

Summer Camps For Diabetic Children

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Those interested in providing summer camp facilities for diabetic children have been encouraged by the establishment of various new camps throughout the country during the past few years. Others are in the planning stage. It seems appropriate, therefore, to summarize available camp information in the hope that this material may be useful to those who are considering the establishment of new camps or are in the process of starting them. In the preparation of this paper the writer has drawn freely from a thesis prepared by Miss Minette Katryn Shanahan in 1947 at the University of California, and entitled "Camping Provisions for Diabetic Children in the United States." Data have also been obtained from the 1948 report of Dr. Henry J. John, then Chairman of the Committee on Camps of the American Diabetes Association.¹ Finally, information has been obtained from questionnaires which were courteously answered by those in charge of the various camps. The writer's comments are based chiefly on observations at the two camps in Massachusetts and may not always reflect the views of others.

HISTORY

The idea of summer camps for diabetic children is not a new one. In 1925, only three years after the introduction of insulin into clinical usage, Dr. Leonard F. C. Wendt of Detroit started a small camp. In the beginning there were only four campers, who were housed in a private cottage owned by a diabetic patient. As the

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camp grew in subsequent seasons, it was held at various sites and under various auspices. The camp was closed during World War II. It reopened in 1946, but since then has again discontinued operations.

The second camp was established by Dr. Henry J. John of Cleveland in 1929, under the name of Camp Ho Mita Koda, a phrase from the language of the Sioux Indians which means "Welcome, my friend." This camp is located on 40 acres of wooded land near Newbury, Ohio, about 30 miles east of Cleveland. The camp was closed while Dr. John was in the Army in World War II, but it reopened for the 1947 season.^{2, 3}

As early as 1927 Dr. Elliott P. Joslin and associates began sponsoring camping facilities for diabetic children. For several years the camps were small and were held under various auspices and in various places in Massachusetts, New Hampshire and Maine. In 1932 a permanent arrangement was made for girls at the Clara Barton Birthplace Camp, North Oxford, Massachusetts. In 1948 a permanent camp was established for boys in the adjoining town of Charlton, Massachusetts; it is called the Elliott P. Joslin Camp.^{4, 5} These camps are administered by the Association of Universalist Women, which for years has donated much time, effort and money. Substantial financial support has also been given by the Massachusetts Committee on Social Service of Unitarian Women.

Another early camp was that sponsored by the Metabolic Clinic of the University of Pennsylvania Hospital. In 1935 small groups of diabetic children were cared for at the University Camps of the Christian

Association of the University of Pennsylvania. In 1936 Camp Firefly, the Pennsylvania Camp for Diabetic Children, was established by the Philadelphia Metabolic Association. Conducted under the auspices of the John B. Deaver Memorial Auxiliary of the Lankenau Hospital, it has used various sites but is now located at Spring Mount, Pennsylvania.

In 1937 the New York Diabetes Association opened a camp for diabetic children which has operated yearly since. The camp has grown and developed steadily. In 1945 a permanent site was purchased for Camp NYDA at Burlingham, N.Y. In 1951 the camp accommodated 171 children.

Also established in 1937 was the Washington Camp for Diabetic Children at Rockville, Md. Medical sponsorship comes from physicians in Washington, D. C.

The establishment of camps has by no means been confined to the eastern part of the country. As early as 1938 Camp Banting and Camp Priscilla White were established in the state of Washington, and in the same year Camp Whitaker was opened in California. University Camp, also in California, was opened in 1941 for one season, closed for the war period, and reopened in 1946.

The number of camps has now grown to 18, including one in Canada. This is Illahee Lodge at Cobourg, Ontario. It is owned and operated by the Neighborhood Workers Association, and sponsored by the Kinsmen Clubs, both of Toronto. It is not run solely for diabetics, but is operated also for children with other medical conditions. Of the 50 children who can be accommodated at each of three camp sessions there are, on the average, about 15 diabetics.

DATA REGARDING CAMPS NOW IN OPERATION

Information regarding the 18 camps has been summarized in Table 1. It is evident that although the camps are scattered quite well over the country, there are certain large areas of the United States and Canada in which a diabetic child would need to go hundreds of miles to a summer camp. The need for new camps in these areas is obvious.

