniel.Gleason1@va.gov) is a general internist at the San Francisco VA Health Care System and professor of medicine at University of California, San Francisco. Dr. Kohlwes (Jeffrey.Kohlwes@va.gov) is Chief of the Division of General Internal Medicine at the San Francisco VA Health Care System and professor of medicine at University of California, San Francisco.

SGIM national meetings often have a prevailing buzzword that captures the salient presentations and hallway conversations that live in our community. Over the past 30 years, important buzzwords included *nucleoside analogs*, *health maintenance organizations*, and *quality of care*. The major new contender, and a rising threat to career sustainability in general internal medicine (GIM), is *asynchronous care*.

Synchronous care occurs when patient and provider convene in real time, either face to face or virtually. Asynchronous care is defined as "communication or information shared between providers, patients, and caregivers that occurs at different points in time."[1] The term captures the triage and management of laboratory and imaging results, addressing patient-portal and phone messages, medication refill requests, facilitating interactions with multidisciplinary teams and home health providers, coordinating care with subspecialists, and completing the myriad panel management tasks. Some of these inputs require high-level clinical decision-making, but many do not. Some meet the important healthcare needs of our patients while others are of low value. These inputs come in addition to time-consuming preparatory data gathering before visits and often lengthy post-visit documentation. The buzz at the 2023 SGIM annual meeting was that this work is unreimbursed, invisible to those without panel management tasks and underappreciated by health systems. Functionally, asynchronous care creates cognitive overload, promotes moral injury through decay of work-life balance, and saps the joy of practicing GIM physicians.

A common sentiment among senior physicians is that processes existed prior to EHR implementation through which clinic staff streamlined physician work by filtering out non-clinical tasks. The EHR supplanted these processes by routing everything directly to the clinician. Secure messaging via patient portals introduced new inputs, and the volume of these messages exploded over the past 10 years, especially during the pandemic.[2]

The causal relationship between asynchronous care and physician burnout is firmly established as is the impact of burnout on care quality and patient satisfaction.[3] The tsunami of asynchronous work is outpacing efforts to meet the demand. In addition to the discussion at the SGIM national meeting, we see increased provider burnout nationally and fewer graduating residents choosing GIM careers.[4]

As always, the SGIM national meeting brought substantial joy—reengaging with old friends and feeling stimulated by novel ideas. However, the gathering also brought memories of past crises that SGIM helped address: primary care for patients with HIV, stewardship of HMOs, and addressing gaps in quality and safety with research and leadership. GIM is disproportionally impacted by the burden of asynchronous care, but we are also well positioned to address this crisis. We excel at defining a problem, employing evidence-based interventions, and expanding that evidence-base through well-reasoned investigation. We are experts in collaboration and embrace interprofessional team-based care. These strengths are needed to address this complex issue.

In Denver, Colorado, several themes on asynchronous care emerged. First, primary care is a "public good," and it is imperative for all stakeholders that primary care be a sustainable job. Second, we lack the analytic tools to target and track interventions designed to reduce the burden of asynchronous care. Investigators have found ingenious ways to use EHR activity logs to characterize asynchronous work, but local medical directors cannot easily measure the impact of interventions on their own clinics. Third, the interprofessional team—patient-aligned care teams (PACT)—with each member working at the top of their license, is the most powerful intervention currently available.[5] We need to further study and refine our teams to maximize this resource. Fourth, the artificial intelligence (AI) revolution provides some optimism with the potential to aggregate and distill individual patient data to create problem representations,

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ALL ABOUT THE LYSIS: GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD) DEFICIENCY AND HEPATITIS B VIRUS INFECTION

Chloe N. Hundman, MD; Christopher D. Jackson, MD

Dr. Hundman (chundman@uthsc.edu) is a third-year internal medicine-pediatrics resident at the University of Tennessee Health Science Center in Memphis (UTHSC), TN. Dr. Jackson (cjacks67@uthsc.edu) is an assistant dean of student affairs at the UTHSC College of Medicine, associate professor of medicine at The University of Tennessee Health Science Center (UTHSC), and associate program director at UTHSC Internal Medicine Residency, Memphis, TN.

Case

A 73-year-old man with a prior diagnosis of chronic immune thrombocytopenic purpura (ITP) and intermittent steroid treatment presents to the emergency room with a two-day history of scleral icterus and a one-day history of dark-colored urine. Pertinent positives on his review of systems include lethargy, decreased urine output, decreased appetite, non-bilious non-bloody emesis, and shortness of breath. He denied chest pain, sick contacts, orthopnea, lower extremity swelling, abdominal pain, hemoptysis, vision changes, weakness, or diarrhea. He denied any aggravating or alleviating factors for his symptoms. His family history was negative for any bleeding disorders. He reported no alcohol, tobacco, or intravenous drug use.

