HEALTH CARE CONSUMER

NEWSLETTER of the Champaign County Health Care Consumers

FALL 1982

Carle Clinic Complies – CCHCC Victory

"Please have patients who are concerned about this problem talk with their psychiatrist or psychologist." This was the initial response of Carle Clinic Administrators when CCHCC informed them that the Clinic's policy of including psychiatric and psychological records with the patient's general medical record was in violation of state law.

But now, Dr. Pollard, Chief Executive Officer of Carle Clinic, is dancing to a different tune. Not only has he approved a separate filing system for psychiatric and psychological records but he has approved a mechanism which allows patients to review their records and request removal of offending material. In addition to these changes, Dr. Pollard has approved a plan to inform Carle Clinic patients about the change in policies.

It would be nice to think that Dr. Pollard, and the Clinic he represents, had a change of heart and voluntarily moved to bring Carle's record-keeping policy into compliance with the law. Unfortunately, this isn't the case. Carle's change in policy was the hard-won result of a year-long campaign launched by CCHCC's Consumer Health Hotline, involving government and professional regulatory agencies.

"It riled me to see an institution such as Carle Clinic not only brazenly defying the law—but somehow thinking that they were exempt from it," states Debbie Doyle, CCHCC member. "It was very satisfying to see Carle knocked off their high and mighty horse—down to the level of ordinary folks—who must comply with the law," she added.

Although several regulatory agencies were involved in the case, it was the Human Rights Authority (HRA) and the Guardianship and Advocacy Commission (GAC) that were most instrumental in negotiating a settlement with Carle Clinic. The HRA and GAC are state agencies set up to monitor and administer compliance with the Mental Health and Developmental Disabilities Act. In Dec., 1981, they voted to accept our case against Carle Clinic, and to advocate on behalf of CCHCC and consumers of mental health services.

It had been Carle's original stance that they were essentially "above the law." On several occasions they stated that they were different from other health care institutions in Illinois—

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Hill-Burton Finale

After nearly two years of organizing, CCHCC has negotiated an agreement with Burnham Hospital in Champaign to provide approximately $450,000 a year in free care for low-income residents when Burnham's federal obligation to provide such care expires in two years. The announcement, announced at a June 24 news conference by CCHCC Board member Katy Murphy, was the culmination of six months of negotiations and discussions with the three hospitals.

According to Murphy, Burnham was the most responsive to the problems facing low-income consumers. "Mercy Hospital agreed to some minor adjustments such as dropping interest rate charges for low-income persons but remained uncommitted concerning the provision of free health care after its federal obligation expired. And Carle Hospital refused to do anything at all," explained Murphy. "We see the Burnham agreement as an important milestone and don't intend to let this issue die."

In May 1981, federal officials had also decided to investigate Champaign-Urbana hospitals. By September 1981, both local and federal investigations issued reports critical of local Hill-Burton programs (*Health Care Consumer*, Fall 1981). Both reports recommended several changes in local programs, however, the local health planning board expressed a deep concern about what would happen in two or three years when local Hill-Burton obligations expire.

Although the HSA committee recommended that hospitals develop concrete plans to provide free care after Hill-Burton expires, it took no steps to implement this or any other recommendation. Recognizing the need to address these recommendations, CCHCC contacted local hospitals last fall, inviting them to meet and discuss the implementation of these recommendations. Over a six month period, CCHCC met with all three Hill-Burton facilities with the hope of developing a cooperative plan of action for meeting the needs of low-income consumers in our community.

The actual discussions with hospital administrators focused on five key recommendations made by the HSA committee:

a.) Public Education—The HSA committee felt hospitals should do more to inform and educate the public about Hill-Burton.

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Health Advocate Reports....

Over 150 calls have been received on CCHCC's Consumer Health Hotline in the last four months from consumers with questions, concerns and complaints about local health care facilities and practitioners. In addition to providing a service to these individual consumers, the Hotline provides CCHCC with a means to stay abreast of local problems and issues in health care. Through "Health Advocate Reports," these issues and problem areas will be presented as a regular feature of *Health Care Consumer.*

Hospitals Falter on Hill-Burton

In the last months it's become apparent that local hospitals are again providing inadequate and/or wrong information about Hill-Burton. We've received numerous calls from consumers who have not been informed that they may be eligible for free or reduced-cost care through the Hill-Burton program. In addition, several consumers were given inaccurate information about their *right* to Hill-Burton funds. To Review . . .

—You have the right to free or reduced-cost medical care if you are eligible and the facility has not met its annual obligation level.

