

Forward to Basics In Family Medicine

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Welcome to the new, improved horse and buggy days!

Imagine a general medical practice with an overhead of just \$10,000 per year, a minimum gross personal income of \$42,000 with 12 weeks vacation. Imagine office charges for this base income of only \$10 per patient!

Impossible you say? It couldn't be in the United States? Though I have not yet completely reached these goals, I believe they can be, with God's help, and I am well on the way. I wish that I could give you a fact sheet showing successful figures for a few years, but I am just in the process of following the Lord forward into an old fashioned way, forward to basics. I think this is the way of the future. When I first began the changes in my practice, patients were confused and would ask me what on earth was I doing. I would answer, "I'm going back to the horse and buggy doctor days." That didn't sound right to me, and after a few weeks I began saying, "I'm going FORWARD to the horse and buggy doctor days." Then something hit me and I said, "Welcome to the new, improved horse and buggy doctor days!"

Let me lay out a few features of the program, then tell you a little about how I believe God has led me here and why. I have no idea how many doctors God may be stirring in a similar fashion, but my desire is to see more and more doctors finding a way to deliver quality care to the body of Christ for a reasonable fee, and to the community at large as an outreach to the lost. We need a new missionary zeal in the medical profession, a fresh look at the ministry of medicine, and a turning

away from the "big business" approach to medical practice.

People in the United States need a "missionary" approach to medical care - not free care, but affordable care. Most doctors have built barriers around themselves that prevent them from seeing the needs here at home. We have allowed our advisors to set up our policies, and together we have instructed our staff in applying the policies so that we are separated from patients in need.

In general, the patients in real need will be intercepted by our policies and never make it past the front door. The few not intercepted are the very assertive ones or some whom we know from church activities. Let me say that I primarily write from urban experience. I am sure that there are some doctors in rural areas who know almost everyone in their community and understand their needs. But this understanding is probably almost totally lost in the majority of communities.

In small towns of the past "doc" knew everyone, and saw them all around town. He knew when they were having a rough time financially, when the cow had dried up or died, and he knew their character. If he heard they were ill and didn't have money for his services and were "too proud" to ask for help, he likely found some way to stop by casually and offer help. He probably would accept payment in kind for services and could walk away feeling truly compensated, if not monetarily, knowing that giving to the poor is lending to God (Prov. 19:17). But, I suspect even the rural doctor has been mostly overcome with the world system of how to "properly" do the "business" of medicine.

The purpose of this article is to tell where God is calling

me, and to affirm to some of you with a similar unusual call. You are not alone. There are other strange people out here. For those of you who are already doing something strange, thank you. There are more of us coming and we would appreciate your help, communion and communication.

How can you make \$42,000 a year with 12 weeks vacation, charging only \$10 per visit? Over the years, I have had a nurse or secretary call in ill and have had to continue the office without a temporary person

to fill in. At times, when a nurse quit, I would do all the back office work, until I found a replacement. The strange thing was that I frequently found that I could do all the work with very little extra effort. Overall, I began to suspect that I might not need any staff at all if I made some radical changes - radical to the mind has been brainwashed by modern thought, at least.

A recent newspaper cartoon depicts a father and son sitting on their ant hill. The son says, "Dad, what's 'technology'?" The father replies, "That's a euphemism for commercial exploitation." I am convinced that the largest portion of medical practice requires neither a large office filled with the latest equipment nor a large ancillary staff. With my experience prior to January, 1989, I suspected that I could see 20 to 25 patients per day with no staff at all, and that is what I began doing on January 2, 1989.

I have rarely had more than 20 patients, but I am confident that I can see 25 per day in a typical eight hour day, and have proven that to my own satisfaction. If I were to take every weekend off, three weeks vacation, three days for education, six holidays a year, and 52 half days off, that leaves 211 days to see patients. Twenty-five patients per day times \$10 per patient comes to \$52,750 per year gross business income. With \$10,750 overhead that leaves \$42,000 for gross personal income. This does not consider that some patients can pay the regular fees of around \$30 per visit, some patients will have sufficient income to afford a fee of about \$20 per visit, some patients will be having longer visits and will be paying more for that extra time, and some patients will be having lab work done, EKG's, suturing lacerations, removing lesions,

etc., which will add considerably to the income.