On examination, the patient was alert and oriented, and his vitals included a temperature of 36.8 C°, blood pressure 135/70 mm Hg, heart rate 116 bpm, and an oxygen saturation 83% on 10L nonrebreather mask. He had scleral icterus with no hepatomegaly, splenomegaly, or lymphadenopathy noted. Cardiopulmonary examination was notable for a faint S1, S2 but no adventitious breath sounds noted. Pertinent labs included a hemoglobin of 9 g/dL, hematocrit of 27%, Aspartate aminotransferase (AST) was 3017 U/L, alanine aminotransferase (ALT) 2712 U/L, blood urea nitrogen (BUN) 74 mg/dL, creatinine 3.6 mg/dL, total bilirubin 72.4 mg/dL, direct bilirubin 41.8 mg/dL, indirect bilirubin 30.6 mg/dL, mean corpuscular volume (MCV) 106 fL, Direct anti-globulin test was negative, and his peripheral smear revealed no schistocytes. Chest x-ray showed no acute cardiopulmonary abnormality. Computed tomography scan of the abdomen and pelvis and a right upper quadrant ultrasound were unrevealing.

The medicine team consulted gastroenterology and hematology due to the significant acute liver injury noted above and the concern for hemolytic anemia based on the high indirect bilirubin level. Additional lab work would later show lactate dehydrogenase 5,417 U/L, international normalized ratio of 1.7, acetaminophen level < 10, urine drug screen negative, positive HBsAg, positive HbcAb IgG, positive HbcAb IgM, and a non-reactive HBV surface antibody. HIV, Hep A total and IgM ab, HCV Ab, HDV Ab, anti-smooth muscle antibody, and CMV Ab were all negative, ferritin < 7500 ng/mL. G6PD level was 60 (low), consistent with G6PD hemolytic anemia triggered by acute HBV infection. The patient received entecavir for treatment of his acute HBV infection. He had clinical improvement in his respiratory status with antiviral treatment and normalization of his liver chemistry studies. With supportive care, the patient improved and he was discharged home with follow-up appointments to gastroenterology and hematology.

Discussion

Glucose-6-phosphate dehydrogenase (G6PD) deficiency affects upwards of 400 million people worldwide.[1] Due to the X-linked nature of the disorder, men are affected more often than women. The defective G6PD enzyme can lead to premature breakdown of red blood cells in the setting of reactive oxygen species. Many patients with G6PD deficiency remain asymptomatic in the absence of triggers. When triggers occur, patients with G6PD deficiency often experience fever, icterus, dark urine, fatigue, tachypnea, and tachycardia. Some of the most common triggers include infections, antibiotics (such as trimethoprim-sulfamethoxazole, nitrofurantoin, ciprofloxacin, chloramphenicol), antimalarial medications, aspirin, quinidine, fava beans, and naphthalene, a chemical found in mothballs.

Infections, including viral hepatitis, may precipitate mild hemolytic anemia. However, an additional underlying disease process (such as G6PD) requires consideration

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INTEGRATING MEANINGFUL ACTIVITY EXPERTS INTO CLINICAL CARE: A ROLE FOR OCCUPATIONAL THERAPY

Benjamin E. Canter, BA; Amy M. Linsky, MD, MSc

Mr. Canter (bcanter@bu.edu) is an Occupational Therapy Doctoral (OTD) Candidate at the College of Health & Rehabilitation Sciences, Sargent College, at Boston University. Dr. Linsky (Amy.Linsky@va.gov) is an associate professor of medicine at Boston University Chobanian and Avedisian School of Medicine and a clinician-investigator in the Section of General Internal Medicine; the Center for Healthcare Organization and Implementation Research; and the Geriatric Research, Education, and Clinical Center at VA Boston Healthcare System.

Age-friendly care prioritizes patient quality of life, which can address one or more of the 5Ms: Mind, Mobility, Medications, Multicomplexity, and What Matters Most. A 2021 *JAMA Internal Medicine* report delineates that meaningful activities cultivate feelings of purpose or satisfaction and are essential to older adults' well-being.[1] Participation in activities that matter most to patients can occur despite physical or mental health challenges.

Occupational therapists and occupational therapy assistants (collectively, occupational therapy professionals [OTPs]) specialize in promotion of meaningful activity engagement and are optimally situated to collaborate with other clinicians to improve health outcomes. However, one of the largest barriers to successfully integrating OT in primary care settings is low understanding of its value.[2] This article defines the role of OTPs as specialists in meaningful activity and discusses benefits of integrating OTPs into clinical care.

Occupational Therapy: Mission, Scope, and Practice

Using a biopsychosocial approach, OTPs help patients increase, maintain, or recover ability to engage in meaningful activities by addressing function, motivation, and independence. OTPs work in numerous settings, including acute care, long-term care, ambulatory, and home-based care. Ensuring that physicians and other practitioners understand OT's scope of practice, clinical domains, and processes will allow effective interprofessional team collaboration.