—You have the right to request free or reduced-cost medical care at any time before or after services are provided.

—You have the right to receive an Individual notice of Free or Reduced-Cost Medical Care if the facility has not met its annual obligation level.

—You have the right to a written determination of eligibility within two working days of the request if the facility has not met its annual obligation level.

Hill-Burton facilities in Champaign-Urbana are Burnham, Mercy and Carle Hospital.

No More Hill-Burton for Carle Emergency Room Visits

If you need emergency room services and don't have money to pay, you'd better not go to Carle. Carle Hospital has changed their allocation plan so that Hill-Burton funds are only available for in-patient visits. In their large ad in the News Gazette (9/28/82) they state that, "hospital outpatient services (including emergency room visits) may be available at no charge or at reduced charge through different financial assistance programs using criteria similar to that used in Hill-Burton." As of yet, we've received no indication as to how these "different financial assistance programs" are managed.

A final note: as a Hill-Burton facility, Carle cannot turn anyone away for emergency services—whether they can pay or not.

Voluntary Admissions Do Not Necessarily Mean Voluntary Discharges

In recent months we have intervened on behalf of several consumers who *voluntarily* admitted themselves to a mental health facility . . . and then were not allowed to leave the facility when they requested to be discharged. And, to our surprise, the facility has the law behind them.

Mental Health Facilities have the right to detain a voluntary admission patient for up to five days after that patient requests to be discharged. In addition, the facility can file a petition for involuntary commitment proceedings and thereby detain the patient for up to an additional five days.

There is however, another category of self-admissions to mental health facilities. These are "*informal*" admissions. Although there is no official definition, when "informally" admitted, a patient simply notifies the caretaker that they wish to be discharged, and if during normal business hours, they will be released immediately. Although the consumer can request an "informal" admission, the final decision is up to the admitting physician. It is possible that an admitting physician could insist upon a voluntary admission and not approve an informal admission.

So, know what you're signing.

The Illusive Public Health District

Many consumers have mistakenly contacted us hoping to find the Public Health District. The Public Health District provides immunizations; screening for hypertension, tuberculosis, venereal disease, vision and hearing; well-child and school physical exams; social services and more. These services are free for residents of Champaign-Urbana. The Public Health District is listed in the phone book under Champaign-Urbana Public Health District. (Most people look under Champaign County...) To make matters more confusing, they have recently moved. But, you'll find them at: **710 N. Neil, Champaign 352-7961**

Staff Changes

On September 1, Mike Doyle stepped down as Executive Director of the Health Care Consumers to become full-time Regional Director of the Illinois Public Action Council. Mike has been with CCHCC since its founding; giving an incredible number of hours as a volunteer, as a staff person and as Executive Director. Even when we didn't have money for staff, Mike continued to work full-time without pay. The dedication and direction he has provided to CCHCC have continually helped us realize and exceed expectations we set for our organization. As Executive Director, he has guided the organization through numerous campaigns and transitions with energy, enthusiasm and vision.

Although Mike is leaving the staff of CCHCC, he's not leaving the organization. He'll continue to be an active participant in CCHCC activities and is a candidate in the current election for CCHCC Board Members. Mike is particularly interested in remaining involved with CCHCC's Midwifery Task Force and Fundraising Committee.

Replacing Mike as Director is Cynthia Ward. Cynthia has been on staff with the Health Care Consumers for two years. After receiving her BA degree in Health and Society from Brown University, she found her way to the Health Care Consumers through the VISTA program. Currently, Cynthia is CCHCC's only staff member. However, in the coming weeks, we will be hiring two new staff members: an organizer to work on the Medicare Campaign and a Fundraiser.

In his new position as Regional Director of IPAC, Mike will be coordinating the activities of IPAC's local affiliates, including CCHCC. Recent issues IPAC has taken on include: cuts in Social Security, Ill. Power's purchase of Algerian Natural Gas, and Toxic Wastes.

We are immeasurably grateful for the time, dedication, and clear-headed leadership Mike has given to us as an organization. We look forward to working with him in his new roles for many more years.

CCHCC Board of Directors
Executive Committee

Nurse Midwives: An Issue of Choice

Midwives have been working almost as long as women have been giving birth. The word literally means "with the woman" in Old English. Certified nurse midwives, however, are a more recent addition to the health care of women. The United States saw its first nurse midwife in 1925 when the Frontier Nursing Service imported a British nurse midwife to work here while sending public health nurses to England to be trained in midwifery. Although nurse midwives have now been with us for almost 60 years, confusion still exists about what they do and their legality.