My actual experience in 1989 was that I made \$63,000 gross business income working in the office only about two and a half days per day! About \$12,000 was income that was floating with insurance companies from 1988 and came in the first two months of 1989. All the rest of the income was "cash on the barrelhead" - right at the time of services. That year, I was (and still am) spending large amounts of time "getting up to speed" in certain areas spiritually. I have spent a lot of time on the phone, going to meetings, reading, writing, praying, and waiting for patients.

It has not been a "bed of roses", and I have battled with my lack of faith in what God is doing. I also still was saddled with some aspects of my old style of practice which still required high overhead of about \$14,000 per month. Over that year, much of that was shed, until the major portion came off in December, 1989. There are still some aspects of the overhead that need to be trimmed, but at this time my overhead is about \$1200 per month, a decrease of more than eleven-fold!

I now sublease from a surgeon who is in his office only about six hours per week. God is providing exactly what I and my family need as He is leading us into this new area where I believe the family will be involved in the practice in some way. We are being disciplined by God to trim our home lifestyle and seek exactly how He would have us live in these times.

I believe that my family needs to be involved with the medical ministry and my medical practice needs to revolve around my family. This aspect is not completely clear to me yet, but I think God is going to be leading me to have my practice to some extent - possibly to a major extent - operating from my house. If I could do this, the family room would be my waiting room during the day. The family bathroom would be the patient bathroom. My office could be a little larger and be a combination office/exam room, or the exam room could double as a study room for the children at night. With this double use, I would only need about 200 square feet extra space in my house and even that would be mostly usable for the family, too.

WHERE HAD I COME FROM?

I had a fairly good practice going from 1978 to 1988. There was a steady buildup to a comfortable level and all appearances of slow growth continuing, especially as I succumbed to joining some of the HMOs and PPOs in the Phoenix area. My personal gross income was about \$72,000. A good chunk of that was going to pay off a large loan I had taken out to start practice, and the IRS considers that personal income (I wasn't incorporated). With some fine-tuning of the overhead, etc., the personal income could have been increased to closer to \$100,000. Of course, I was living at or beyond that level.

How far beyond I was soon to find out. I had a business consultant, a new computer system to handle all the HMO and PPO paperwork, a secretary and one nurse. With some more influx of patients I would probably need more staff, but would be making more money. I wasn't overworked, putting in only about 35 hours a week including hospital and paperwork, and only covered one weekend in five, switching call with four other private GP/FPs in a congenial manner.

Two years ago, I dropped my malpractice insurance. That could be a topic in itself, and I must say that it may not have been well thought through. But, it was a "necessity" since I could not afford the premium.

I had toyed with the thought for 15 years, always succumbing to the norm and disgusted with my gutlessness. I am sure that most physicians have entertained the thought many times. "Forced into" this situation, I believe by God, I finally said that I wasn't going to pay protection money to the extortioners any longer, and I "went bare."

Dropping the malpractice insurance meant that I had to drop out of all the HMO and PPO programs. I hated these programs and it was a relief, at least in the beginning. Then I found out just how much of my income derived from these programs I lost about 70% of my gross business income overnight! You may say that, with a fancy computer system, I should have known what to expect. I did have a good idea of what was going to happen. I just was hoping that it wouldn't.

I was sure God was leading me, but He had not shown me the end of the matter. There was a lot of pain in many ways during this time, and that pain has been continuing in many ways, with many people telling me how crazy I am, that this change couldn't be God's way, etc. The further I go on this way, though, the more sure I am that God is leading me, and that I must not rely on worldly assessments of success, and worldly wisdom for business dealings.

The loss of income from HMO and PPO patients began severely squeezing me in the latter half of 1988. The Phoenix area is heavy in alphabet soup insurance - about 80% of all patients with any insurance are in such programs. There remains a pool of only 20% spread all over the city, and with their doctors already chosen. A vision for a home-based, church-based medical practice which I had in 1978 was coming to pass. I don't yet see exactly what it is going to be, but things are taking shape.