Patient-centered OT practices are evidence-based and effective in promoting physical and mental health, decreasing pain, and improving social function.[3] The hallmark OT expertise is in occupational analysis (i.e., understanding the physical, mental, and cognitive demands of activities and observing potential areas for modification) and adaptation (i.e., designing environmental, personal, or activity-specific modifications). Thus, OTPs promote engagement in activities that are completable and safe for the patient, yet physically and cognitively challenging enough to allow meaning to be derived.

OTPs can assess and modify home environments to address needs so patients with disabilities or illnesses may successfully live in their own homes without need for institutionalization. For an older adult with declines in balance, this may mean adapting the home environment (e.g., adding grab bars, removing tripping hazards). For someone with dementia, an OTP might provide guidance on cognitive strategies to improve performance in complex activities (e.g., sticky notes, repetition of statements). For an older adult with serious mental illness, an OTP may observe the patient's interpersonal behaviors and provide strategies encouraging socialization. Individuals engaged in meaningful activities with the assistance of an OTP can have improved physical, mental, and emotional health outcomes compared to those engaging in meaningful activities without OT involvement.[3] Primary care clinicians concerned about a patient's ability to participate in and derive benefit from meaningful activities should consider referral to OT for evaluation and treatment.

Some activities become engrained as habits, and some habits (e.g., tobacco use, unhealthy eating) are associated with worse health outcomes. OTPs specialize in determining the meaning behind these habits through a nuanced understanding of activities' complexities and examination of patients' personal and environmental factors. They can provide tailored treatment by prescribing interventions for behavior modification. For example, cognitive-behavioral techniques can be used if eating is a coping mechanism and nutrition-literacy techniques (e.g., reading food labels) can address knowledge deficits.

Integrating Occupational Therapy into Clinical Care

As activity experts, OTPs have a strong background in functional cognition and movement. Their unique therapeutic approach can enhance efforts by physicians and other healthcare professionals to integrate patient purpose into goals of care, improving quality of life. Integrating

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A LASTING IMPACT: THE IMPORTANCE OF PATIENT STORIES AND CONSIDERING "WHAT MATTERS MOST"

Jennifer A. Woodard, MD

Dr. Woodard (jwoodard@mcw.edu) is a geriatrics fellow at the Medical College of Wisconsin.

I have a list of patients I continue to think and worry about from my time on service. I find myself reading their charts and trying to find out how they are doing: Did they make it to their granddaughter's graduation? Are they still healing from their wounds? Medicine is not just a science, cold and unfeeling. We work with emotions and unknowns. Even when I am not physically present, my patients have a piece of my heart inextricably linked to them and their families.

In the sterile space of the hospital, we become part of some of the worst and best days of people's lives. In some ways, they also become part of ours. I remember the Christmas when I called a young man's family to tell them his heart had stopped, and we were doing chest compressions. I will never forget the time spent holding hands with a patient in their last hours, knowing that the family would not be able to be with them. I have given people life-changing diagnoses and cried for them on my drive home. I have attended birthday parties and funerals for my patients, and I relish the opportunity to know them outside of this bleach-scented realm.

When I perform a hospital admission, I instruct medical students and interns to go beyond the basics of social history. After asking the usual checklist questions, I always ask my patients, "What do you like to do when you aren't here in the hospital?" I often find this helps me cement a patient in my mind, but it also serves as a springboard for me to approach what matters to a patient. Quite simply, though, this is where I find joy in medicine. I love hearing about people's pets and families, about their puzzle skills and sports collections. We can bring humanity back into medicine. Instead of the 63-year-old woman with heart failure and COPD, my patient becomes the woman who loves crossword puzzles and spending time with her grandchildren.

On the other hand, sometimes this question reveals how ill my patients have become—there are some who can no longer enjoy activities outside of the hospital. Instead, they have things they "used to like" in the past when youth and health were in their favor. As illnesses worsen and their life space narrows, I often find patients who do not like to respond to this question. In some ways, this particular response is my screening tool for depression, a poor prognostic sign, and a determination to help them feel seen. When your world narrows because of physical ailments, humanity becomes more important than ever. I cannot reverse time, aging, or even most illnesses, but I can bear witness.

My most successful days in residency were not always those where I made the most complex diagnosis or saw patients discharged. They were when I developed a care plan informed by my patients' lives. In a world where efficiency and volume dictates practice, humanity is forgotten, but difficult to lose—sometimes, all you must do is ask.

I come back to the response to my question occasionally when things are not improving, and we need to readdress a patient's goals. Having learned early what are my patients' goals makes it easier to address conversations with them and their family. I can frame goals of care in the context of helping them reach the things they enjoy. While it is not always possible, I approach these conversations by stating, when I am worried, that although we may not get them to the point where they can go fishing at their favorite lake, we can get them some cheesecake and bring their families to their side. SGIM

PRESIDENT'S COLUMN *(continued from page 3)*

on the communication skills we will need when discussing this decision. The SGIM Meeting Site Selection Workgroup did extensive work to understand the perspectives of our members in Florida and perspectives of members who feel strongly that SGIM should not meet in Florida, a state with laws that run counter to SGIM's vision and values,[2] or have fears for their safety.