A nurse midwife is a health care professional who has been certified by the American College of Nurse Midwives and is trained to care for a woman before, during, and after an uncomplicated pregnancy. (Complicated pregnancies include those where the mother has a history of high blood pressure or diabetes, breech-births, multiple births, and C-sections.) In addition, a nurse midwife can give routine gynecological exams and act as a counselor in family planning.

Originally, the need for the services of nurse midwives stemmed from severely medically-underserved regions of the country, as in the hills of Kentucky, the home of the Frontier Nursing Service. The aim was to decrease infant prematurity, infant mortality and, in general, to help women deliver healthy infants.

Today, nurse midwives still serve the underserved in both rural and urban settings but they have also added another client: a woman who can afford the care she needs but who wants to improve the quality. These women, who are generally well-educated, are choosing nurse midwives as an improvement upon the care they feel they would receive from obstetricians in hospital settings.

Middle class women are seeking nurse midwives for many reasons. In general, many women feel that nurse midwives treat pregnancy and birth as a normal event in which the mother participates in the decision-making. The goal is to accomplish this with a minimum of medical intervention. This means the woman isn't shaved; IV's, episiotomies (a cut made to enlarge the birth canal), enemas, epidurals (a local anesthetic given in the back to numb the pelvic area) and fetal monitoring (a belt strapped around the woman's belly to measure her uterine contractions and the baby's heart rate, which also restricts her movement) are not routine; and the woman can deliver any way she wants—on her side, sitting up, squatting or on all fours—but preferably not on her back because this can restrict blood vessels which nourish the womb.

Another reason women prefer nurse midwives is that midwives spend a lot of time with their clients during prenatal visits and provide education about nutrition, exercise, parent-infant bonding, and the effect an infant will have on the woman's life.

In addition, once a woman is ready to deliver, the nurse midwife is usually with her immediately. The nurse midwife tries to stay with the woman during all of labor and delivery—which can sometimes amount to over 24 hours—and will massage the woman, comfort her, and coach her through the contractions. If complications arise at any time during the pregnancy or the labor and delivery, a back-up physician will take over and together they co-manage the woman's pregnancy.

Other considerations that women consider in choosing a nurse midwife relate to gender and setting. Most nurse midwives are women (there are presently 12 male nurse midwives in the United States) and many women consider this a plus in the care they will receive. Finally, nurse midwives work in a variety of settings: some deliver in birthing rooms, some in delivery rooms, some in birthing centers and some at home (although in Illinois only two nurse midwives presently do home births).

While nurse midwives have been practicing successfully for decades, their status has not always been clear-cut. At present, Illinois has 80 practicing nurse midwives yet their

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Many babies turned out for the CCHCC community forum on Midwifery at the Champaign Library.

No practicing nurse midwife is available in Champaign County and many health care consumers have expressed concern about the situation. Over the years, the Champaign County Health Care Consumers have received numerous inquiries about alternative birthing practices, including nurse midwives, in this community. Last July a community forum on midwifery, sponsored by the Champaign County Health Care Consumers, was attended by over 80 area residents who had questions concerning midwifery and nurse midwifery. Two Chicago nurse midwives from Illinois Masonic Medical Center were present to answer questions. The forum also featured a film called "Daughters of Time," which profiled three different nurse midwives.

The desire for a nurse midwife in this community has led to the creation of a CCHCC Task Force on this issue which has begun interviewing local doctors and obstetricians to gain an understanding of local feelings about nurse midwives. Future work includes more interviews and the development of a strategy to make the option of nurse midwives available to local consumers. Anyone interested in joining or finding out more should call CCHCC's office, 352-6533.

VIEWPOINTS... Health Care Through Prevention

by Thom Moore

The 1979 U.S. Surgeon General reported that health expenditures have increased elevenfold since 1950 while mortality and disability have remained virtually constant since 1955. Jerrald Michael, dean of the School of Public Health at University of Hawaii, says that this trend suggests that the traditional physician-hospital system has not been improving the *measured* health status of the general population. Furthermore he argues that behavior patterns, environmental health, and self-care are a stronger influence in changes in a population's health status than are medical services.

Both increasing costs and new findings on health and health care have led the public to seek new strategies and techniques for maintaining good health. A number of researchers and practitioners are suggesting that a second health revolution is in progress. The focus of this revolution is prevention. The Center for Disease Control reports that half of all mortality in the U.S. is due to unhealthy behavior or life-style. Of the remaining causes 20% was due to environmental factors, 20% to human biological factors and 10% to inadequacies in health care. The implication is that Americans can take simple measures to enhance their prospects for good health and for extending their lifespans.

