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.

David N. Sundwall, MD
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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

precursors or substantiating outcome to demonstrate actual reduction of known prevalence and incidence levels shortchange not only the integrity and credibility of the program's basic premise but create a bandwagon effect for those wrestling with implementing intervention programs of their own.

Fourth, in reality, the outcomes presented lead to validation of methodology and approach based on too few results. This leads to the question of what constitutes true success in community-based programming. The success in this case is based on whether there is control of weight and subsequently of blood glucose. The success should be measured by the total number of the target population that engages in the activity for a substantial period of time. This is the true measurement not only of the efficacy of the program but also of the acceptance of the program by the population in question.

Finally, the authors declare that "The ultimate goal of the Zuni Diabetes Project is to create within the Zuni community a culture that encourages healthy lifestyles and insures sustained behavior change." The creation of a culture is a far cry from incorporation of exercise and diet as a means to combat disease. Attempts to create a "culture" or to indoctrinate an existing culture in the name of "health" smack of professional arrogance and a total disregard for the integrity of the existing culture.

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Reference

1. Leonard, B., Leonard, C., and Wilson, R.: Zuni diabetes project. Public Health Rep 101:282-288, May-June 1986.

This letter is a condensed version of a much longer communication. Readers interested in obtaining a copy of Mr. Walden's original letter may write to him at Rt. 1, Box 12, Parker, AZ 85344—Editor.

Response: Improved Health Is the Aim

As a general response to a letter expressing concern with our program description, we would first like to reassure Mr. Walden that we are all working toward the same end: to improve the health of people. Our intention was in no way meant to slight the health promotion efforts at Gila River. We would eagerly welcome a description of Mr. Walden's program design, results, and experience in hopes that it would contribute to the small but growing body of knowledge in this area.

More specifically, we would like to address Mr. Walden's criticism of our problem description and philosophical approach. Our article takes the same stance that lifestyles changed dramatically in a short period (mid-20th century) for Indian populations. Following on the heels of these changes were sudden, rapid increases in prevalence rates of diabetes and its complications. We disagree with Mr. Walden in his charge that our "logic implies that the restoration of lost values will institute behavior change." This conclusion is his own; it is not stated or implied in the text of our article. Sedentary living and year-round calorie-dense diets are common in the American, non-Indian population and the populations of many rapidly developing nations. High incidence and prevalence of diabetes is a recent finding in many aboriginal populations subjected to these lifestyle changes. Restoration of higher caloric expenditure and lower caloric intake—not "lost values"—is the goal of our program and the subject of our paper.

We also disagree with Mr. Walden in his charge that use of the term "prevention" is inappropriate with regard to diabetes in Native Americans. If Type II diabetes is frequently controllable to euglycemic levels with the initiation of diet and regular aerobic exercise, it follows that with the same measures earlier on, the onset of clinically apparent diabetes could have been prevented or postponed until other diabetogenic conditions (age, illness, pregnancy) intervened. Recent epidemiologic evidence reveals that long-term athletic training is associated with a lower risk of developing diabetes (*1*). Mr. Walden certainly understands that preventability is never 100 percent, yet that fact does not provide a rationale for abandoning preventive practices. Would the incidence of cardiovascular deaths be decreasing now if aerobic exercise had not been promoted 20 years ago on the basis of its theoretical prophylactic benefit?

Finally, we appreciate Mr. Walden's suggestions regarding research strategy, but we emphasize that the data presented were the result of a simple, retrospective pilot study. The primary purpose of the article was to describe a community-based health promotion program.

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Reference

1. Frisch, R., et al.: Lower prevalence of diabetes in female former college athletes compared with nonatheletes. Diabetes 35: 1101-1105, October 1986.