How we talk with each other about our views and values regarding this decision will be important. We are a diverse professional society; yet, we have much in common. I hope we can find common ground and support each other no matter what our views are about the 2025 Annual Meeting. We need to use the

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ACNE IN THE PROSTATE: A CASE OF AN EMPHYSEMATOUS PROSTATIC ABSCESS

Anna Conner, BBA; Christopher D. Jackson, MD

Ms. Conner (aconne16@uthsc.edu) is a third-year medical student at The University of Tennessee Health Science Center. Dr. Jackson (cjacks67@uthsc.edu) is an associate professor of medicine at The University of Tennessee Health Science Center (UTHSC) and associate program director at UTHSC Internal Medicine Residency, Memphis, TN.

Case

Our patient is a 78-year-old man who presents to the emergency room with fever and perineal pain. His medical history includes prostate cancer, status post external beam radiation therapy 15 years ago as well as a urethral stricture, status post-dilation five years ago. He has no recent history of urethral instrumentation or procedures. He denies tobacco, alcohol, and intravenous drug use. Current medications are amlodipine, atorvastatin, tamsulosin, finasteride, and hydrochlorothiazide.

On physical exam, his temperature is 99.5°F and other vitals are within normal limits. He is an elderly male who appears uncomfortable and disoriented. He is alert and oriented to his name with no other focal deficits but could not name the days of the week backward. The abdomen is scaphoid, non-tender, and non-distended, with normoactive bowel sounds. There is a prior suprapubic catheter scar. A prostate exam shows an enlarged prostate with prostatic fluctuance. He has left inguinal pain. There is no urethral discharge or ulcers.

Pertinent labs include an elevated white count (15,300) with 84% PMNs and a basic metabolic profile is within normal limits. Urinalysis shows 15-25 WBC/hpf, 15-25 RBC/hpf, 2+ bacteria, + leukocyte esterase, and + nitrite. CT scan of the abdomen and pelvis with contrast shows an air collection that communicates with the undersurface of the bladder and a focus of air in the prostatic urethra with no definitive abscess. Blood cultures x two grow *Propionibacterium acnes (Cutibacterium acnes)* in two of four bottles (sensitive to penicillin). The patient is treated with IV penicillin G 20 million units daily and scheduled for transurethral resection of the prostate (TURP) with biopsy. He undergoes a TURP without complications. Prostate chip pathology is positive for acute and chronic inflammation with eosinophilia and gangrenous necrotic foci without evidence of malignancy. The patient completes a 6-week course of IV penicillin G without complication, and his mentation, perineal pain, and other clinical parameters return to baseline.

> **"EPA cases are uncommon, serious infections caused by various bacteria that can cause high mortality if they are not quickly diagnosed and treated."**

Discussion

An emphysematous prostatic abscess (EPA) is an uncommon condition first described in 1983, with limited cases reported in the literature. EPA is an inflammatory condition where gas and purulent exudate form within the prostate gland. Before antibiotics were readily available, mortality reached 30%, and the causative agent was *Neisseria gonorrhea*.[1] Enterobacter is the most reported pathogen worldwide; mortality ranges from 3-18%.[1] Another review found Klebsiella to be the highest causative agent in Asia.[2] Studies also attribute EPA to Candida spp., Proteus spp., and Citrobacter spp.[2] Despite treatment, a review of 12 patients observed a 25% mortality rate.[2]

Risks for EPA include diabetes mellitus, urinary retention, recurrent urinary tract infections, and the use of urethral instruments like catheters or various therapeutic devices.[2] A prior history of prostate cancer, as well as systemic diseases like cirrhosis, post-renal transplant status, and alcoholism, may influence EPA development.

EPA can also present with nonspecific symptoms; reported cases include patients presenting with dysuria, increased frequency, urgency, fever, urinary retention, perineal pain, lower abdominal pain, and general malaise.[3] Our differential diagnosis included iatrogenic air accumulation due to urethral instrumentation, emphysematous cystitis, emphysematous pyelonephritis, and infected prostate cancer tumor. Potential misdiagnoses may settle on prostatitis or bacteremia, but these fail to appreciate the aggressive clinical behavior of patients with an emphysematous prostatic abscess.

EPA presentations are challenging to diagnose and differentiate from other conditions. In a review of 12 reported cases, all patients received a plain film of the kidney,

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BLASTOID MANTLE CELL LYMPHOMA (MCL): AN AGGRESSIVE VARIANT

Anna Conner, BBA; Christopher D. Jackson, MD

Ms. Conner (aconne16@uthsc.edu) is a third-year medical student at The University of Tennessee Health Science Center. Dr. Jackson (cjacks67@uthsc.edu) is an associate professor of medicine at The University of Tennessee Health Science Center (UTHSC) and associate program director at UTHSC Internal Medicine Residency, Memphis, TN.