In pursuing alternatives to traditional medical care such concepts as whole-person medicine, holistic health and wellness have found their way into the public's thinking. Each of these concepts is concerned with attending to self help notions of health and the numerous areas of life. Also stressed in these concepts is the idea that the quality of life can improve. Let's take wellness for instance. While there are any number of definitions one most commonly cited model includes six dimensions of wellness: intellectual, emotional, physical, social, occupational, and spiritual. In exercising these areas the individual plays an active role and gains some control over his/her health. Traditional medical practices then become one of many health strategies. Adoption of a wellness model will demand the doctor-patient role to be more of a collaborative one. It also suggests that health should be of an on-going concern.

The promotion of the wellness model rests on education of the public, access to resources and positive outcome. The first criterion will make the public more aware of the specific things they can do, but more importantly it will help them identify the personal and community resources that are needed to pursue wellness. Behavioral factors and environmental hazards are examples of the causes of poor health that can come under the control of individuals and communities.

A one day Wellness Awareness Workshop was recently held in Champaign-Urbana. The workshop dealt with physical fitness from an exercise and nutritional perspective, emotional understanding, spiritual growth, and social and interpersonal relationships.

These specific topics were selected because they lent themselves to practices that each member in the audience could engage in immediately. A major focus of each presentation alerted the audience to the influence that stress plays in their life. There were also suggestions for how to better manage it in the different aspects of one's life. The interrelationships between different aspects were also highlighted. For example one presenter, a certified Rolfer, demonstrated certain procedures that could be either self administered, or performed by someone else. In so doing he stipulated in the latter situation, interpersonal interdependence is created and is related to the social dimension of wellness.

Successful revolutions must offer better alternatives to the existing way of doing things. The second health revolution is no different. There is enough information that the present health-care system cannot deliver all it promises. More importantly there are options into which the present system can be incorporated. A successful revolution must develop mechanisms for getting useful information to those who are unaware of the limits of the existing system, and the new practices. The promise of an improved quality of life through prevention and wellness is the news to be communicated.

*If you are interested in a Wellness Workshop for a group or organization please contact:

Thom Moore	351-2108
John Cottingham	356-7650

Overexpansion Hurts Mercy

In August, Mercy Hospital laid off more than 90 employees because of financial problems. Although the official explanation has blamed declining hospital occupancy rates and the proposed cuts in Medicaid and Medicare, the real cause for the layoffs is poor planning and overexpansion.

In 1979, Mercy embarked on an ambitious 21 million dollar expansion project, despite objections of local consumers, including CCHCC. In opposing the project, the Health Care Consumers noted that the project was excessive, utilization projections were unreasonable, and Mercy's ability to finance the project was questionable.

The project was recognized by many as exceeding community needs. It added medical/surgical beds even though there was already an excess of 110 medical/surgical beds in Champaign-Urbana. Recognition that the gross square footage of the project was double the recommended ratio (16,819 vs. 68,220 sq. ft.) caused the Health System Agency (HSA) staff reviewing the project to question "the need of the size of the proposed project."

Further questions were raised about Mercy's utilization figures. According to Mercy administrators, the hospital would see an 8.5% increase in inpatient days. Critics charged that this goal would be difficult to achieve since a major portion of the project was an outpatient facility projected to increase outpatient visits by 16%, while reducing inpatient surgery by 25%. The HSA staff report questioned those figures and noted that population growth was expected to increase only by 3%.

Mercy's ability to pay for the project was also dependent on a high Average Length of Stay (ALOS). Again, the HSA staff challenged Mercy's projections of 7.7 days since Mercy's ALOS was already 15% higher than the regional average and because pressure was growing within the system to reduce the Average Length of Stay.

The questions about the need and utilization raised serious doubts about the financial feasibility of the project. To pay

for the project, Mercy proposed borrowing 96% of the money for the project, requiring a special waiver because the maximum allowable level under state guidelines was only 80%. Considering this, the HSA staff report suggested that Mercy "may be near the prudent maximum debt level . . . if operating results are inadequate, the high debt ratio will place Mercy in a precarious financial situation." The staff report went on to state: "Even a *slight* decrease in the Average Length of Stay could seriously affect the *financial stability of the institution.*" (emphasis added)

But Mercy Administrator Ron Aldrich shrugged off such concerns, as did highly paid consultants from Touche Ross, who refuted each and every concern. In response to the staff report, Aldrich wrote, "A slight decrease in the Average Length of Stay would not significantly affect the financial feasibility of the project since revenues per patient day tends to increase as average length of stay decreases." The translation: prices will go up. Even without a decrease in the Average Length of Stay, Mercy projected a jump in the cost per patient day from $264 to $417.