Taking into account the increased capacity of those camps which have more than one session, the number of children which can be accommodated in all camps is 1996. During the summer of 1951 a total of 1304 children actually attended. This lower figure was due in part to the fact that, in camps having more than one session, certain campers stayed for more than one period. However, the figures do indicate that, in ad-

dition to the need for additional camps in certain areas now unserved, the facilities of some of those camps already established could be used more completely. Physicians caring for diabetic children should urge them to seek the benefits of a summer camp stay.

The rates quoted in Table 1. cannot in most instances be regarded in the same way as listings for private camps. In most camps the money received is more in the nature of a contribution, since the camps are non-profit organizations usually dependent upon public support of one type or another. Furthermore, the rates listed in the table cannot be compared from one camp to another, since each camp, to the full extent of its resources, accommodates children regardless of ability to pay. The matter of the cost of camp operation is discussed later in the paper.

ESTABLISHMENT AND OPERATION OF A SUMMER CAMP

Sponsorship

The operation of a summer camp for diabetic children can never be a money-making venture. To accommodate the children who most need the benefit of a camp stay, the cost must be subsidized in large part. Fortunately for this purpose, the health and welfare of children have a strong public appeal. Prior to the organization of the American Diabetes Association and its Affiliates, camps were established by physicians or groups of physicians who often secured the support and cooperation of church organizations, civic clubs, nonmedical professional societies, business associations with charitable programs, and similar groups. In view of the increasing interest in the formation and development of Affiliate Associations, it is likely that in the future the sponsorship, organization and financing of new camps will become an important and extremely worthwhile activity of these Affiliates. Financial support can be found among the groups mentioned above. Physicians interested in and responsible for the medical aspects of summer camp work can usually help most by concentrating on professional activities among the children. Consequently it is often better if the operation and administration of the camp is the responsibility of the lay organization which has helped to organize and finance the camp, such as the Lay Society of an Affiliate.

Site

Ideally a camp should be located in a wooded area and include, or have access to, a pond, lake or stream for

water sports. Facilities for walks in the woods, nature study, "cook-outs" and overnight camping add a great deal to the pleasure and benefit derived by the diabetic child. However, almost any camp site is acceptable provided the sponsors of the camp offer a carefully planned and executed program. Land and buildings may be owned by the sponsoring group, trust or foundation. However, if this is found to be too costly an enterprise, often an arrangement may be made to rent part or all of a camp already established, such as a Boy or Girl Scout Camp, a civic or church camp or retreat, etc., for a few weeks of each summer.

Length of Camp Season

In establishing a new camp it is wise to start modestly, providing at first for single sessions of 2 or 3 weeks, with perhaps one session for boys and one for girls or a combined session if only younger children are to be accommodated. Local needs, estimates of attendance, and availability of facilities must govern the decision in this regard. If at all possible, the camp session should last at least 2 weeks to provide maximal benefit both from a recreational and medical standpoint. If the number of prospective applicants and facilities allow, arrangements may be made for 2 to 4 sessions of 2 or more weeks each.

Age of Campers

Children from 5 or 6 up to 15 or 16 years of age may be handled successfully. Those less than 5 years old present a problem in individual care, and even for children who are 5 and 6 years old, arrangements for special supervision will be necessary. Those in the highest age groups may become "counsellors-in-training."

Organization

In smaller camps with perhaps only one session of 2 weeks, the organization may well be informal, with most if not all workers on a voluntary basis. However, in larger camps the organization must be made quite business-like and the whole affair will necessitate much careful planning year after year. The basic structure resembles that of the privately operated summer camp, but the organization is made more complex by the need for a medical as well as a recreational staff. The Camp Director is aided by a Program Director and by counsellors especially chosen for their experience and skill in directing various camp activities. Among the more important of these are swimming; land sports including baseball, volleyball, track and archery; and nature study,

music and dramatics. It is desirable to have one counselor for each four campers. The medical staff should include a Resident Physician, nurses, dietitian and laboratory technicians. There must be close cooperation between recreational and medical staffs.

Program

In a camp for diabetic children it is essential that the Camp Director and the Resident Physician work together closely so that the program may allow time for necessary events of a medical nature. Insulin must be given at a definite time, meals and between-meal lunches must be served regularly and a certain minimum of laboratory tests must be carried out. Some thought in scheduling times of physical activity and of quiet periods will do much to lower the incidence of insulin reactions.

