REPORTS FROM THE WORKING GROUPS

Through intensive dialogue in the Working Group sessions, Leadership Conference participants agreed on the following findings, objectives, and recommendations for achieving greater physician involvement in the prevention, identification, and management of SUDs.

UNDERGRADUATE MEDICAL EDUCATION

Findings.

Medical schools in the United States are accredited either by the Liaison Committee for Medical Education (for the M.D. degree) or by the Council on Predoctoral Education of the American Osteopathic Association (for the D.O. degree). These entities set standards for educational programs that lead to eligibility for licensure as a physician.

In both allopathic and osteopathic medical schools, most of the first two years of education takes place in classrooms and laboratories, as students learn basic medical sciences, in general and then by organ system. Students also learn basic communication skills and how to take a patient history and perform a physical examination in the first two years. Most schools require some clinical experience in the first two years, most of which is observational. Much of the third and fourth years of medical education takes place in clinical settings, where students learn to apply their knowledge of basic science and clinical skills in caring for patients under the direct supervision of faculty and residents.

Students may be exposed to substance abuse education in a variety of settings. During the first two years of medical school, substance abuse topics may be integrated into standard course work or taught as separate courses in addiction medicine. During the third and fourth years of medical school, students on required and elective clinical clerkship rotations may engage in specific substance abuse services. More commonly, however, educators formally or informally integrate substance abuse goals and objectives into clinical rotations such as internal medicine, family medicine, neurology, and psychiatry.

Dedicated training in SUDs is rarely offered. For example, a 1981 national survey of allopathic medical schools found that, while 40 percent offered elective courses in substance abuse, fewer than one percent provided required courses (Pokorny & Solomon, 1983; Lewis, 1987). A survey of 98 medical schools in 1986 (with an 85 percent overall response rate) found that the proportion of departments that offered a curriculum unit in substance abuse was 41/89 (46 percent) for internal medicine, 52/78 (67 percent) for family medicine, and 82/84 (98 percent) for psychiatry (Davis et al., 1988), with just more than half (53 percent) of these offering clinical experiences. A 1998-1999 LCME (1999) survey found that of the 125 accredited U.S. medical schools, training in substance abuse was provided as part of a larger required course in 119 (95 percent). Only 10 (8 percent) had a separate required course, while 45 (36 percent) offered an elective course.

The American Association of Colleges of Osteopathic Medicine (AACOM) surveyed colleges of osteopathic medicine to evaluate curricular offerings during the 1998-1999 academic year. All colleges reported offering substance abuse content in their curricula. On average, four percent of the curriculum time was reported as dedicated to substance abuse (Douglas Wood, personal communication). In a separate 1998 survey of 17 osteopathic medical schools by the American Osteopathic Academy of Addiction Medicine, only three of 11 schools that responded reported offering separate courses in addiction medicine during the first two years of medical school (Anthony Dekker, personal communication). None of the schools required a clinical clerkship rotation in substance abuse during years three and four; however, most offered elective rotations for interested students. Data are not available on the percentage of osteopathic students electing substance abuse rotations.

Objectives.

The Working Group on Undergraduate Medical Education defined the following objectives:

- Training in how to employ instruments and techniques useful in screening, preventive counseling, and brief interventions with patients at risk for or evidencing signs of SUDs should be integrated into the standard curricula of all medical schools. As a requirement for graduation, medical

students should be able to demonstrate that they know how to screen, counsel, and intervene with patients so as to prevent the development of, or arrest the progression of, SUDs.

- Training in the identification and management of medical and psychiatric comorbidities and complications of SUDs should be integrated into the standard curricula of all medical schools. As a requirement for graduation, medical students should be able to demonstrate that they know how to identify and manage such co-occurring medical and psychiatric disorders and complications.
- Training in the clinical, legal, and ethical issues involved in prescribing drugs with abuse potential should be integrated into the standard curricula of all medical schools. As a requirement for graduation, medical students should be able to demonstrate that they understand these considerations in prescribing for patients, including patients at risk for, presenting with, or with a history of SUDs, so as to minimize the risk of inducing or perpetuating an SUD.
- Licensure examinations should include questions that test the applicant's mastery of the relevant body of knowledge and skills.

Recommendations.