Case

Our patient was a 69-year-old man with mantle cell lymphoma (MCL) diagnosed 5 years prior and managed with active surveillance. He presented with a 20-pound weight loss over 4 weeks, although the patient was not sure of the exact timing. He had associated symptoms, which included anorexia, malaise, drenching night sweats, and subjective fevers. No interventions made his condition better or worse. He had hepatitis C infection treated with sofosbuvir/ledipasvir with a sustained virologic response when checked six months earlier. He did not use tobacco, alcohol, or intravenous drugs. He lived at home alone and had increasing difficulty with completing his activities of daily living due to weakness.

On physical exam, vital signs were temperature of 38.1°C, blood pressure 100/65 mm Hg, respirations of 26 breaths per minute, and heart rate of 110 beats per minute. He was a cachectic, pale, and ill-appearing male lying in bed. He had prominent bi-temporal wasting. There was bilateral anterior cervical lymphadenopathy with multiple lymph nodes measuring 2 cm. He had an unremarkable cardiovascular exam. He had mildly labored breathing, but his lungs were clear to auscultation bilaterally. The abdomen was soft with bowel sounds, and splenomegaly was noted.

Laboratory values were notable for a white blood cell count of 10,090 with 3.4% basophils (elevated). His hemoglobin was 13.2 mg/Dl, hematocrit was 39%, and platelet count was low at 48,000. He had elevated lactate dehydrogenase (16,849), uric acid (10.7 mg/dL), and creatinine (1mg/dL). The patient underwent a bone marrow biopsy with the following results: 50% abnormal lymphoid cells with immunohistochemistry positive for c-myc, bcl2, and cyclin D1 translations. Testing also revealed P53 mutations.

He was diagnosed with blastoid variant MCL and treated with bendamustine and rituximab. Unfortunately, he developed progressive multi-organ failure during his multi-week hospital course and passed away.

Discussion

Blastoid variant mantle cell lymphoma (MCL) is a very uncommon variant of non-Hodgkin lymphoma with an unclear incidence or prevalence. It is a subtype of MCL that arises from the naïve germinal center B cell and comprises 10-15% of MCLs.[1] Among 183 patients, 152 patients had blastoid MCL, males comprised 75% of patients, and the median age was 65.[4] Blastoid cells are always positive for BCL2 and sometimes express D1, as our patient's histology did. Ki-67 index is an important prognostic factor more so than cytology, and the media Ki-67% was 70%.[5] Currently, no described genetic alterations are unique to and differentiate blastoid MCL from classic MCL.[5]

Typically, MCLs are lymphoid cell proliferation with irregular nuclei and dispersed chromatin. Histopathology of recurrent MCLs often has these features and no mantle zone growth pattern, pleomorphism, or high mitotic activity.[2] Blastoid MCL differs from standard MCL in that cells resemble lymphoblasts typically seen in lymphoma or leukemia with more dispersed chromatin and higher mitotic activity.[5] Histopathologic confirmation is needed to establish the diagnosis.

Patients like ours can present with advanced disease, including splenomegaly, bone marrow involvement, and bulky lymphadenopathy. Blastoid MCL may spread extranodal to the gastrointestinal tract and Waldeyer ring.[2] Gastrointestinal spread is associated with a more indolent disease course.[5] Blastoid MCL has a higher rate of CNS involvement (28%) than classic MCL.[5] Up to half of cases have "B" symptoms of fever, weight loss, and night sweats.[3] High leukocyte count, mitotic activity, Ki-67 index, and peripheral spread are poor prognostic factors.[1]

Current treatment strategies recommend intensive chemotherapy, including cytarabine-based therapy, autologous stem cell transplant, and clinical trials. The dosing and frequency of treatments are different than that for classic MCL. Blastoid MCL is often refractory. Ibrutinib, lenalidomide, and temsirolimus can lead to short-term remission.[5] In the future, targeted therapies like acalabrutinib, ibrutinib, venetoclax, and CD19 CAR-T therapies may improve outcomes.[4]

SGIM *Forum* clinicians should be aware that not all forms of mantle cell lymphoma are indolent. Many

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communication skills we teach our trainees to be sure we understand the views and context of those with whom we may not agree.

A general model for communication skills, which I learned, is likely familiar to many of you: the Three Function Model of the Medical Interview.[3] Although developed to guide interactions with patients, it is useful in other areas. The skills I find most helpful and use frequently are grouped into two functions: 1) information gathering to build understanding and 2) rapport development to build relationships.

Information-gathering skills promote understanding of another person and their perspective. The skill is in using them at the right times in a conversation. They include the following:

- *Using focused open-ended questions*. This question format invites individuals to share their viewpoints and experiences about something specific (e.g., "Tell me about your concerns," or "past experiences," or "goals in doing…").
- *Facilitation*. This technique encourages individuals to expand on what they said and maybe offer new insights (e.g., "Tell me more about…" or "Help me understand…").
- *Surveying*. These questions probe to determine if there are other potentially related issues underlying a viewpoint (e.g., "What else are you concerned about?").
- *Summarizing*. Providing a summary of what you heard, lets others know that you heard them and gives them the opportunity to correct any misunderstandings (e.g., "Let me make sure I understand what you just told me… [give a brief summary of what you heard]").

