Reflections on 45 Years As a Clinical Hematologist

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How I Chose Hematology

I became interested in hematology while working as a hematology technician during the summers after my senior year in high school and first two years of college (1963-1965). I loved looking at peripheral smears and immediately became hooked. My enthusiasm continued even after the hospital where I worked purchased a Coulter counter in 1965, which took away much of the fun of pipetting small aliquots of blood into a hemocytometer and doing a hand count of the white cells and platelets. Suddenly, a CBC took only 5 minutes instead of 30.

In late 1976, my wife and I left the northeast—where I was raised and had completed my training—for Tucson, Arizona. Tucson is a high desert, midsized city that is surrounded by four mountain ranges and offers many outdoor activities. Another major draw is the University of Arizona, including its medical school. I began practicing internal medicine, hematology, and oncology on December 6 of that year. I joined a multispecialty internal medical group with an emphasis on rheumatology; the opportunity to focus on immunohematology was very attractive.

Solo Practice

In 1979, the group practice disbanded, and I was on my own. I rented office space from an established hematologist/oncologist, and we shared coverage. A small loan of $5000 allowed me to open my own practice, as my overhead was minimal. Medical practices did not need to invest in computers in the early 1980s, and electronic medical records didn't even exist.

I was diligently building my referral base, but I still relied heavily on general internal medicine to make ends meet. My referral practice developed slowly. For many months, my most interesting "consult" was from a veterinarian who showed me a peripheral smear from a rabbit. I learned that healthy rabbits have circulating nucleated red cells.

Most of my hematology patients fell into the benign category. I have compared my consultative practice to panning for gold. Perhaps one of every five or ten consults was of considerable interest and challenging. Eventually, I was doing up to a hundred new consults a month. My practice became a treasure trove of fascinating hematology, both benign and malignant. For the past 15 years, my practice has been 98% hematology.

I continue to enjoy doing hospital consults and reviewing peripheral smears. This necessary exercise has led to the immediate diagnosis of numerous cases of microangiopathic hemolytic anemia and half a dozen cases of acute progranulocytic leukemia that quickly led to curative therapies in all. Of course, at the other end of the spectrum is in vitro platelet aggregation, which quickly (and inexpensively) ended the need for further hematologic input. Having done so many hospital consults for thrombocytopenia, I compiled my experiences in a paper that will be published later this year in *The American Journal of Medicine*.

US Oncology

After 20 years in solo practice, the writing was on the wall. Coding for drug reimbursement was becoming opaque and complex, and denials for expensive medications were increasing. I was a decade younger than my covering colleagues who were contemplating retirement. I would have been without coverage, and attempts to recruit new associates failed. I sold my practice to US Oncology, which was a decision that enormously enhanced my career.

For many years, a firewall existed between research and clinical practice. The university medical centers did the investigations, while the community physicians supplied them with patients. After my training at Washington University in St Louis and at Harvard, I knew that I would pursue a clinical practice rather than an academic career. With US Oncology, however, the town-gown divide was bridged because US Oncology emphasized and encouraged clinical research.

I became a US Oncology sub-investigator for studies in lymphoma and CLL, which have been published in journals. The fact that I see so many hematologic disorders in my practice has led to collaboration with investigators from many renowned institutions. For example,

I was able to participate in phase 3 studies in idiopathic thrombocytopenic purpura and in both cold and warm autoimmune hemolytic anemia. These studies are professionally gratifying, but what brings still greater satisfaction is the ability to offer patients entry into clinical trials when responses to conventional therapy either have been exhausted or are not likely to be beneficial.

At the heart of it all is the pleasure derived from caring for patients, many of whom I've known for more than 20 years and have come to see as friends. These relationships are the most memorable ones from my practice and will help sustain me after I say goodbye to 45 years in hematology.

What to make of these relationships? What causes them to flourish or wither? Perhaps it is an unspoken covenant in which the patients put their trust in the physician, and the physician pledges to be both compassionate and knowledgeable. The compassion consists of an accumulation of small acts of kindness, such as visiting a patient nearly every day in the hospital—often without charge when hematologic input is no longer needed, sending thank-you notes for gifts, writing sympathy notes to families, and phoning with test results.

Knowledge can come from many sources, including observing what surrounds you. I recently presented a poster at the 2019 ASH annual meeting about iron deficiency caused by iron malabsorption related to PPIs. I had been seeing patients with obvious iron deficiency who had normal GI workups and no menorrhagia or bariatric surgery. All were unresponsive to oral iron, and many were taking PPIs and had elevated gastrin levels. Virtually all have responded to IV iron. Once I thought about this phenomenon, the answer was in plain sight.

What Next?

My last day in practice will be June 30, 2020. I will retain my medical license but will no longer care for patients. Two years ago, I stopped seeing patients on Fridays. I now work 3 1/2 days a week, which is the minimum required to retain partnership status in my practice. Starting May 1, I will no longer see new patients. A few years ago, I began to cut back on hospital consultations. I have assembled "Team Boxer," which includes my lawyer, accountant, and stockbroker/financial planner. A letter announcing my retirement has been sent to physicians and patients. The letter to patients is not only a courtesy but also, very importantly, a legal document. Without such a letter, one can be charged with abandonment of patients.

We all know about MRD, but upon retirement a different acronym—RMD (required minimal distribution)—may generate considerable financial angst. Unless one has a Roth IRA, previously untaxed income distributions from an IRA will result in substantial taxes, especially when combined with untaxed 401k withdrawals and unanticipated mutual fund distributions. So be prepared.

I am nearly 75 years old, but I think (perhaps delusionally) I still may have a purpose in hematology. I have offered my services to drug companies, medical foundations, and professional societies. I could participate in rounds with residents and fellows. I have proposed to a local hospital that we undertake a community outreach program about the consequences of aging bone marrow. I am working with others to create an artificial intelligence algorithm for a rare hematologic disorder. I am not worried. I have worked steadily for 60 years, however, so retirement will require some adjustment.

Many experiences await. These include longer, more frequent trips with my wife; visits to children and grandchildren; ski trips, hikes, and lecture series; reconnecting with friends; and gazing at the majestic Santa Catalina mountains, especially at sunset.

I have had a full and rewarding career and survived the cold winds of constant and inevitable change. At the center of it all are the patients.

Upon the death of a patient, I send a handwritten condolence note to the family of the deceased. I like to write, "may his/her memory be both a comfort and a blessing," which is inspired by a Jewish expression of condolence.

My practice has been a comfort and a blessing to me and, I hope, to many of my patients as well. The memories will sustain me for years to come.

Advice and Reflections

- Try to reduce your workload as you age.
- Consult with legal and financial experts, and be aware of significant tax exposure.
- Decide how much patient care you want to assume.
- Find out how much time off your group will allow, and whether an emeritus status is available that is appropriate for your needs.
- Be flexible because change is constant.
- Be observant because new knowledge is everywhere and often hidden in plain sight.
- Be patient-centered because everyone appreciates a thank-you note or a phone call (especially when your new office phone system loses most of your incoming calls in the cloud).
- Be patient because success will eventually come.
- Always look at the peripheral smear.

Would you like to write about your exit from practice? If so, contact us at info@clinicaladvances.com