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.

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-

*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.*

ing to designated areas within the facility.

Seventy percent of the hospitals surveyed do not sell cigarettes within the institution, and 86 percent of the hospitals said patients are assigned to a nonsmoking room on request whenever possible. Eighty-one percent of the hospitals assign patients to nonsmoking rooms at the physician's request.

About 85 percent of the hospitals responding to the survey felt they were doing as much as they could to discourage smoking. When asked to specify obstacles to doing more, respondents said they did not want to infringe on the "rights" of smokers or risk antagonizing the community with more restrictive policies. The psychological need of some patients to smoke was cited by others, who felt the hospital was not the appropriate setting to prohibit such behavior. A respondent from a Virginia hospital said the hospital "should discourage smoking, but our role isn't to punish."

Hospitals say they cannot restrict smoking as much as they should because enforcement is too difficult. Nurses are expected to enforce the policies but have enough to do with other responsibilities they must handle, a Missouri hospital spokesman said. The time and effort it takes to police patient rooms to enforce smoking policies places too much of a burden on the staff, a Pennsylvania hospital spokesman said.

The fact that many hospitals no longer permit smoking in patient rooms is one indication that some progress is being made in discouragement efforts. In interviews with hospitals about their smoking policies, most indicated that the restriction of patient smoking to lounges and waiting areas has proven to be

## Commitment is key to successful policy

The commitment of top management to support a no-smoking policy is a major ingredient in a successful pro gram, according to the chairman of the smoking committee at Boston's New England Deaconess Hospital. Since 1977, smoking has been eliminated throughout most of the hospital, according to Joseph Andrews, M.D., who is also chief of the pulmonary section of the hospital. Although the hospital's ultimate goal is to ban smoking entirely, Andrews said an effective smoking policy must be achieved gradually, with the support of all hospital personnel.

In early 1977, the hospital formed a smoking committee with representation from all departments. From the outset the committee agreed that a vigorous anti-smoking campaign would be more effective than outright prohibitive measures. To gain support for the no-smoking policy, meetings were held by all departments to discuss the policy, anti-smoking literature was displayed, and signs about the policy were posted throughout the hospital.

The policy, which has been in effect since July 1977, specifies restrictions on smoking in the hospital. Patients need a physician's permission to smoke, staff members and employees can smoke in designated areas only, and visitors can smoke only in a vending area near the cafeteria. They are not allowed to smoke in any of the hospital's waiting areas.

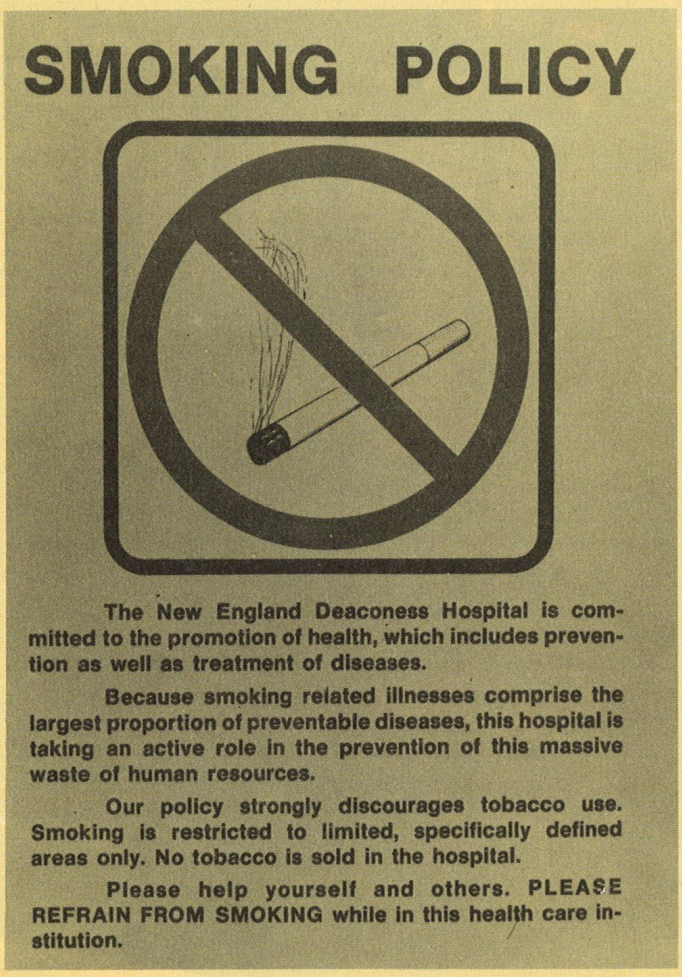
The keys to a successful no-smoking program, according to Andrews, are:

1. Commitment from top management to support the program.

2. Monthly follow-up of the program by a group representing all hospital departments.

3. Making adjustments as needed to the program.

4. Making sure everyone is aware of the goals of the smoking program. "Legislation alone does not help," Andrews said. "Institutional and personal commitment plus consistent follow-through are essential." —**Joyce Riffer** □



successful. When confined to bed, patients at most hospitals must have their physician's approval to smoke in the room under the constant supervision of a responsible adult.