Despite these limitations, it is entirely possible to arrange a full and varied program of sports, nature study, music and dramatics which will both please and develop the diabetic child. The program in certain camps is discussed in papers already published.²⁻⁸

Buildings

It would not be profitable here to discuss the number and type of buildings necessary and desirable since use must be made of what is available or what can be afforded. Ideally the structures should include cabins for housing small groups of campers and their counsellors, a dining hall and kitchen, a recreation hall, an administration building, an infirmary, a laboratory, and staff quarters. The infirmary should provide one or more beds for campers with minor ailments. The laboratory should provide facilities for the determinations of sugar in urine and blood, for general urine analyses, and such other tests as are contemplated. For descriptions of the physical plant of certain camps, the articles by John,² Gabriele and Marble,⁴ Grishaw⁶ and Sweeney⁸ should be consulted.

Cost

In the present day it is costly to run a summer camp of any type. When one adds to the recreational features the medical provisions cited above, the expense is increased considerably. One must pay acceptable salaries for a Camp Director, for counsellors, for nurses, dietitians and laboratory technicians if one is to attract well-qualified workers. At the Clara Barton Birthplace Camp the cost in 1951 was \$45 per girl per week. At the neighboring Elliott P. Joslin Camp the correspond-

Table 1. CAMPS FOR DIABETIC CHILDREN IN THE UNITED STATES AND CANADA

NO.	NAME	STATE OR PROVINCE	LOCATION	OWNER OR SPONSOR	DATE FOUNDED	TERM
1.	Seale Harris Camp	Ala.	Citronelle near Mobile, Ala.	Diabetic Clinic of Mobile, Inc.	1949	2 weeks
2.	University Camp	Cal.	San Bernardino Mountains above Redlands, Cal.	Los Angeles Metabolic Clinic	1941	2 weeks
3.	Camp Whitaker	Cal.	Near King's Canyon National Park	Diabetic Youth Foundation	1938	Two 2-week periods
4.	Washington Camp for Diabetic Children	Md.	Rockville, Md.	Christ Child Farm for Convalescent Children	1937	One month
5.	Clara Barton Birthplace Camp	Mass.	North Oxford, Mass.	Association of Universalist Women and The Diabetic Fund	1931	Five 2-week periods
6.	Elliott P. Joslin Camp	Mass.	Charlton, Mass.	Association of Universalist Women and The Diabetic Fund	1948	Three 3-week periods
7.	Camp Friendly	Mich.	Lake Olcott, Napoleon, Mich.	Toledo Diabetes League	1950	2 weeks
8.	Camp Lake of the Woods	Mo.	Swope Park, Kansas City, Mo.	City and Lay Diabetic Society of Kansas City	1951	2 weeks
9.	Springdale Camp	Nebr.	Nebraska City, Nebraska	Springdale Camp Corp.	1951	2 weeks
10.	Camp NYDA	N. Y.	Burlingham, New York	New York Diabetes Association, Inc.	1937	Three 3-week periods
11.	Camp Ho Mita Koda	Ohio	Newburg, Ohio	Board of Trustees of Camp	1929	Two 1-month periods
12.	Illahee Lodge	Ontario	Cobourg, Ontario	Neighborhood Workers Association and Kinsman Clubs of Toronto	1946	Three 3-week periods
13.	Camp Firefly	Penna.	Spring Mountain, Penna.	Philadelphia Metabolic Association	1935	Boys: 3 weeks Girls: 3 weeks
14.	Sweeney Camp for Diabetic Children	Texas	Gainesville, Texas	Sweeney Diabetic Foundation	1950	Three 4-week periods; also 2-week
15.	Camp Banting	Wash.	Seattle, Wash.	Diabetic Trust Fund, Virginia Mason Hospital	1938	2 weeks
16.	Camp Priscilla White	Wash.	Seattle, Wash.	Diabetic Trust Fund, Virginia Mason Hospital	1938	2 weeks
17.	Camp Kno-Koma	West Va.	Near Charleston, West Va.	West Va. Diabetes Association; Carbide and Chemical Corp.	1950	9 days
18.	Holiday Home Camp	Wisc.	Lake Geneva, Wisc.	Chicago Diabetes Association	1949	3 weeks