To achieve these objectives, the members of Group 1 recommended the following action steps:

1. Establish an expert panel or special content group to assist the National Board of Medical Examiners with test questions on SUDs.
2. Compile and disseminate information about potential model curricula for teaching about SUDs at the undergraduate level. As a first step, ask the conferees to submit information about possible models for compilation in the project database and dissemination to interested parties. Ask the Surgeon General to convene a meeting of medical school leaders to discuss ways to get the curricula adopted.
3. Work with the Federation of State Medical Boards (FSMB) to strengthen the language addressing the requirements of the medical licensing boards concerning the content of board examinations related to SUDs.
4. Work with the Surgeon General and medical societies to draft a strong ethical statement that says physicians may not ignore the signs or symptoms of SUDs: "Substance use disorders are medical illnesses and may not be ignored or go untreated. We do not choose the illnesses we treat."
5. Work with medical student organizations to help them advocate for better education on the identification and management of SUDs (this was enthusiastically supported by the two medical students who were present in Group 1).
6. Create a "marketing strategy" through which medical schools are rated on the SUDs content of their curricula, with the results prominently disseminated in medical and addiction journals (just as the rankings of U.S. colleges and universities are published in *U.S. News & World Report*).
7. Work with NIAAA, NIDA, and the Association of American Medical Colleges (AAMC) to establish and fund programs to support the development of young medical school faculty as substance abuse researchers, teachers, and mentors.

Graduate Medical Education

Findings.

The Accreditation Council for Graduate Medical Education (ACGME) oversees the training of 98,220 postgraduate (resident) physicians and the accreditation of 7,731 residency training programs in 99 specialty and subspecialty areas. Although several professional organizations have called for a greater integration of substance abuse education into allopathic and osteopathic residency training programs, the impact of these recommendations has been variable. For example, although the ACGME was represented in the development of the Policy Report of the Physician Consortium on Substance Abuse Education, substantive changes in Residency Review Committee (RRC) standards, requiring expanded integration of substance abuse curriculum into residency programs, never occurred (John Gienapp, personal communication).

A similar lack of impact was seen in osteopathic residency training standards (Eugene Oliveri, personal communication). Recent data indicate that there are RRC program requirements regarding substance abuse education in only five of the 99 specialty training programs (anesthesiology, family practice, internal medicine, obstetrics/gynecology, and psychiatry) (AMA, 1998).

A survey conducted in 1988 with a 74 percent response rate revealed that the proportion of departments that offered a curriculum unit in substance abuse was 93/232 (40 percent) for internal medicine, 195/288 (68 percent) for family medicine, 38/139 (27 percent) for pediatrics, and 153/169 (91 percent) for psychiatry (Davis et al., 1988). A recent national survey was conducted to determine the extent of substance abuse training in residency programs. This survey of 1,831 allopathic and osteopathic residency program directors in emergency medicine, family medicine, internal medicine, pediatrics, psychiatry, and obstetrics/gynecology found that the percentage of programs requiring substance abuse training ranged from 32 percent (pediatrics) to 95 percent (psychiatry), yielding a combined average of 65 percent. The median number of curricular hours ranged from three to 12. The traditional grand rounds lecture was the most common

curricular format used to teach substance abuse topics; only family medicine (55 percent) and psychiatry (75 percent) reported that a majority of their programs required clinical rotations. In recent surveys, the most commonly cited factors limiting further integration of substance abuse training into residency programs include a perceived lack of time, faculty expertise, identified training sites, and institutional support (Fleming et al., 1999; Isaacson et al., 2000).

While physician training should be geared toward a broad range of skills, including screening, intervention, referral, and follow-up care, it would be desirable that some proportion of substance abuse training be performed in specialized settings in order to expose trainees to this type of care. A separate survey has revealed that fewer than 10 percent of the faculty who teach substance abuse topics perform clinical work in addiction treatment programs, and that teaching is infrequently performed in these settings (Fleming et al., 1999).

Implementing screening, preventive counseling, and brief intervention is best approached as a systems issue (Fleming, 2002). Clinical services and the providers who deliver them need to be linked in terms of both location and reimbursement. Health care settings are complex systems with multiple competing agendas; therefore, implementation strategies must involve convincing purchasers (e.g., employers and government agencies) and payers (e.g., insurance companies and HMOs) to provide financial support and leadership. Both the purchasers and the providers need to be convinced that prevention of and early intervention for SUDs will improve the health of their covered populations and reduce health care and social costs. Similarly, professional organizations need to take a more active role in persuading payers to allocate a level of resources to the problem that approximates the impact of SUDs on the public health and economy (Fleming, 2002).

Objectives.