Rapport-development skills strengthen relationships because they let people know that you heard them and want to be engaged. These skills include the following:

- *Reflection*. The intent of reflection is to recognize the feelings underlying a viewpoint or experience in a non-judgmental manner (e.g., "I can see you really care about…" or "this issue really worries you…").
- *Support*. These statements acknowledge diverse experiences or viewpoints and end with the common ground you may share or the value the relationship (e.g., "I want you to know that although we don't agree on this, I am here as your colleague, friend, etc.").
- *Partnership*. Fostering a sense of partnership helps build bridges and understanding (e.g., "Let's work together on… [the areas where you agree with each other]").
- *Respect*. Statements that show respect for another person, even though you do not agree on a viewpoint, foster cooperation, and promote positive interactions. Finding something you respect about someone deepens your understanding of them and helps you maintain a positive relationship. Ruth Bader Ginsburg and Antonin Scalia maintained a friendship built on finding common ground and respect, even though they often ended up on different sides of Supreme Court decisions[4] (e.g., "I'm impressed by how well you've…" or "You really care about…").

I recently had the opportunity to use these skills when in Celina, Texas, to help my brother who was hospitalized. My brother and I joke about our differing views. I'm his bleeding-heart, liberal, doctor sister, and he is my fiercely independent, conservative brother who raises cattle in Texas. We often agree to disagree and respect each other's hard work and commitments to improve the lives of others, each in our own way.

How we talk with each other about the 2025 Annual Meeting will matter. Effective communication facilitates meaningful dialogue, encourages empathy, and lays the groundwork for finding commonalities that can unite and move us forward despite different viewpoints. Although there may be times when we must agree to disagree, we will continue to work together and support each other. Dr. Jada Bussey-Jones, our President-Elect, and her Annual Meeting Committee will work with SGIM members over the coming year to understand what you would like to see and do during the 2025 meeting in Florida. Please contribute your ideas and be a part of the planning!

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EB: How did the workgroup reach a consensus on its recommendation to host SGIM25 in Florida?

BR: The workgroup met over several months and focused on safety concerns brought forward by members amid the political landscape in Florida, including legislation on reproductive rights, access to care for immigrants, and health care for the lesbian, gay, bisexual, transgender, queer or questioning community. The workgroup surveyed a sample of members, conducted focus groups with members living and caring for patients in Florida, and met with members from other states who expressed concern about attending a meeting in Florida. The group also considered financial, relocation, and staffing issues that would affect the Society if we were to cancel the existing SGIM25 contract.

EB: What did the workgroup learn from talking with members?

BR: Members in Florida felt that cancelling the meeting would be akin to abandoning members in the state when a presence was needed most. Keeping the meeting in Florida shows our support for physicians living and working in the state and in other states with similar legislative environments. By supporting physicians working under restrictive circumstances, we intentionally support them and the patients they serve. As stated by one member, "taking SGIM out of states that have restrictions removes the conversation from the places where we need to have it the most." Other members had serious reservations about attending a meeting in Florida, but recognized the challenges faced by members and their patients in Florida. Ultimately, the workgroup concluded that SGIM should maintain a commitment to all members, including those in states where legislation does not align with the core values of members.

EB: What did the workgroup recommend?

BR: The workgroup voted unanimously to recommend keeping the SGIM25 annual meeting in Florida while simultaneously taking actions that include giving attention to meeting safety, engaging legal counsel to help interpret state policies, engaging in meaningful sustained advocacy, exploring a hybrid meeting option, and clearly communicating to members about the decision-making process. Council approved the recommendations and has committed to having speakers, educational sessions, and advocacy initiatives at the SGIM25 meeting that address the issues of concern with thoughtful consideration of relevant scientific evidence and divergent points of view. The SGIM25 Program Committee has already begun forming to start planning sessions and developing local partnerships for advocacy for our meeting in 2025. We look forward to seeing you in Hollywood, Florida, in May 2025.

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problem-based medication lists, or organize study results from voluminous medical records to support clinical decisions and streamline provider documentation.

SGIM should expand the dedicated space at future regional and national meetings for presentation of research and programmatic innovations addressing asynchronous care to drive change as it has for past healthcare dilemmas. Similarly, until asynchronous work is right-sized, SGIM needs to advocate for adequate time and meaningful credit from our hospital leaders. SGIM can be part of the solution by lobbying for work-credit for clinicians as their asynchronous workload skyrockets. Creating agreed-upon asynchronous care practice standards among our membership will not only improve our ability to effect change among healthcare organizations but also reinvigorate the sustainability of a primary care career.