CAPACITY AT ANY ONE TIME			CHILDREN ACCOMMODATED 1951			AGES YEARS	RATES*	RESIDENT PHYSICIANS	NURSES	DIETITIANS	CONTACTS
Boys	Girls	Total	Boys	Girls	Total						
30	30	60	14	16	30	8-14	\$40 for 2 weeks	1	2	1 full time 1 part time	Miss Jeannette Overstreet 815 Van Antwerp Building Mobile, Ala.
		75	34	33	67	8-16	\$65 for 2 weeks	2	1	1	Los Angeles Metabolic Clinic 1930 Wilshire Blvd. Los Angeles 5, Cal.
50	50	100	64	66	130	6-16	\$40 for 2 weeks plus travel	1	1	4	Mary B. Olney, M.D. 1429 4th Avenue San Francisco 22, Cal.
		10	4	5	9	6-12	\$4 daily	0	3	1	K. Hammond Mish, M.D. 1726 Eye St., N. W. Washington 6, D. C.
0	55	55	0	170	170	5-15	\$45 per week	1	3	0	Priscilla White, M.D. 81 Bay State Road Boston 15, Mass.
56	0	56	135	0	135	5-16	\$50 per week	1	3	1	Alexander Marble, M.D. 81 Bay State Road Boston 15, Mass.
		40	6	12	18	—	\$5-\$10 weekly	1 or more	2	1 or 2	Miss Eleanor Peterson Toledo Diabetes League Acad. of Med. Bldg., Toledo, O.
50	50	100	11	9	20	8-16	\$35 for 2 weeks	1	1	2	Harry M. Gilkey, M.D. 1103 Grand Avenue Kansas City, Mo.
12	24	36	8	12	20	9-16	\$50 for 2 weeks	1	1	1	Miss Anna Smrha Dept. of Health State Capitol Bldg., Lincoln, Nebr.
40	40	80	83	88	171	6-16	Cost per week: \$75 - \$80	1	4	2	Thomas H. McGavack, M.D. New York Diabetes Assn. 2 E. 103rd St., N. Y. 29, N. Y.
30	30	60	39	34	73	6-16	\$175 per month	1	2	2	Mr. Rex W. Thornburgh R.F.D. 2 Chardon, O.
app. 15	app. 15	app. 30	26	18	44	5-16	\$128 for 3 weeks	1	1	2	Miss M. Collver 22 Wellesley Street Toronto, Can.
30	32	62	30	32	62	6-15	Up to \$5 a day	1	1	1	Miss Clara Woodward 1530 Spruce Street Philadelphia 2, Pa.
44	44	88	114	112	226	6-18	\$300 for 6 weeks	2	3	2	J. Shirley Sweeney, M.D. Gainesville, Tex.
18		18	7		7	10-14	\$28 for 2 weeks	0	1	1	Lester J. Palmer, M.D. 1115 Terry Avenue Seattle, Wash.
	18	18		10	10	10-14	\$30.50 for 2 weeks	0	1	0	Lester J. Palmer, M.D. 1115 Terry Avenue Seattle, Wash.
70	70	140	22	23	45	7-15	No charge	1	3	2	George P. Heffner, M.D. West Va. Diabetes Assn. 1115 Quarrier St., Charleston, W. Va.
40	40	80	33	34	67	8-14	\$120 for 3 weeks	1	2	2 or 3	Chicago Diabetes Assn. 110 South Dearborn Street Chicago, Ill.

* In most instances the stated rates are not absolute but are given only as a guide. The usual statement is that no child will be refused admission because of lack of ability to pay.

ing figure was \$50 per boy per week. These are minimum figures, since both camps are operated as non-profit undertakings with no charge whatever for the services of sponsoring physicians. It is obvious that relatively few parents of diabetic children are able or willing to pay this much for two or more weeks each summer. Consequently the policy in these two camps has been to make no set charge but to ask the parent to contribute as much as he can up to the actual cost. Experience over years of time has shown that approximately 40 per cent of the cost of the camp will be cared for by such contributions by parents. The rest must be made up by funds obtained by appeal to the public, to diabetic patients, to church and civic organizations and other sources. *One must be in a position to state that no child will be turned away because of lack of finances.* On the other hand, an arrangement in which almost everyone contributes something, even though a small sum, creates self-respect, increased interest, and better appreciation of the privilege of going to camp.

OBJECTIVES OF THE SUMMER CAMP PROGRAM

Among those interested in summer camps for diabetic children there are two viewpoints as to the prime objective. One group takes the stand that the recreational aspects are most important and that medical matters should be relegated to the background. According to this view, urine and blood testing should be kept to a minimum and the children be allowed to enjoy camp life. Those of opposite mind believe that the summer camp affords an unparalleled opportunity for a "check-up" with regulation of the diabetic condition, and for the education of the child regarding home care.