The Working Group on Graduate Medical Education identified the following objectives:

- Training in how to employ instruments and techniques useful in screening, preventive counseling, and brief interventions with patients at risk for or evidencing signs of SUDs should be integrated into the standard curricula of all residency training programs. Such programs should require residents to demonstrate that they know how to screen, counsel, and intervene with patients so as to prevent the development of, or arrest the progression of, SUDs.
- Instruction in the identification and management of medical and psychiatric comorbidities and complications of SUDs also should be integrated into the standard curricula of all residency training programs. Such programs should require residents to demonstrate that they know how to identify and manage such co-occurring medical and psychiatric disorders and complications.
- Training in the clinical, legal, and ethical issues involved in prescribing drugs with abuse potential should be integrated into the standard curricula of all residency training programs. Such programs should require residents to demonstrate that they understand these considerations in prescribing for patients, including patients at risk for, presenting with, or with a history of SUDs, so as to minimize the risk of inducing or perpetuating an SUD.
- Specialty board examinations should include questions that test the applicant's mastery of the relevant body of knowledge and skills.

Recommendations.

The members of Group 2 designed a two-pronged approach to achieve these objectives: (1) address the ***extrinsic*** larger systems factors outside medicine, such as factors that impede the identification, treatment, and referral of patients with SUDs: for example, insurance coverage that does not work, loss of treatment facilities, and carve-outs that mean doctors are not being paid for what we want them to do in caring for patients with SUDs, and (2) attack the ***intrinsic*** systems factors inside medicine, such as residency programs, stigma associated with alcoholics and other patients with SUD, and transmission of negative attitudes toward SUDs from older medical staff to younger staff. To achieve this, the members of Group 2 proposed the following action steps:

1. To address the *extrinsic factors*, identify a sponsor and potential funders for a high-level think tank-type meeting to bring together the major purchasers and administrators of health care to focus on the economic implications of SUDs. Attendees would include private sector employers, such as IBM and General Motors; public sector funders, such as the Centers for Medicare & Medicaid Services, Medicaid claims administrators, state alcohol and other drug agencies, presidents of Blue Cross Blue Shield plans and of "big medicine" educational groups (e.g., AAMC, ABMS, and ACGME), and the Chair of the Deans' Association of AAMC; and business and health consulting groups capable of offering econometric and business analyses, such as Leapfrog, Lewin, and RAND.
2. To address the *intrinsic factors*, identify a sponsor and potential funders for a second meeting, to bring together representatives of the institutions of medicine to focus on the overarching need to set minimum standards for training all medical students and residents in the recognition of SUDs. Attendees would include the ACGME leadership, the heads of the respective American Board of Medical Specialties (ABMS) boards, the Chairs of the RRCs, and others who create and maintain the core content for each of the specialties.

3. Approach the ACGME and RRCs for help in identifying and disseminating information about model residency training programs that incorporate teaching about SUDs. As a first step, ask the conferees to submit information about possible models for compilation in the project database and dissemination to interested parties.
4. Work with the ABMS to strengthen the language articulating the requirements of the various specialty boards for the content of examinations related to SUDs. As a first step, ask the conferees to submit copies of relevant special board requirements for compilation in the project database and dissemination to interested parties.
5. Compile and disseminate information about available fellowship opportunities in addiction medicine and addiction psychiatry. As a first step, ask the conferees to submit information about fellowship opportunities for compilation in the project database and dissemination to interested parties.
6. Compile and disseminate information about sources of available funding to support modification of residency training curricula to include greater attention to substance use disorders. As a first step, ask the Federal agency and foundation representatives to submit information on funding sources, for compilation in the project database and dissemination to interested parties.

Continuing Medical Education

Findings.

Continuing medical education is a system that provides resources to physicians engaged in individualized "learning projects." Such projects are designed to support an individual's continuous and personal professional development agenda, which reflects his or her scope of practice (e.g., clinical, educational, administrative, leadership). Some of these activities have been identified by the AMA as credible and valid learning activities deserving of Category I Credit in the Physicians Recognition Award of the American Medical Association. This system of recognizing continued learning is administered by the Accreditation Council for Continuing Medical Education (ACCME).

Continuing education is effective in changing practice behaviors if it is framed correctly. Each type of activity is suited to a particular learning need. For example, didactic lectures and books transfer data and information. Supervised work and coaching support the development of skills. Reflection and small group work facilitate the transition to competence. This is why CME that is effective in promoting change in practice always involves multiple steps and modalities spread over time, and includes feedback as well as reminders in practice.