On January 1, 1989, I said goodbye to my secretary and nurse, and began running my office with no staff people. My main phone number is answered by an answering machine that tells callers to come directly to the office during regular office hours and that they will be seen without appointment. Then, it gives patients a phone number to call for urgent problems, followed by the office hours and address. Finally, it gives them a phone number for non-urgent messages. This arrangement could be simplified in some ways, but seems to me to be necessary for the time being, especially with the Arizona Board of Medical Examiners' scrutiny of such novel practices.

PATIENTS AS MEDICAL RECORDS CUSTODIANS

I began giving each patient his/her chart. They take the charts home, and are told to bring them in when they come to see me. Oh, what a ruckus this practice has raised in some of the medical community! I love it and the patients love it. It works great! Patients almost never forget their chart, they enjoy reading it, they remember much better what I said was wrong, what I intended to do, what lab tests were for and the results, what I found on the exam, etc., If they need to see a

specialist, I usually write a little more of a summary note for his/her benefit, but may not. If the specialist needs a copy of any of the chart, it is directly available to him.

Have you any idea how much your office spends in actual dollars for a copy machine and supplies? Do you know how much time your office personnel spend in copying records? I estimate that half of all visits charged to an insurance company will elicit a letter from that company demanding a copy of the chart. At least half of those copies will be "lost" and a second copy demanded. Every time a patient applies for new life or health insurance, the company sends for a copy of the chart. I believe that the staff of an office seeing 25 patients per day will spend at least 3 hours pulling, copying, and re-filing charts or doing similar work. This does not include postal costs. Why should we do this?

Furthermore, consider all the requests from attorneys. Yuck! If patients have their charts, they can make the copies and do all the paperwork. It is their insurance anyway, isn't it? Eventually, this practice could save money for everyone, since the insurance company wouldn't need to pay \$35 for the "attending physician's statement," which almost always requires only a copy of the chart anyway. If something else is needed, the patient may come in and pay for an office visit as they should in that case. If it only takes two minutes you can charge a minimum fee instead of ripping everyone off with the usual \$35 fee. I know that many offices look at APSs as a good way to make an easy \$35. I consider it borderline insurance fraud, and it is certainly a waste of a doctor's time.

Giving patients their charts started something I never dreamed of with the Arizona Board of Medical Examiners. God won a victory on my behalf in regard to this matter, of which more below.

A few other issues related to the keeping of charts by patients need explanation. If I get a call on the phone, I can have the patient read me the information in the chart. Neither I nor a nurse need to pull the chart or put it away. (If you haven't done this work for yourself, you cannot imagine how much time it takes and the hassle it is to do for one patient, much less an entire day's patients). If I am not in the office the information is still

available to me since the patient has it and can read it to me. If I need to see the patient, we can meet anywhere at my convenience, since the chart can be there, I can make my note in it, provide a bill, accept payment, and all is taken care of.

Because this last aspect is exciting to me, I want to enlarge on it. I love to go to meetings and seminars with Christian friends. I hate to be interrupted and have to leave. Patients are more than willing to come to where I am rather than go to the hospital emergency room, and they are frequently exposed to some interesting things about the Christian life by coming to such meetings. I have told them how to find me, and no one has yet refused me some private room for an exam. Children can be easily examined in a car seat, and I have done this frequently in the past fourteen months. It is exhilarating. Also, since the patient has come to me, it takes me no more time than a regular office appointment, so I rarely charge extra for evening or weekend calls at this time. Most doctors charge an extra \$40 to \$100 or more over the office charge for after hours emergency visits.

From my point of view, and patients seem to agree, I seldom get behind any more than I used to when I took appointments. Patients usually wait only a few minutes, possibly an average of 10 minutes. Occasionally, I do get 30 minutes behind, and rarely as much as one hour. When I get behind, I will tell the patients in the waiting room, try to ascertain if some problems are urgent, and give the patients an option to return later or continue to wait.

My waiting room has become a social center. Patients interact constantly, keeping up what occasionally sounds like a party. It is not unusual to say goodbye to a patient only to have them sit down to have a conversation with someone they know. Also, some waiting patients invite the next patient in, saying, "Why don't you take him next? He seems sicker and I'm not in a hurry."

