have been dramatically increased to speed the development of more answers on such pressing problems as cocaine and crack use, drug use in the workplace, acquired immunodeficiency syndrome (AIDS) among intravenous drug users, and drug and alcohol abuse treatment evaluation. The research budget of the National Institute on Drug Abuse for fiscal year 1987 was boosted by $27 million, to a total of $107 million, and that of the National Institute on Alcohol Abuse and Alcoholism by $3 million, to a total of $69 million, both historic high levels of investment in research on these problems.

ADAMHA also will collaborate with the Department of Education in a $2 million school initiative included in the President's crusade.

We look forward to these steps making deep inroads into the serious alcohol and drug problems affecting our citizens. The year 1987 will be recognized as the year the nation decided that alcohol and drug abuse would no longer be tolerated—either among our youths or in the adult population—and started to reestablish a truly "drug-free" America.

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Alcohol, Drug Abuse, and Mental Health Administration

Setting an Agenda for the Council on Graduate Medical Education

With increasing pressure to reduce the Federal budget, the Federal Government is undertaking a fundamental re-examination of its role in subsidizing medical education. Congress has made a number of changes in recent years in the way physician training is financed by Medicare—the single largest source of payment for medical education. Some of the latest changes are contained in the budget reconciliation bill known as COBRA—the Consolidated Omnibus Budget Reconciliation Act of 1985—which authorized the Council on Graduate Medical Education.

I was privileged, as a former staff member of the Senate Committee on Labor and Human Resources, to have worked on this legislation and now I am pleased to be able to help implement it. Support services for the newly established Council are being provided by the Health Resources and Services Administration (HRSA), which I direct, and Dr. Robert E. Windom, Assistant Secretary for Health, has designated me to represent him on the Council.

When Congress was considering the legislation that emerged as COBRA, it was impossible to reach a consensus on many provisions. There was agreement, however, that decisions based largely on financial considerations were having major implications for the training of physicians and other health professionals. There was concern that cost-cutting efforts be balanced by the need to assure a sound financing system for the clinical training required to produce an adequate supply of health practitioners. A high-level body was needed to look at the issues in depth. Both the Senate and the House agreed that the Council was a good idea.

It should be recognized that the Council on Graduate Medical Education was envisioned by Congress as a simpler effort than the Graduate Medical Education National Advisory Committee (GMENAC). That Committee advised the Secretary of Health and Human Services (HHS) on physician supply and requirements by specialty in a seven-volume final report issued in 1980. The Council does not have the resources to mount a similar large-scale undertaking.

In view of this limitation, it is vital that the Council focus its efforts. The statute mentions a broad range of concerns, and if the Council attempts to evaluate all of them equally, it could become bogged down in laborious tasks. I would recommend that it be concerned with the larger issues.

Dr. Otis R. Bowen, HHS Secretary, told the Council at its first meeting: "We need Federal policies in graduate medical education that will not fan the flames of medical care price inflation, and we need your best advice on how to accomplish that. As I see it, that is your biggest challenge."

Financing may be an excellent topic around which to structure the Council's agenda. In terms of financing, the Council could discuss changes regarding foreign medical graduates, changes in reimbursement regarding teaching facilities and ambulatory settings, and so forth. The Council should not only look at financing through Medicare and Medicaid but also at alternative mechanisms.

The Council also should focus to the extent possible on foreign medical graduates and their role, whether the graduates be aliens or U.S. citizens trained in foreign medical schools.

Although the legislation addresses both graduate and undergraduate medical education, I believe the primary focus should be on graduate training, as the title of the Council implies. However, undergraduate training should be examined to the extent that we have to consider students in the training pipeline.

A number of activities relevant to the Council's deliberations are already under way. HRSA, for example, produces for the President and Congress a biennial report on the status of U.S. health personnel. The agency recently completed a significant study on financial disincentives affecting the career choices of health students.

Important information also is available from other parts of HHS as well as the Veterans' Administration and the Department of Defense.

New studies of three significant topics are authorized by COBRA: reimbursement for educational costs related to nursing and other health professions, the need for special reimbursement provisions regarding geriatric training, and the types of services and quality provided by foreign medical graduates in the Medicare Program.

The council should gather whatever information is available and not duplicate other efforts.

There has been some concern that the data base is inadequate for the Council's work. If that is correct, we will have to find out how it can be strengthened so that there is enough information to make informed choices. However, this effort must be balanced with the mandate to perform the tasks the Congress has given us.

The Council has a 10-year life, and its first report is due before July 1, 1988. The date seems distant, but I believe it will be a challenge to meet it with the kind of report the HHS Secretary and Congress expect.

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LETTERS TO THE EDITOR

A Second Opinion on Zuni Diabetes

I read with great interest "Zuni Diabetes Project" in the May-June 1986 issue (*1*). I must, however, take exception to various points presented by the authors. As a former director of the nationally recognized Project Health Promotion, Gila River Indian Community, Sacaton, AZ, National Model, 1982, Centers for Disease Control, I feel I must address not only methodology and approach, but professional, moral, and ethical issues as well.

First, in presenting a "traditional historic" viewpoint of the Zuni peoples' past, the author(s) make particular reference to "foot transportation and foot racing." One can easily read between the lines and assume that all Zuni peoples, regardless of social strata and age, at one time engaged in daily rituals of running and foot racing. Leaving out the fact that this diabetes program has gained its reputation by promoting running (another issue), one begins to see an effortless transition from "history" to "traditional values." And logic implies that the restoration of lost values will institute behavioral change.

For those who know little or nothing about the group with which they work, the logic is flawless, witness the outcropping of this type of programming. It should also be mentioned that this program fits nicely with America's latest fad and fascination with running.

Second, the authors state, "We are not aware, however, of any other public or community programs structured for the purpose of enlisting diabetics in regular physical activity, providing motivation, guidance, and education, and following their clinical response." At least one author (Mr. Leonard) has full knowledge of an existing program (Project Health Promotion, Gila River Indian Community) which is nearly identical to the Zuni project, even to enlisting the participation of the medical care providers themselves in the classes.

Third, the term "prevention" with regard to Native Americans and diabetes insinuates that the onset of the disease process can be totally prevented. Prevention programs among the Native American population have not existed long enough to show whether intervention measures can actually reduce incidence. Articles such as this one that lead readers into assuming such programs prevent a disease process without validating the true