for primary care services, but specialty and referral care must be obtained from staff physicians at a designated hospital.

The CHOICE program differs from prepaid group practice HMOs by providing participants with the freedom to choose their own personal, private physician for primary care, according to Leslie Levy, M.D., president of Aetna Healthcare Systems Inc. "Unlike traditional insurance and Blue Cross/Blue Shield, it also assures cost-effective specialty and referral care by physicians and hospitals who are recognized for their excellence," he said.

Patients will be able to maintain their relationships with their primary care physicians under the CHOICE program, which will provide continuity of care and help control unnecessary treatment, Levy explained. In addition, patients' freedom of choice is extended under the program by giving them the opportunity to select physicians and hospitals they otherwise might not have access to through their own doctors, Levy said.

Pending state regulatory approval, a pilot CHOICE program is expected to begin in the next six months in the Chicago area at Evanston (IL) Hospital. "CHOICE could provide a powerful stimulus for other physicians and hospitals to become more cost effective," according to Bernard Lachner, president of Evanston Hospital. Lachner, who is also the speaker of the AHA's House of Delegates, said the program will reward those hospitals that foster "a professional staff that is concerned about costs and hospitalizes only patients who need care—rather than the incentives we are most accustomed to—simply aiming for more doctors and more patients." Aetna eventually hopes to extend CHOICE to other metropolitan areas around the country. □

Trends and topics

Hospitals challenged to restrict smoking

"Smoking is not permitted in patient rooms. Patients who continue to smoke will be subject to discharge, and visitors will be asked to leave the hospital."

A Chicago hospital used to broadcast that message four times a day over its public address system to make sure people knew of its no-smoking policy. Now, the public announcements are no longer made, says Joseph Thomas, chief executive officer of St. Bernard Hospital, because of the difficulty in enforcing the policy. There was not enough cooperation from physicians to enforce the rules, and many patients smoked in their rooms anyway.

Hospitals across the country are in the same dilemma—they recognize their responsibility as health care institutions to discourage smoking, yet problems with enforcing smoking policies, concern for patients' rights, and attitudes and smoking behavior of the hospital staff are major obstacles to doing more to control smoking.

Faced with the staggering cost of treating smoking-related diseases and the rising number of deaths each year from smoking, hospitals are being asked to get around those obstacles and play a more exemplary role in discouragement efforts. Medical costs from smoking rose to $27 billion last year, according to the Surgeon General's office, and claimed 350,000 lives from coronary heart disease, respiratory disease, and cancers of the lung, larynx, oral cavity, and esophagus. Smoking is also linked with cancers of the pancreas, bladder, and kidney.

FUNERAL FOR A KILLER—Mourners eulogize "Nick O'Teen," the three-foot-long vinyl cigarette whose life was snuffed out during the "Great American Smokeout" at Shawnee Mission (KS) Medical Center. Pallbearers carried the casket to a waiting antique horse-drawn hearse, which led the funeral procession past the hospital entrance.

To find out what hospitals are doing to discourage smoking, the AHA conducted a survey last year of 20 percent of all community hospitals in the country. "A surprising finding was the number of hospitals that have smoking policies," according to Lynn Jones of the AHA's Center for Health Promotion. The survey results indicate that 91 percent of all hospitals have a written policy on smoking, and 97 percent restrict smok-