Mercy Hospital's utilization rate has dropped from 88% in 1979 to 81.4% in 1981, its financial situation has worsened to the point that employees are being laid off, and consumers are paying ever-higher hospital bills. Who's to blame?

In a statement released to the local media, Aldrich pointed the finger at the poor economy and the proposed cuts in Medicaid and Medicare funding. There are two major problems with these arguments. First, most of the proposed cuts in Medicaid and Medicare hadn't even been passed yet and therefore hadn't begun to affect hospital finances. Second, none of the other three local hospitals (which also would have been affected by such factors) have resorted to such drastic measures.

Those persons sympathetic to Mercy say it is unfair to blame the hospital because Mercy "could not possibly have forseen" these different factors three years ago. But these problems *were* raised three years ago; Aldrich and his traveling show of highly paid consultants not only chose to ignore them, but did their best to convince the local HSA that such predictions were unfounded horror stories.

But now that people are being put out of work and consumers are paying higher bills, the highly paid consultants are nowhere to be found. As is often the case, those at the bottom of the economic pyramid pay for the errors and miscalculations of those at the top. Although much of the damage is already done, we do have on suggestion: If Mercy Hospital is faced with more layoffs, they might be better off starting off at the top.

Christie Clinic's Prepayment Policy

"We are a private enterprise with the sole purpose of providing professional, medical and surgical services. These services have a cost and a value and we charge fees for them. In some situations we require payment in advance. Generally charges are payable in the month the services are provided."

This seemingly innocent paragraph, located or buried in a 31-page booklet entitled *Christie Clinic Information for Patients* has been causing some Christie Clinic patients a great deal of concern. At issue is the sentence, "In some situations, we require payment in advance."

CCHCC's Hotline has received several calls from consumers with complaints about Christie Clinic's prepayment policy. Most of these calls came from consumers after their first visit to Christie Clinic. These consumers had made appointments to visit a physician at Christie and were requested to come early and report to the billing office. After being interviewed by an employee, they were told they must pay for the visit *before* they could see the physician.

For some, the experience of being questioned about personal finances, and being required to prepay for medical services was aggravating and distasteful. For others who had taken time off work, and who did not have enough money with them to pay the service fee, the experience was more disturbing. Since they were turned away without receiving services, they not only were subjected to the patient's-accounts interview, but wasted time and money taking off work.

This matter came to our attention in June 1982; since then we have been corresponding with Christie Clinic's administration. We originally sought to clarify the Clinic's criterion for requiring prepayments, the amount of the payments, and the manner in which the Clinic notified consumers of their prepayment policy.

The Christie Clinic Administrators have been courteous, if not thorough, in their responses. John K. Evans, Christie Clinic's business manager, stated that the Clinic's policies have "served well to date." He did add that he was "extremely interested in improvement," and that "your (CCHCC's) support and assistance will be greatly appreciated." In the coming weeks we will be preparing a response to this request. If you've had an experience with Christie Clinic's prepayment policy and/or would like to have input into our response, please contact us at 352-6533.

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b.) Hill-Burton Notice with Hospital Bill—The committee argued that a notice with each bill would notify people at a time when they were thinking about finances.

c.) Write-Off Past Bills—The committee urged hospitals to write-off any outstanding amounts owed by persons who were Hill-Burton eligible, but not informed about Hill-Burton.

d.) No Interest Payments—Local hospitals were asked to end the practice of charging interest on unpaid balances for low-income persons when no charitable arrangements can be made.

e.) Free Care After Hill-Burton—The most important recommendation urged hospitals to develop concrete plans to provide "a specified amount of health care" even after their Hill-Burton obligation expires. The amount of care provided and eligibility for that care should be at the "minimum" equal to their Hill-Burton obligations.

In a May 30th letter to CCHCC, Burnham Hospital explained that they "recognize a need to develop a process to formulate the specifics (exact amounts, eligibility, etcetera) so that they are in place and publicly known before the phase out occurs." At the news conference, CCHCC Director Mike Doyle acknowledged Burnham's effort and recognized "the courage it took to step forward and accept our offer to meet and discuss this sensitive issue." However, Doyle also expressed "frustration and disappointment in the response of Carle Foundation Hospital. Despite Carle's repeated statements about their commitment to serving the poor, we found little evidence to support these claims."