The common features of all CME activities are that the content, objectives, and elements of evaluation share the following features: (1) they are anchored to the learner's practice-based questions or needs, (2) their content is valid, and (3) they are free of commercial bias. The CME system, through its accredited providers, brings form and function to these features by structuring or facilitating them as learning activities that are designed to advance the learner along a knowledge, competence, or performance agenda.

The contents of accredited CME programs are derived from practice-based needs, whether at the level of individual physicians, medical communities, or larger physician populations. Physicians are involved in CME programs to fulfill their learning goals. Not all learning requires an accredited provider-based activity, but all accredited provider-based activities should result in, or at least be designed to promote, learning. The presence of a method to assure that all three features are present in a learning activity is the value that the CME accreditation system brings to the learner.

Objectives.

The Working Group on Continuing Medical Education identified the following objectives, which it designated "strategic imperatives":

* Mainstream education about SUDs by teaching them in the same way that knowledge and skills in addressing other chronic disorders are taught.
* Overcome stigma by engaging experienced physicians who are experts on SUDs in mentoring younger/novice physicians. Also, encourage colleagues and organizations to present positive public messages about SUDs and to avoid implicitly negative language and messages.
* Engage health care purchasers and payers in addressing reimbursement and coding issues (as represented by parity and the Uniform Accident and Sickness Policy and Provision Laws).
* Encourage all medical organizations to adopt a standard, clinically focused terminology, as CSAP has done over the years with prevention terminology. For example, in medical forums, refer to "relapse" rather than "recidivism," to "opioids" rather than "narcotics," and to "patients" rather than "clients."

Recommendations.

To achieve the foregoing objectives, the members of Group 3 proposed the following action steps:

1. Work with ACGME and the various specialty boards to strengthen the requirements for continuing education on SUDs. In addition, encourage the specialty boards to include questions that test the applicant's mastery of the body of knowledge and skills relevant to SUDs in their recertification examinations.

2. Work with ABMS and the state medical boards to include questions that test the applicant's mastery of the body of knowledge and skills relevant to SUDs in their licensure examinations.
3. Compile and disseminate information about potential model CME programs about SUDs. As a first step, ask the conferees to submit information about possible models for compilation in the project database and dissemination to interested parties. Collaborate with ACCME to develop a "www.accme.gov" Web site, where approved educational programs could be listed.
4. Facilitate a connection between ONDCP, other leaders of the initiative, and organizations that represent the CME infrastructure (i.e., those that provide and accredit CME programs). Through such a relationship, the CME providers could be engaged in promoting the concept that public health issues (including SUDs) should be addressed through their systems and members.
5 Facilitate a connection between Federal agency staff who have CME responsibilities and the group of experts within ONDCP and other leaders of the initiative. If government CME providers were to embrace the concept of partnering with private sector organizations, the dissemination strategy would be in place. For example, the National Institutes of Health, Centers for Disease Control and Prevention, or Federal Drug Administration could invite the national medical specialty societies to become partners in developing and presenting clinical modules on identifying and managing SUDs (few would decline such an offer). Look to the buprenorphine training courses (the curricula for which were developed through a collaboration between CSAT and selected medical specialty societies) as a model.
6. Teach about prescribing drugs with abuse potential in the same way other areas of clinical knowledge and skills are taught. Use all the educational media available, including new media such as teleconferencing and online CME programs. Employ multiple focused interventions (in the same way pharmaceutical manufacturers do with the roll-out of a new drug) through partnerships between Federal agencies and relevant private sector organizations.
7. Work with NIAAA and NIDA to identify and disseminate information about sources of funding to support clinical research into the prevention, identification, and management of prescription drug abuse.
8. Incorporate language that reflects competency in prescribing controlled drugs into licensure standards and certification/recertification programs. Require that at the time of re-registration with DEA, physicians present evidence of CME credits and/or focused self-assessment to achieve this competency.
9. Revise patient charts to move the personal/family history of alcohol and drug problems from the "Social History" to the "Past Medical History," where it is more likely to be considered in the prescribing decision. Add similar cues to the screens of electronic medical records.
10. Add reminders about prescribing considerations and cautions to the backs of prescription forms (especially state-issued forms).
11. Through public-private partnerships (e.g., NIDA and ACOG), identify and/or develop educational materials that physicians can give to patients for whom they prescribe drugs with abuse potential.

Role of the Federal Agencies

Findings.