Lab and X-ray results are somewhat of a problem. Most semi-urgent problems will be requiring a recheck fairly soon, so I tell the patient that if the results will not be requiring a change in treatment, we can discuss the

results in a few days. If I suspect the patient will be anxious, I will call the results. When I see the patient for follow-up, I will put the result in the chart. But, I have accumulated a stack of lab and x-ray reports on patients who did not need in-office follow-up or who did not return as recommended. These are kept in an alphabetical file folder. A total of just over 100 pieces of paper representing about 50 patients has accumulated. I may mail these out to them to be put with the chart. Occasionally, I hand patients an envelope and have them address it so that I can mail reports to them. There are other ways to streamline this aspect.

What is the negative side of these practices? I have not yet noted many. Early in the process, I did get many requests for copies of lab and X-ray that I should not have gotten, but now only a few. Patients know that if something extra is needed they need to come in with the chart and perhaps get a short disability exam for a dictated letter.

MALPRACTICE IMPLICATIONS

What about the malpractice aspect? We have been told for years that we need to keep a tight grip on medical charts or patients may be able to sue us. I could never quite understand this view. I suppose we have been convinced that there is a lawyer waiting to look at our charts to find something for which he can convince the patient to sue. I have decided to trust God in this area.

The other big concern always brought up in this regard is that the patient may make changes in the chart which would put the doctor in a bad light, allowing a lawsuit. An article published in 1978 discussed the concepts of despoilation and despoiler' Whoever alters, loses or damages evidence is a despoiler, and their actions are called despoilation. Courts have decided that whoever damages evidence must have done so to benefit their side of the case and that no one should benefit from damaging evidence.

Since only doctors have generally kept medical records doctors are generally the "bad guys." But, it should work the other way, too. When patients have the charts, then despoilation removes ground for adverse

use of the chart in the suit. In the usual situation, the doctor has all the hassle of the charts yet the patient has legal access to the chart, and all the legal onus falls on the doctor. When patients have the chart, they have the hassles, and I have the legal benefit. With this in mind, I believe that I am safer with my new practice than in the old system.

FEEES FOR SERVICES

What about charges? I have a set of standard fees that I believe are fair for all patients. They are lower than most of my colleagues' in two ways. First, the fee for each services is, in general, somewhat lower. Additionally, some of my colleagues are practicing what could be construed as a variation of the "bait and switch" game so often played by butchers. Patients are told what the usual charges are, but almost all visits end up being charged as a longer visit. Various lab tests can always be suggested. Patients are frequently anxious to have "something" done. They are impressed with our technology [commercial exploitation?].

Most HMO and PPO and Medicare patients never realize that they were charged for a longer visit, or in some cases, for a procedure that was either never done or claimed to be longer or more extensive than it really was. Their unawareness occurs because they make only a "co-payment" or because the doctor accepts assignment for Medicare. The patient never sees the bill and they, generally, don't care, thinking: "the government/insurance is paying for it. It doesn't cost me anything." What ignorance!

For patients without insurance my fees are discounted across the board, even if the patient makes quite a bit of money. Those fees are \$25 for a first time visit, and \$20 for regular visits after that. Recheck visits for ear infections, pneumonia, bronchitis, and so on, are usually \$15 to \$10, sometimes \$5. If the patient brings up an "Oh, by the way . . ." at a recheck visit, that will usually become a regular visit unless it is something very short.

I believe patients and doctors need to return to a system of exchange which is mutually acceptable, and I have found that there is something very healthy about my personal presentation of the bill to the patient,

observation of their reaction, and response to that reaction. We reach any needed compromise and I collect the payment myself. I believe that this practice will lead to much more honest system of charges and an important interchange in which doctors will find out something about their patients' financial status.

Just two months after I began this system God impressed on me not to put anyone in debt for my services. Reasons for avoidance of indebting patients are not abundantly clear to me, but it has something to do with the following impressions I had at that time. Patients should not be coerced into borrowing money for medical care (I believe God wants His people to refrain from borrowing money for anything), and I should be sensitive to this. If a patient cannot pay the fee I have set, we need to do some kind of negotiation at the time.