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the curriculum in both the small- and large-group settings (median 4, IQR 1 and median 4, IQR 1). Although residents agreed that intervisit care was an important aspect of patient care prior to the curriculum (median 4, IQR 1), they agreed more strongly that intervisit care was an important aspect of patient care after the curriculum (median 5, IQR 0). We also asked residents about factors that negatively affect their ability to perform intervisit care on a Likert Scale from no impact (0) to severely negatively impact (10), and residents' identified time as the biggest barrier to performing intervisit care (median of 7, IQR 2), followed by system factors (median 6, IQR 2), medical knowledge (median 5, IQR 3), and care team support (median 4, IQR 3).

On review of our curriculum, residents' perceived baseline confidence in managing intervisit care was initially low, but brief educational interventions yielded a significant increase in both their *perception* of intervisit care's importance and their *confidence* in managing intervisit care. This combination—low resident baseline confidence with high perception of intervisit care's importance—highlights the necessity of intentional intervisit education, which aligns with prior findings suggesting a need for explicit teaching of indirect patient care activities such as intervisit care.[5]

This was a small pilot curricular change and, although successful, leaves an opportunity to determine the ideal curricular delivery of this content. We believe that partnering with residents to improve confidence in managing intervisit care is a necessary first step, and we continue to work to optimize future iterations of this curriculum. Areas that need ongoing attention include the development of well-established metrics for assessing intervisit care. The lack of metrics limits our evaluation of the curricular impact on clinical outcomes, intervisit efficiency, and physician burnout. SGIM members can assist in improving intervisit care by creating and disseminating metrics of intervisit care used across their health systems.

Residents identified time and system factors as major barriers to the management of intervisit care—it is crucial that these are addressed in intervisit education. We believe that intentional education on intervisit care can reduce time as a barrier through improved intervisit knowledge and skills and explicit acknowledgement of time as a limited resource for physicians. Though our large-group curriculum broadly addressed system-based factors, we were unable to address nuanced site-level resources due to the nature of our multi-clinical site residency program—this is better addressed in smaller group settings. We also acknowledged the overall ongoing system limitations through open and dynamic conversations; this transparency helps trainees identify current opportunities and increase preparation as they transition to independent practices.

There are also unique challenges for intervisit care in residency, including prolonged time away from clinic and competing inpatient and outpatient demands. To combat these factors, it is imperative that intervisit education be combined with residency- and clinic-specific policies that support residents in providing this essential aspect of clinical care.

In conclusion, our pilot showed that the introduction of a novel intervisit curriculum for internal medicine residents, in both small- and large-group settings, increased resident confidence in managing intervisit care and recognition of its importance in medical care. However, more work is needed to further refine our intervisit curriculum to identify best practices for delivery as well as develop metrics for assessment to ultimately achieve increased efficiency and improved patient care. SGIM members should begin (or continue) to intentionally teach trainees intervisit care at their respective institutions and disseminate lessons learned, best practices, and metrics for assessment. This will improve intervisit education for trainees and intervisit care for all internists. Given the impact on inbox messages and physician burnout, effective intervisit care skills will be crucial to the longevity of the physician workforce.

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when severe hemolytic anemia is present. Entecavir, a selective inhibitor of hepatitis B virus replication, has shown to be well tolerated and beneficial in the treatment of hepatitis B-associated acute liver failure and can be considered in G6PD deficient patients with severe hemolysis precipitated by acute HBV.[2,3] This clinical case was unique in that this is the first reported case of severe hemolysis and renal failure precipitated by acute HBV in an undiagnosed G6PD deficient patient. SGIM members should always consider G6PD deficiency as a cause of unexplained hemolytic anemia, especially in patients with newly diagnosed hepatitis. Moreover, prompt consultation with gastroenterology and hematology can lead to better clinical outcomes.

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ureter, and bladder. Still, nonspecific findings led to difficulty in differentiating EPAs from other prostatic pathologies.[2] CT scans that show gas formation and abscess are considered the first-line diagnostic tool.[4] Imaging helped establish the diagnosis of EPA in our patient.

EPA patients are commonly treated with TURPs, which require caution due to the risk of a high-pressure system propelling bacteria into the systemic bloodstream. Aspiration under ultrasound guidance can be performed but may be difficult due to the ultrasound wave reflection from the gas and interference of shadows from air and calcifications.[2] Surgical drainage of abscesses is critical for treatment. In prior published articles, antibiotic combinations included either a third-generation cephalosporin or quinolone alone or with metronidazole or gentamicin for 4-6 weeks.[2] We used IV penicillin G, which successfully treated his infection and added to the clinical base of potential therapies for EPA cases dependent on the identified pathogen and sensitivity.

While transurethral radiofrequency needle ablation (TUNA) is a treatment for benign prostatic hyperplasia treatment, EPA can be a rare complication. After this procedure, prostatic tissue undergoes edema, hemorrhage, and coagulation necrosis of smooth muscle, eventually obliterating the blood vessel lumina and transitioning to hemorrhagic necrosis.[5] While rare, the potential for an EPA could be considered when performing TUNAs.