Conferees agreed that the Federal health agencies have an important role to play in physician education, acting through multiple mechanisms:

RESEARCH GRANT SUPPORT. Increased grant support for research designed to foster physicians' competencies in identifying and addressing SUDs will not only stimulate research in the field, but also provide needed support to faculty with critical research agendas. Examples of potential research agendas for these faculty include determining the appropriate health care profession to perform a brief intervention, determining the critical components of brief interventions, exploring the need to adapt screening and brief intervention strategies to special populations, and determining the most effective teaching strategies for training clinicians in screening and brief interventions. The opportunities to compete for research grants in these areas will help stimulate faculty interest, promote career development for faculty interested in this field, create new and useful knowledge, and add legitimacy to the field. Successful grantees will also serve as role models or mentors for junior faculty members.

INSTITUTIONAL SUPPORT. Institutional support for faculty teaching about SUDs can be developed via funding mechanisms that are designed to foster development of curriculum or research efforts. Funds that are targeted toward programs that cut across disciplines (e.g., medicine, social work, nursing) will foster development of collaborative research and training efforts and help engender institutional support.

CENTERS OF EXCELLENCE. Federally funded National Centers of Excellence are needed to serve as model programs that are focused on developing, disseminating, and implementing methods of research, clinical care, and education on SUDs. Such centers could participate in a network to develop and implement a standard curriculum for undergraduate, graduate, and postgraduate medical education. Current Federally supported initiatives with national infrastructures, such as the Area Health Education Centers supported by the Health Resources and Services Administration (HRSA), the Addiction Technology Transfer Centers supported by CSAT, and the Clinical Trials Network supported by NIDA, can provide a framework on which to build the proposed centers.

Objectives.
The members of the Working Group of Federal Agencies identified the following objectives:

- Training in how to employ instruments and techniques useful in screening, preventive counseling, and brief interventions with patients at risk for or evidencing signs of SUDs should be integrated into the standard curricula of all medical schools, residency training, and continuing education programs.
- Training in the identification and management of medical and psychiatric comorbidities and complications of SUDs should be integrated into the standard curricula of all medical schools, residency training, and continuing education programs.
- Training in the clinical, legal, and ethical issues involved in prescribing drugs with abuse potential should be integrated into the standard curricula of medical schools, residency training, and continuing medical education programs in all specialties.
- Federal agencies should assist in the development, dissemination, and evaluation of these curricula at all levels of physician training.

Recommendations.
The members of Group 4, all of whom represented Federal agencies, responded to the following question: "Assume we have accomplished all the competencies by the year 2010, what did the government do to make it happen?" They agreed that the Federal government could play the following roles:

1. Bring resources and authority to the issue (as the ONDCP Director, the Surgeon General, the NIDA and NIAAA Directors, and the NHTSA Administrator did at the Leadership Conference).
2. Elevate the visibility of the subject to the highest levels of the agencies, and encourage collaboration across agencies (e.g., Department of Health and Human Services and VA working together).
3. Keep working to find ways to convince physicians that SUDs are medical disorders. Simultaneously, help physicians understand the impact of SUDs on other medical disorders for which they provide care (as Dr. Volkow advised in her presentation).
4. Break the problem down by stage of illness. Develop different treatment and referral models for the early, middle, and late stages of the disorder, as is done with other chronic disorders.
5. Use information that is already available (such as the SAMHSA Treatment Improvement Protocols and the VA clinical practice guidelines) to provide frameworks for the development of clinical models. (SAMHSA's initiatives with the recovery and faith-based communities would be an important piece.)
6. The VA system can begin to develop models for medical education, then use its clout to renegotiate contracts with medical schools to incorporate them.
7. HRSA could provide funding for the development and implementation of clinical models for its target populations (e.g., for treatment in rural areas) in collaboration with other agencies.
8. Work together across multiple agencies, including payers such as Medicare and Medicaid and other organizations to develop more ideas about clinical models. Such clinical models would, in turn, facilitate the development of reimbursement models. (Alternatively, develop guidelines, then let economists develop the models.)
9. Support research into strategies that promote system change and provider change. Work with the credentialing bodies to develop and maintain incentives for change. Test the models' efficacy with demonstration projects, funded through contracts and requests for applications.
10. Compile and disseminate information about sources of available funding to support modification of medical school curricula and residency training programs, as well as development of continuing education programs, to include greater attention to SUDs. As a first step, ask the Federal agency and foundation representatives to submit information about available funding for compilation in the project database and dissemination to interested parties.