A total ban on smoking would not be feasible, most hospital spokesmen said, because of the fire risks from people who would ignore the rules. "People would be sneaking smokes under the covers," according to the safety director of a Chicago hospital. A risk manager at a Philadelphia hospital said "outlawing cigarettes will only cause more problems."

One hospital that has placed a total ban on smoking is Elmcrest Psychiatric Institute, Portland, CT. "As a health care provider, we didn't feel we could run an institution where we'd allow patients to kill themselves with cigarettes," according to George Thiffault, director of public information.

The transition to a no-smoking environment in February 1980 was not an easy one, Thiffault explained. Some employees quit because of the policy. Others stayed and participated in stop-smoking groups sponsored by the hospital for patients and employees. "There was a tremendous amount of grousing from both staff and patients," according to Thiffault, but he said the program has been working. The hospital now hires only nonsmokers or a smoker who agrees to refrain from smoking while at Elmcrest, Thiffault said. This policy, which "has had no perceptible effect on recruitment," has been approved by the Labor Department, he said.

"I'm shocked and embarrassed that hospitals have lagged behind on the issue of smoking," said Alan Blum, M.D., of the Chicago-based Doctors Ought to Care (DOC). An organization with 1,000 members and 40 chapters nationwide, DOC aims to educate the public about good health habits and to dispel the myths used in advertising unhealthy products. "It is offensive to the nature of what we do for a living to permit smoking in hospitals," Blum said, contending that hospitals do not have more stringent smoking policies because it is not in their self-interest to be more restrictive. "There is no profit incentive for the hospital to prohibit smoking."

To change hospital policies, Blum suggested appealing directly to the self-interest of the institution. "If you can't convince hospital leaders that smoking is bad for people, you should appeal to the fact that smoking is responsible for 60 percent of all hospital fires." By focusing on safety and fire prevention and the adverse publicity from hospital fires, Blum said, hospitals will recognize that smoking restrictions *are* in their self-interest.

Hospitals should "put their money where their mouth is" and get out in the community to educate people about the health risks and high medical costs associated with smoking, Blum said. For starters, he urged hospitals to use "positive, upbeat signs" that discourage smoking, to permit smoking in designated areas only, and to make sure the entire hospital knows about the smoking policy.

The key to discouraging smoking in the hospital setting is making sure the smoking policy is enforced, according to Harold Dawley, Ph.D., smoking control and education officer of the VA Medical Center in New Orleans. "Designation of smoking and no-smoking areas, educational discouragement efforts, restricting cigarette sales, and restrictions on employee smoking in the presence of patients should be the main points of a hospital's smoking policy," he said.

Finding ways to increase involvement by hospitals in reducing smoking was addressed by participants of the American Cancer Society's National Conference on Smoking Or Health last November. Participants concluded that action plans need commitment of hospital administration, medical staff, and board to a smoking policy and implementation plan; monitoring mechanisms to maintain policies; and hospital involvement with community agencies to discourage smoking. The AHA's Center for Health Promotion is also preparing an information packet to provide hospitals with resources on what they can do to discourage smoking along with case studies of hospitals with successful policies. —**Joyce Riffer** □

# Nebraska hospitals file to challenge Medicare

Medicare decisions that have eroded cost reimbursement markedly over recent years will be jointly appealed by 45 Nebraska hospitals, the Nebraska Hospital Association (NHA) has announced. The focus of the group appeal, which is being organized by the NHA, will probably be on about five of the approximately 140 Medicare decisions that the 45 hospitals said affected them "most grievously," according to Stuart Mount, NHA executive director.

The decisions most likely to be appealed are those dealing with Hill-Burton uncompensated costs and section 223 limits, Mount said. Most of the appeals are still in the organizational stages, Mount explained, although some specific appeals are under way. The number of appeals that will be filed is expected to be determined by the expense involved.

Pointing out that Nebraska has the fifth largest over-65 population in the country, Mount said the need for group appeals is particularly great in the state. He estimated that about 11 percent of the state's population is in the over-65 age group. "Nebraska hospitals are being driven to the wall financially by shortfalls in Medicare reimbursement policies and face the choice of either appealing these arbitrary decisions or passing the loss on to the public," Mount said. □