Herpes — The New Epidemic

Herpes has become one of the year's most talked about medical conditions, and with good reason. Currently, 60% of adults in the U.S. are estimated to be suffering from Herpes. Despite the publicity and prevalence, much about Herpes is not understood—both by the public and medical community. The following questions and answers are adapted from the following sources: The *Health Advocate* Newsletter, *Our Bodies, Our Selves,* and a publication of the Santa Cruz Women's Health Center, *Herpes.*

- *What is Herpes?*

The term Herpes, as it is commonly used, refers to Herpes Simplex Virus Type 2 (HSV 2)—a virus that causes small blister-like sores on the mucus membranes in the genital area.

Cold Sores, or fever blisters, are caused by Herpes Simplex Virus Type 1 (HSV 1)—a virus that is closely related to Herpes Simplex Virus Type 2. Herpes Simplex 1 causes small blister-like sores on the mucus membranes around the mouth.

- *How do you catch Herpes?*

The most likely way to contract HSV 2 is through direct contact with an active sore. Therefore, HSV 2 is usually, but not necessarily, spread through sexual intercourse. An estimated 5% of genital herpes is caused by HSV Type 1 through oral-genital contact.

Although transmission via sexual contact is the most common mode of catching HSV 2, other ways may exist. It's been shown that HSV 2 can survive on warm moist objects, such as towels. Although rare, others may contract HSV 2 through contact with these inanimate objects.

Men and women can be "carriers" of HSV 2 by carrying the virus and yet having no visible symptoms. A woman can have sores on her cervix and a man have sores in his urethra without being aware of their presence.

- *What are the symptoms of Herpes?*

The incubation period for a Herpes outbreak is from two to fifteen days after the virus enters the body. The sores will develop where contact was made with an open sore. The sores start as a small red measle-like patch of skin that develops into greyish moist blisters with red edges. Then, from itching, contact with clothing, etcetera, the blisters burst and have a "punched-out" look.

On women these sores may be inside the vagina, on the external genitals or thighs, in or near the anus, or on the buttocks. Sores also appear on the cervix, where they are not painful. On men the sores usually appear somewhere in the penis or near the anus.

Symptoms range from being mildly uncomfortable to terribly painful. Sores commonly will burn and itch to varying degrees. Other possible symptoms are fever, enlarged lymph-nodes, and flu-like symptoms. For women, one of the most distressing aspects of genital Herpes is painful urination as urine passes over an open sore. The sores sometimes heal by themselves in anywhere from a week to a month.

- *Is there a cure for Herpes?*

The discouraging, frustrating and often depressing aspect about Herpes is that the virus lasts a lifetime once you get it. The initial attack is often the most uncomfortable and will frequently last the longest (approximately 6 weeks). When the sores heal, the virus enters a latent stage during which it is not contagious. Some people only experience one initial attack and never again have to deal with the uncomfortable symptoms. Yet others suffer periodically with outbreaks of sores. These outbreaks appear to be related to stress—either physical or emotional. For some women, the outbreaks recur after prolonged intercourse or are connected with their menstrual cycles.

- *How can Herpes be diagnosed?*

Individuals can take an active role in diagnosing Herpes and other medical conditions by performing regular self-exams. Self-exams are invaluable in understanding what is normal for you. For women, self-exams are especially important since so much of the genital area is not visible otherwise.

If you detect a possible Herpes sore through a self-exam or through experiencing other symptoms, conclusive diagnosis can be made by a medical practitioner. Besides examining the sores, a medical practitioner can make an accurate diagnosis by taking a smear from a sore or by doing a tissue culture to see if Herpes is present.

If you think you may have contracted Herpes, but do not have any visible sores, it is possible to detect Herpes through a serum test for antibodies. For this test (Titer Test), a blood sample is taken during your initial attack and a second blood sample is taken when the symptoms subside. The blood samples will measure the difference in antibody levels.

- *Is there a treatment for the sores?*

Medical practitioners can prescribe surface antibodies and oral painkillers. There is also an increasing amount of information available about self-care symptomatic remedies. These methods are not standard treatment, nor have they been proven effective by medical scientists, but they are methods devised and used successfully by those who have Herpes. They range from milk compresses, to volcanic ash poultices, to color therapy. (For more information, see the resource section.)