Patients need to take personal responsibility for the time and effort they request. (As an aside fitting here, it should be noted that I make all my notes in the patient's record in their presence. Thus, the patient sees and hears virtually all that I do for them and with their chart. This practice helps prevent erroneous ideas of how much of the doctor's time has been required.) Doctors should do some charity work, but their whole practice should be ministry in some way with every patient. So, if a patient indicates dismay at the charges, I find some way to inquire what they can afford and can decrease the charges to that amount.

I believe there should be a minimum of \$5.00 in order that the patient retain some responsibility. If a patient indicates ability to pay in the next week or so I will possibly write some off and wait for the rest, but I have never used a collection agency with brethren and never will. However, I have to be careful not to keep account in my heart in some way, allowing bitterness to creep in. In general, I now believe that patients unable to pay my bill in one to two weeks should not have the bill "held over their head." I may keep the bill for some time, but usually write it off. I have had a few patients to insist on paying me twice what they owed when they "struck it rich" two or more years later.

It is amazing how many people pay the charges in full at

the time of the visit - about 99%. In fourteen months only two checks have bounced. One was a simple error and was replaced immediately. One was a wrong mastercharge number with a check to replace it shortly. When patients perceive that charges are "fair" they are generally happy to pay the full amount.

WHAT TROUBLE HAVE I HAD?

(1) Some patients couldn't handle the new system and left for another doctor.

(2) Some patients have been disgusted at the answering machine and want to talk to a person in the office. Many want a free phone consultation from me. Most phone conversations, however, are an incredible waste of time.

I estimate it takes five minutes to listen to the patient's symptoms, another five to schedule an appointment. Twenty-five patients a day times five minutes to schedule and five minutes to listen to symptoms is over four hours of your staff's time, every day! I have concluded that people are either sick enough to be seen and pay for my services or they are not. For me to presume to be able to tell people over the phone whether or not they need to come in is a very dangerous game to play, disregarding the wasted time and the frustration. I do return every call I receive. It appears that patients who chronically produce nuisance calls are migrating to greener pastures or learning that they have to come in and pay for services.

(3) Early in the implementation of the new system, some pharmacists would call and never leave a message, thinking that eventually someone would answer the phone. Both they and the patient needing a refill would get upset. Simply listening to the message and leaving their own message would have solved that. I have learned to give patients enough medication to last until they should be better or are supposed to return for a recheck visit. It has worked very well and I now receive only one call a day for a refill, usually an error on the patient's part. With more time in the system, I expect the problem to clear up.

Actually, I think that the answering machine would be

preferred by pharmacists. Instead of calling and being put on hold for the nurse, giving the request twice or more, waiting for the nurse to give the message to the doctor, etc., a simple call now suffices. It does require that they endure listening to the message, but during that time they could type a medication label or some other chore.

(4) Conflict resulted with the State Board of Medical Examiners (BOMEX). This was exciting! I had no idea that I might elicit any problems with BOMEX. About two months after implementing the system, I received a letter from BOMEX stating that they thought I was in violation of the Medical Practice Act of Arizona. The board had several areas of concern. Their letter was fascinating. They knew as much about what I was doing as I did! Evidently, someone had called anonymously and complained. Initially, the board was concerned about several areas. Following are these concerns with a short version of my reply:

(a) No one answers the phone. Was I really available to patients when they needed me? I wear my pager in the office, and the answering service calls me in the office if someone needs me. But patients with urgent problems during office hours should be even more likely and responsible to come directly to the office. Virtually every doctor has an answering service, most of which are now initially answered with a machine, for a majority of the hours of the week.

(b) I do not have a female chaperone for female exams. This situation could be a problem. When I still had my own office, I had on the recording that a female chaperone or the patient's husband should come if the patient needed a female exam. I did not require that the chaperone be in the exam room, but merely in the office area. This weakness in the system has a couple of solutions. I am now subleasing from a surgeon who has a secretary. I do not have her come into the exam room, but she is in the office area. Better yet will be if I work in my home, my wife will be around as chaperone.

(c) If my patient needed to see a specialist or to go to the emergency room, and I did not have the patient's chart, how would the other doctor have access to the

patient's chart? I really felt like getting sarcastic on this objection. My patients' charts are more available than ever to anyone the patient sees fit to give access to the chart.