In conclusion, EPA cases are uncommon, serious infections caused by various bacteria that can cause high mortality if they are not quickly diagnosed and treated. Due to nonspecific symptoms, SGIM members should maintain a high index of suspicion for EPA in patients with known risk factors like diabetes or presenting with nonspecific symptoms discussed in prior cases, such as dysuria, increased frequency, fever, and malaise. CT scan and ultrasound can assist in making the diagnosis. Prompt diagnosis leading to surgical drainage and systemic antibiotics are necessary for treatment and improved morbidity and mortality. Future research could describe long-term sequelae and outcomes of patients with this clinical entity.

SGIM *Forum* clinicians should know that male patients presenting with symptoms of a UTI and perineal pain could have prostatitis. For patients with signs concerning for sepsis, clinicians should have a low threshold for obtaining clinical imaging to confirm the diagnosis of prostatitis and the presence or absence of air in the prostate gland. Most patients do not have long-term sequelae with appropriate treatment for their infection.

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43% quit by the end of January."[2] In sum, a glass half-empty view is a failure rate of 43%; a glass half-full view is a success rate of 57%. As a physician, I would be overjoyed at the prospect of a 57% behavior change rate for my patients over the course of a month and perhaps a year.

What are the reasons for failure? Richard Batts, an instructional design coordinator for the Fisher Leadership Initiative, writes:

"There are four reasons why people seem to fail at New Year's resolutions.

1. **Goals should start at a time of change...**Goals are your vision of what you would like the future to look like. If you are setting a resolution for tradition's sake, then your motivation will be lacking.
2. **Expect Obstacles...**There is always a chance for an obstacle. To keep your optimism, identify obstacles and create plans to avoid barriers.
3. **Set goals into challenging, measured but smaller chunks...** Goals that are measured will not only show your progress, but will inspire you when you see the data. It also gives you a chance to celebrate small wins.
4. **Accountability...**Accountability means that you are responsible to someone to accomplish the goal; this can be motivating."[2]

We often ask our patients "what is important from your perspective that we cover during your visit today?" Specifically asking them about their 2024 resolutions is another way to determine what is important to them.

SGIM members can help their patients with behavior changes by helping them set realistic goals for the future and capitalizing on their new resolutions. Although the resolution may be set due to tradition (which is more likely to fail, according to Batts), we should capitalize on our patient's interest in changing behavior. SGIM members can help patients develop plans to overcome obstacles and setbacks as we do this regularly with our care plans. We can help patients celebrate small wins as part of the bigger health plan (e.g., that first week of no cigarettes, the five-pound weight loss, or the improvement in their blood glucose readings).

Finally, many patients wish to avoid disappointing their physician. This physician-patient relationship can assist with the patient's resolution by providing the accountability needed to achieve success.

As we start 2024, many SGIM members have made personal resolutions. Why not add a professional resolution this year? My resolution this year is: As an individual, I resolve to keep my personal 2024 New Year's resolution going longer and achieve my goal. As a physician, I resolve to ask my patients about their 2024 resolutions so I can better understand what is important to them and what behaviors they are motivated to change. SGIM members, do you want to join me in this resolution for 2024?

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patients with mantle cell lymphoma are seen in GIM clinics, and thus, primary care clinicians should be aware of this form of mantle cell lymphoma. Patients with new weight loss and either lymphadenopathy or a history of mantle cell lymphoma should receive an evaluation for the aggressive subtype of this disease described in the case above.

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SGIM Forum
Society of General Internal Medicine
Society of General Internal Medicine
1500 King Street, Suite 303, Alexandria, VA 22314
202-887-5150 (tel) / 202-887-5405 (fax)
www.sgim.org

BEST PRACTICES *(continued from page 7)*

OT into clinical care may reduce workload and time pressures for physicians. This is particularly applicable to time-intensive processes, such as improving treatment adherence and reducing unhealthy behaviors, where OTPs can work with patients to make healthy adjustments to unhealthy activities. Clinicians in primary care and subspecialties may see patients only a few times per year or may not have time or expertise in behavior change to identify the meaning behind specific unhealthy habits. OTPs often can see patients more regularly and are situated to support lifestyle habit changes. Expanding interprofessional delivery of care where OTPs promote necessary behavior change can allow all clinicians to practice to the top of their license, delivering comprehensive care to patients.

Occupational therapy practitioners can also work with individuals using a preventive approach, mitigating risk of future bodily pain and physical and mental health declines.[3] Preventing functional decline decreases need for caregiving and other social services (e.g., prepared meal delivery). Thus, physicians should strongly consider OT referrals, even for relatively healthy patients.

As primary care, geriatrics, and other medical specialties adopt age-friendly principles of care, with explicit inclusion of and emphasis on what matters most to patients, OTPs can contribute to improving health outcomes. Occupational therapy professionals are meaning-making healthcare experts who help patients flourish through purpose-filled activity. SGIM members are encouraged to consult with OTPs and capitalize on their unique and tailored expertise to better integrate meaningful activities into patient care.

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The ISSN for SGIM *Forum* is: Print-ISSN 1940-2899 and eISSN 1940-2902.