- *Is there a way to prevent getting Herpes?*

There are several laboratories working to develop a vaccine to prevent initial attacks of Herpes and to prevent recurring outbreaks in people who already have Herpes. There is a vaccine of this type in use in Europe. However, the FDA has yet to do testing with the vaccine in order to permit its use in the U.S. and many U.S. doctors believe that it isn't effective.

Until a vaccine is developed and available in the U.S., some preventive measures include:

Stay in good health, maintain proper nutrition, (especially getting enough B vitamins) and have conscious ways of dealing with stress and tension.

Be aware of the possibility of Herpes. If you are being sexual with someone, find out if she or he has Herpes. If a friend has Herpes, make sure you don't come in contact with an active sore.

If you have having intercourse and either of you has Herpes, condoms, although not totally safe, can help prevent infection of the other partner.

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that there were only six clinics across the country to which they could be compared. In the initial negotiations with the HRA, Carle Clinic's representatives used this line of argument as their sole defense. Naming themselves as purveyors of "wholistic health care," they asserted that all members of Carle's professional staff needed access to a patient's complete psychiatric record.

The fact that the Illinois Mental Health and Developmental Disabilities Act had been designed and implemented by the state legislature to protect mental health consumers' rights was discounted by Carle Clinic. In February 1982, the GAC decided that this was not an adequate defense for ignoring the Mental Health Act. They requested that Carle Clinic develop a proposal for revising their system for mental health records that would fulfill the letter and spirit of the law.

During their ten-month investigation of Carle Clinic's policy, the HRA and GAC responded to the Health Care Consumers' input with a diminishing degree of interest. We were, they said at one point, the most actively involved client they had ever had. At the time it was not clear whether this was a compliment or not. Their position soon became clear, however, when HRA staff members began avoiding our phone calls and then requested that we conduct all future communications by written correspondence.

Why did the HRA and GAC shift from being our allies to our seemingly unwilling hosts in this case? We speculated that they were more concerned with wrapping up the case than in seeing that Carle Clinic was actually brought into compliance with the law. This speculation was confirmed in the closing months of the investigation.

Carle Clinic's final proposal for revising their mental health record keeping system addressed two of our central concerns: establishment of a separate filing system for personal notes from psychiatric and psychological sessions and a mechanism to inform consumers applying for mental health services at Carle that certain information from their sessions would be included in their Carle Clinic general medical record. Yet, in some ways the proposal still did not conform to the letter and spirit of the law. In developing their policy, Carle Clinic again relied on their "unique philosophy" of providing "wholistic health care" to circumvent specific criteria and limitations spelled out in the law. Despite our continued protests, the GAC approved Carle's plan at their October meeting.

CCHCC will continue to monitor Carle Clinic's compliance with the law and with their recently revised record-keeping policy. We encourage anyone with a complaint or concerns about Carle Clinic's mental health record-keeping system to contact the CCHCC Health Hotline at 352-6533. All Hotline calls are strictly confidential.

Blues Under Attack

In July, Blue Cross/Blue Shield insurance policies, sold by Health Improvement Association in Illinois, rose an average of 48%, with rates for some categories increasing an incredible 131%. As might be expected, the increases were strongly criticized by consumers at a series of public hearings held by the Illinois Department of Insurance throughout the state.

The hearings were originally scheduled by the Department as part of an ongoing effort to monitor the Blues performance in the area of cost containment. Unlike independent insurance companies, Blue Cross/Blue Shield is a not-for-profit charitable organization. As such, the Blues are exempt from state and federal tax and are not required to maintain substantial cash reserves. In return for being granted not-for-profit status, the Blues are subject to state regulation by the Department of Insurance. The Department monitors certain rates charged to consumers for insurance and the reimbursement rates paid to providers.

One segment not covered by state regulations is group policies, including Health Improvement Associations (HIA's). In theory, group policies are excluded from regulation so that groups can negotiate their own coverage. If rates are raised too high, a group is free to seek coverage elsewhere, thereby holding down rate increases. However, according to Frank Giarrizzo, President of the Association of Health Care Consumers, "The HIA's were established to see Blue Cross/Blue Shield insurance. The direct ties between HIA and the Blues undermines the very concept of negotiation." HIA's are supposedly independent brokers of insurance—free to contract with any insurance company to provide comprehensive coverage at a competitive rate for their subscribers. However, Giarrizzo charged, HIA's "are basically a convenient way for the Blues to avoid state regulation for 300,000 subscribers."