(d) What if the answering machine malfunctioned? Again, I felt like getting sarcastic. Does no one else's phone ever malfunction? Do no other doctors ever have their pager batteries go dead, or forget to turn them on?

(e) How could I keep track of phone calls, requests for medication refills, etc. This objection may reveal a bit of bookkeeping weakness in my system. Since all my calls are from one phone, I keep a manila folder with plain paper in it. I start a sheet with the date and take the messages from the machine, leaving about one inch of space for each message. As I call and take care of the message I record what was done, then cross it out so that it can still be read, but is obviously finished. When a page is done I file it in a "message finished" file. Virtually everything I do on the phone is there.

I do not attempt to file these notes in the patients' files when they come in. I usually remember or ask them what we decided and make a short note of any significant phone messages, then continue with the day's business. If a person wanted to be compulsive they could use self-carbon message forms and keep them alphabetically, filing them as the patients came in or mailing them to the patient. I have been astonished at the unimportance of this issue. The important material is easy to remember, or the patient comes in.

(f) The Medical Practice Act of Arizona states that the Board or its designees can enter your practice without notice and demand to see any and all records pertaining to your practice. It is unprofessional conduct not to make these records available in a "timely fashion." I believe I can comply relatively easily. A sign-in sheet is kept for all patients by date. The board could request records from that list, or they could have me retain the records from all the patients who come in for a certain time period, or they could have a representative stay in my office and collect the records. I could rent a copy machine for a few days and copy the records, letting patients take the originals home.

I had a private interview with a board investigator - a semi-retired internist. We talked for about an hour. At the end of that time, he said that he really liked what I was doing, and he was going to recommend that the board drop the investigation. He said that I would have to come in for another interview if anyone on the board wanted to hear more.

I walked out and told God that I would prefer not to go back. I am an original gutless wonder, and have a really hard time with confrontation, being so easily intimidated that it shames me. About four months later, after I believed I was "home free" I received a letter summoning me to an open hearing with the entire board and their lawyers. They reiterated that they felt I was in violation of the Medical Practice Act in "improper medical record keeping and other unusual medical practices." They said that they did not mean the rest of the letter to be intimidating, but that they recommended I come with legal representation. Miserable comforters are ye all, indeed, "not meant to be intimidating!" To their original concerns they added a new one. When I read it, I almost fell out of my chair laughing.

(g) I allow patients to write their blood pressures, taken at home, in their charts. They also write in their home blood sugar tests and phone conversations with me. The board said they were concerned that my patients might not write legibly! (This reminds me of another advantage of the patient retaining the chart - specialists or visiting nurses can put in their notes, recommendations, etc., directly in and you don't have to wait for dictation.)

All of these things led me to read with great interest the Medical Practice Act of Arizona. Most doctors have not read their state act, or, if they have, have not read it carefully. In regard to legibility - in Arizona it is considered unprofessional conduct and a doctor can have his license suspended or revoked for writing illegibly. If the board decided to play hard ball on this item, I could cause much trouble around the state.

As for making records available "in a timely fashion" there is a clause which illuminates how much time may be involved. The clause states that patients who decide to switch to another doctor may request their records

which you must provide "promptly" lest you be found guilty of unprofessional conduct. While "timely" can be less than a second in a cardiac arrest, in my opinion, "promptly" is faster than "timely." A doctor should have at least as long to provide records as the board allows for the mailing of requested records when a patient switches doctors. In my experience, it takes one to two months to get records from most doctors, and frequently two requests. I should get at least that much time from the board. If not, I could report practically every doctor in the state for review on the same grounds.

Another problem was a section which states that a doctor has to provide the "records maintained by the physician." It does not say "kept on the premises." I believe that I do maintain my patients' charts by writing in them, providing the paper, etc. Your car may be maintained by one mechanic, but it certainly is not kept on his premises.

I felt that I had helped God with all these thoughts, and I was ready to go in and do battle for the Lord. Over the few weeks before the hearing, God continued to comfort me that He had it all taken care of, and that He would do the battle. I was to let go of everything, including my "right" to practice medicine. I went to the board meeting with incredible peace in anticipation of whatever God was going to do.