The members of Group 4 pointed to nutrition and geriatrics as good examples of how cross-cutting ideas are incorporated into medical education, and suggested that these and other specialties should be studied as models.

PUBLIC INPUT

Recommendations.
The following recommendations were presented by Dr. Sidney Schnoll, representing the Public Input Working Group:

1. Work with NIAAA and other agencies to develop and fund a program (like that outlined by Dr. Li in his presentation) that would support the development of medical school faculty who are experts on SUDs. Such individuals become "champions" for adding addiction-related content to the curriculum in undergraduate and graduate medical education and become role models and mentors for students.
2. Work with ASAM, AOAAM, and the American Academy of Addiction Psychiatry to develop a joint committee to develop questions on SUD-related topics for medical schools, the National Board of Medical Examiners, and other developers of certification/recertification examinations. As part of this, look at the case simulation materials developed by Barry Stimmel, M.D., and

colleagues at the Mount Sinai Medical School for use in clinical skills testing. (Some years ago, copies of these materials were sent to every medical school dean in the United States. Unfortunately, the information is probably tucked away on a shelf gathering dust.)

3. Include the pharmaceutical industry in all plans for educational programs to address prescription drug abuse, because industry has more resources and better data than the Federal government and already is a major sponsor of continuing medical education.

Action Plans

To sustain the momentum generated at the Leadership Conference, the conferees recommended that the following actions be initiated as quickly as possible:

1. In lieu of a standard written conference evaluation, arrange for the facilitators to individually debrief conference participants to learn their reactions, ideas, and suggestions for follow-up activities. Revise the follow-up plan to reflect the information gathered through the debriefing process. *[Completed]*
2. Compile the "next steps" proposed by each of the Working Groups and disseminate the resulting draft document to all Leadership Conference participants. Arrange a conference call with the chairs, co-chairs, facilitators, and reporters of the Working Groups to review the document and to identify common issues and themes. *[Completed]*
3. Send the draft conference report to Working Group members for review and comment. Arrange a follow-up conference call with each of the Working Groups to discuss the report and follow-up plans. *[Completed]*
4. Invite the conference participants, the Federal agencies, and the medical specialty societies to submit relevant educational programs and curricula for undergraduate, graduate, and continuing medical education for compilation in the project database and dissemination to interested parties. Ask the Expert Panel members to assist in compiling and evaluating this information. *[Underway]*
5. Ask the Federal agency and foundation representatives and other conference participants to submit information on available program and research funding for compilation in the project database and dissemination to interested parties. *[Underway]*
6. Develop articles describing the conference and submit them to refereed journals for publication, including the *Journal of the American Medical Association*, the *Journal of the American Osteopathic Association*, specialty journals for the various medical specialties, policy journals such as *Health Affairs*, newsletters, and other publications. Frame different aspects of the conference to address the interests of particular audiences. *[Underway]*
7. Initiate meetings between representatives of appropriate Federal agencies and educational providers, organizations representing the prescribing professions, and other stakeholder groups to identify mutual goals and initiate collaboration on project development and dissemination. *[Underway]*
8. Invite the Leadership Conference participants to identify opportunities to gather informally at forthcoming meetings of their organizations. Ask the participating organizations to consider helping to organize and/or sponsor such gatherings. *[Underway, with the first gathering held at ASAM's annual meeting in April 2005]*
9. Arrange meetings between ONDCP staff and representatives of Groups 1 and 2 with executives of ABMS and the Association of American Medical Colleges (whose leaders were unable to attend the conference because of a conflicting engagement). *[Underway]*

There was virtually unanimous agreement among the conference participants that considerable progress had been made and that a follow-up meeting should be scheduled in one year to revisit the objectives, strategies, and action steps and to assess progress toward achieving them. In the interim, the conferees suggested that the Expert Panel continue to meet as an organizing nucleus and that task forces be appointed to pursue specific objectives.

In his closing remarks, conference chair Addison D. "Tad" Davis IV, ONDCP's Assistant Deputy Director for Demand Reduction, pledged that his office would work to sustain the energy and commitment evidenced by the conferees, saying "I met with the Surgeon General within the last two weeks. He's fully on board with what we're trying to accomplish here, and he's committed to staying with us, as are Dr. Runge and Director Walters and others in the community. I think that your presence here as a group has reinforced the importance of the efforts that are underway."

Mr. Davis added that "We will continue to work with other agencies, organizations, health care professionals, and leaders in the medical community to develop strategies to integrate new knowledge about alcohol and drug abuse and addiction into medical education."

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