In addition to the issue of HIA's, the Blues were also criticized for failing to take an active effort to hold down health care costs. Historically, Blue Cross/Blue Shield has been closely connected with the providers that it reimburses, leading to accusations that the Blues would rather raise rates than hold down costs. CCHCC Board member Tom O'Rourke raised exactly this point at the Danville hearing, noting that the Blues' "present policy, as indicated by the recent rate increases, is more oriented to raising premiums to meet costs than to vigorously pursuing efforts aimed at provider reimbursement." O'Rourke and CCHCC staff member Cynthia Ward both criticized the Blues for not fulfilling the intent of past directives from the Department of Insurance.

Herpes from page 6

- *Where can I get more information about Herpes?*
- Literature available —
  Herpes—a 20 page comprehensive booklet including information about self-care remedies.
  Send $2 to: Santa Cruz Women's Health Ctr.
  250 Locust Street
  Santa Cruz, CA 95060

  The Herpes Book
  Richard Hamilton, M.D.
  1980
  Houghton Mifflin Company, Boston
- Herpes Organizations —
  HELP (Herpetics Engaged in Living Productively)
  P.O. Box 100
  Palo Alto, CA 94306
  (with a membership you receive a quarterly newsletter, The Helper)

Volunteers Needed.....

- Implement and develop our "Consumer Report on Health Care Services" project. When complete, this project will provide consumers with qualitative information from a consumer perspective about local health care providers and facilities.

  The actual reporting form is developed and available —but in order for the project to be operational we need: (a) to develop a file system for the reports; (b) to develop a policy for passing out information from the reports; and (c) to publicize this service to the community.
- Maintain our computerized membership list. This involves making changes on file cards and on our computer list. The computer work can be done at our office or at a University terminal. The computer program is the Cyber Mailing List program. (If you have ever wanted to learn how simple it is to use a computer, here's your chance.) Training provided.
- Research topics for the Consumer Health Hotline. Including: (a) Malpractice suits—how to find a lawyer, important facts for consumers to know; (b) Community resources—develop a complete listing of resources (contact names, etc.) and organize in an easy-to-use manner; (c) and more .....
- Compile newspaper articles related to health issues and CCHCC projects. Anyone who regularly (and thoroughly) reads local, regional, and/or national newspapers and periodicals could help CCHCC by clipping health-related articles and passing them along to us. Assistance is also needed filing this information.

NURSE MIDWIFES *from page 3*

legality has at times been questioned. The role that nurses can play in the health care field is defined by the Nursing Act. Although the Act does not mention nurse midwives or any other nursing specialty such as nurse practitioners, the Illinois Nurse's Association believes that the Illinois Nursing Act allows for the expanded role of nurse midwives without mentioning the specialty by name. However, state agencies such as the Illinois Department of Health and the Department of Registration and Education have interpreted the Act to mean that nurse midwives are practicing illegally. An amendment to include "nursing specialties" in the Illinois Nursing Act, supported by the INA and CCHCC last spring (*Health Care Consumer*, Spring 1982), was defeated by the state legislature early this year. But nurse midwives continue to practice in Illinois.

Where they practice in Illinois is another problem. Of the 80 practicing nurse midwives in Illinois, only three practice outside the Chicago area—two in Rockford and one in Peru, a town halfway between Rockford and Bloomington. This means that women in downstate Illinois have one less choice when it comes to health care during their pregnancy. Although the American College of Obstetricians and Gynecologists supports nurse midwives as part of a health care team in which the physician has the ultimate responsibility, finding individual doctors who are willing to work with a nurse midwife is not always easy. It is the lack of back-up physicians that has limited the number of nurse midwives practicing in Illinois.

While for some women nurse midwives provide the compassion, time and care that they want during their pregnancy, other women are not as enthusiastic. They feel that because nurse midwives are trained in the same way as doctors—to detect illness and pathology—their approach to birthing cannot be much different from that of doctors.

But whatever the praises and critiques of nurse midwives, the fact remains that their availability gives the health care consumers one additional choice, a choice that is not available to many consumers.

HEALTH CARE CONSUMER is the quarterly newsletter of the Champaign County Health Care Consumers, 813 North Lincoln, Urbana, Illinois 61801, (217) 384-4070. It is produced as a voluntary effort of community residents to help consumers stay abreast of health consumer problems and emerging solutions. Comments and contributions are invited and should be directed to the above address. HEALTH CARE CONSUMER is supported through tax-deductible donations from readers and local community residents.

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