The board interviewed me for about 45 minutes, asking me why I was doing these things. I was able to explain much of what was going on, but God prevented me from presenting any "legal" arguments such as those outlined above. I had a good time answering their questions, and I am sure they were consternated, to say the least. No one seemed antagonistic. They couldn't understand what I was doing, but they didn't seem angry. A doctor who seemed very supportive said that she felt I was not in violation of the Act since I was keeping adequate records and she did not see that the Act required the records to be kept on the doctor's property.

This comment of hers elicited a negative response from someone and the board went into executive session to get an opinion of their lawyers.

After a few minutes we were allowed back into the room. The chairman made a statement that he felt I was in violation of the Act and that the board should find me guilty and make me stop doing whatever it was that I was doing.

He then called on a doctor who responded with, "What, making me the bad guy? O.K., I move that we censure Dr. Glanville and make him stop doing what he is doing." Wow! I felt like I was in the hot seat. Wait a minute, Lord. You didn't let me present any legal defense. I didn't even get the chance to say that I would stop or to make any "plea bargains."

No one would second the motion! The chairman said, "Motion fails for lack of a second." Another doctor made the motion to drop all charges. It was immediately seconded. The doctor who had moved for censure interrupted and said that they were setting a dangerous legal precedent and that they hadn't set precedent in eight or nine years. A lay person on the board who had seconded the motion to drop the charges interrupted and said, "Blazing trails!" A little ruckus began and the chairman settled it down. A vote was taken. Seven to drop the charges, three against, one abstained and two absent. With that, we were ushered out of the room.

I was in mild shock. My license had apparently been on the chopping block. Not to God, though. Many things went through my mind over the next minutes, hours and days. God had won the victory. God had wanted me to do this; it was a battle He had wanted me to enter into. Having patients keep the charts was not just a little whim on my part. It was a part of His plan for me and He had gone to this extent to confirm it to me, personally. Friends had advised me specifically against this aspect of my practice and, if the board had presented that to me as a "plea option" I am afraid I would have backed down and taken the option. Thank God, I never had the option!

This was "dangerous, legal precedent" for all doctors across the nation who may want to do this. (There probably are some mavericks who have done this for years.) How did it ever become illegal for patients to have their charts in the first place? What gives a board the right to govern some of the inane things they think

they need to watch over? Does the State really have the right to govern all these things? Is any of this part of a leftover "guild" system designed to keep others from knowing the secrets of the guild and so to keep outsiders out?

What could be the end of these things? If enough doctors would leave the system and get radical, how much could we cut off the costs of the surgery? Could we build our own hospitals again, not needing JCAH accreditation? We could take care of most simple problems in a much less expensive setting. If a general practitioner has about 2,000 to 3,000 people who look for him for their primary care, what would happen if each paid him \$30 per year? That would be an income of \$60,000 to \$90,000! If they paid \$20 each and then a \$5 office visit to help reduce frivolous visits it would be very interesting. Patients could still keep some catastrophic coverage.

The cost for a family of four for the usual private, non-group insurance (I do mean UNsurance) is about \$5,000 per year! Put yourself in the place of a man earning \$12 an hour, considered an excellent wage by most people. With no vacation or holidays, that is about \$25,000 per year. Health insurance of this sort takes 25% of his gross income!

In summary, I feel like a country doctor in the city. I know my patients again, and they know me. I remember their names much better than ever. Most of them seem like personal friends, and we have a good time during the office visits. I am ready to tighten the belt if needed, and plan to learn to live below my income, something I always said I was going to do, felt I should do, but never really did. I have always felt a "call" to ministry in my life, and began my medical practice full time with a Christian community and Bible study center. I was happy making \$6,500 the first year and was up to \$10,500 after four years. We had godliness with contentment, which is great gain (I Tim. 6:6).

That work lasted five years, then the community fell apart. At that time I felt God call me to start a "typical middle class medical practice, and to make it a success from a business point of view." Where that took me,

and where I ended up three years ago could best be summarized by Scripture to set to song, reverberating in my mind two years ago. It was not distracting, but rather pleasant and reassuring. The words are from Isaiah 55:2, "Wherefore do you spend your money for that which is not food, and labor for that which satisfieth not?"

REFERENCES

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