were occurring in the United States were being reported. The FDA continues to receive reports from about 85 hospitals, mostly military and Federal, throughout the country.

The AMA Registry continues to receive reports from interested physicians who detect adverse reactions. At the present time, the council on drugs of the American Medical Association is in the process of devising an elastic prototype program that will enable hospitals of every size and mission to establish ongoing studies on adverse drug reactions and drug utilization practices.

As a working member of this committee, I can assure you that progress is being made. If such machinery can be established—and we have every reason to believe that it will be—and the data gathering made painless for the physician, yet pertinent to the statisticians, and we begin to help physicians learn more about drugs, this will certainly be worth the effort.

At this point I would like to say a word about the hospital pharmacist.

In this schema—and that's the one that we are devising for the AMA council to begin to do drug utilization studies—the hospital pharmacist will play an essential role. Under optimal circumstances, he should be integrated into the therapeutic team as an active member. While I feel it is inappropriate to have pharmacists participate in patient care decisions—an area which should remain the exclusive province of the physicians—pharmacists should serve as therapeutic advisers. The treatment of a patient includes too many variables beyond drug therapy. Social and psychologic perturbations, in addition to physiologic disruptions, add up to escalate the problems of "treatment" to a plane beyond consideration of drug therapy per se.

Nevertheless, the pharmacist has a vital role. In our hospital, pharmacists are active members of the therapeutic agents board and the drug utilization and adverse drug reactions committee. Teams of pharmacists visit all wards of the hospital twice each week and contact individual ward officers to inquire about adverse drug reactions that have occurred. The pharmacists then complete the FD 1639 form from information derived from the patient's chart and from direct communication with the responsible ward officer.

The FDA forms are reviewed by our drug utilization and adverse drug reactions committee, whch consists of one physician and three pharmacists; the pertinent data is presented at the next meeting of the therapeutic agents board, and then copies of FD 1639 are forwarded to the FDA and to the Army Surgeon General's Office.

In the future it is anticipated that our hospital, the Drug Utilization and Adverse Reactions Committee, will conduct drug utilization studies and ultimately drug efficacy studies.

In addition, the pharmacists—and this is the case at Walter Reed—maintain a ready file of FDA adverse reactions reports as a rapid information source for physicians. They also maintain current files of books and journals—available to physicians for immediate information on drugs, including efficacy, interactions, and toxicity.

Thus the pharmacist, with his special interest in pharmacology, has become an essential, permanent member of the therapeutic team. A logical question at this juncture might be, "What is the source of drug information utilized by most prescribing physicians?"