Actually these two viewpoints conflict very little and can easily be reconciled. One aim of a camp should be to provide for the diabetic child an enjoyable vacation such as his nondiabetic brothers and sisters have, with a chance to camp out, to learn to swim, to engage in land and water sports and to experience the pleasures of group living. The other aim, entirely compatible with the first, should be to work out an adequate yet restricted diet; to arrive at a workable insulin schedule; and to teach by example and by informal discussions the meaning of good control of diabetes, the means of attaining it, and the necessity for it if complications are to be avoided. This means that medical attendants in an unobtrusive way arrange for diet, insulin and laboratory tests in a fashion not unlike that provided in well-run hospitals accustomed to caring for diabetic patients.

In a summer camp the diabetic child who may have felt "different" and lonely while at home with nondiabetic companions is comforted by association with others whose condition is the same as his. He develops a satisfying group spirit. He gains confidence and becomes more self-reliant. These psychological advantages are great. In this connection it is well to emphasize the need for further understanding of the psychological problems of the diabetic child and adolescent so that one may be in a better position to cope with them. The summer camp provides an unparalleled opportunity for such a study.

An advantage of summer camps that must not be overlooked is the rest and freedom from worry afforded the parents during the period of the camp session.

THE FUTURE OF CAMPS FOR DIABETICS

Those who have had experience with camps for diabetic children agree that they are extremely worth while. Any time and money invested in them will yield extraordinarily high returns in health, happiness and character-building. Furthermore, they provide a means of diabetes regulation for children who otherwise would lack detailed supervision in these days of high hospital costs. As previously stated, money should not be a barrier preventing a child from benefiting from camp experience. Not only are additional camps needed to take care of certain sections of the country now lacking facilities, but those camps already in operation must use all possible means to encourage attendance by diabetic children in the area served. Estimates vary widely as to the number of children under 16 who have diabetes in this country, but whether the number is 15,000 or 50,000 (to quote different estimates) it is obvious that extension of camp privileges to more children is needed.

One other development of the summer camp program deserves mention, and that is the extension of the medical and recreational benefits to older diabetic patients. For the last few years at the Clara Barton Birthplace Camp, the fifth session of two weeks at the close of summer has provided camp experience for older girls and young women. A similar program will be attempted this summer at the Elliott P. Joslin Camp for one week following the close of the regular camp season. Such plans, if proven feasible and of definite value to the older camper, would provide greater usage of the physical facilities of the camp.

The development of camps for diabetics, particularly those in younger age groups, is closely related to the

future of the diabetics themselves. Evidence is accumulating to indicate that the late vascular complications of diabetes are related not only to the duration of the disease but also to the degree of its control over the years. Although there is not as yet unanimity of opinion in this regard, the writer believes that only by careful, continuous control can these complications, as well as the late neuropathies, be prevented or delayed. A yearly stay at a well-run summer camp will contribute much to the regulation, education and development of diabetic children, and will help them to live longer, healthier and happier lives.

SUMMARY

1. Data are presented regarding the 18 summer camps for diabetic children in the United States and Canada. Suggestions are given regarding the establishment and operation of camps.

2. With a capacity of about 2000, camps in 1951 accommodated about 1300 children. The need for addi-

tional camps in unserved areas as well as for greater usage of established camps, is stressed.

3. The objectives and future of the summer camp program are discussed.

REFERENCES

- ¹ John, H. J.: Report of the Committee on Camps. Survey of camps for diabetic children in the U. S. *Proc. Amer. Diabetes A.* 3:321-26, 1948.
- ² John, H. J.: The planning of a camp for diabetic children. *Am. J. Med.* 1:642-48, December 1946.
- ³ McCullagh, E. P., Russell, P. W., and Schneckloth, R. E.: A summer camp for diabetic children. *Ohio State M. J.* 46:452-54, May 1950.
- ⁴ Gabriele, A. J., and Marble, A.: Experiences with 116 juvenile campers in a new summer camp for diabetic boys. *Am. J. M. Sc.* 218:161-71, August 1949.
- ⁵ Stephens, J. W., and Marble, A.: Place and value of summer camps in management of juvenile diabetes. *Am. J. Dis. Child.* 82:259-67, September 1951.
- ⁶ Grishaw, W. H.: Diabetes camp. *A.D.A. Forecast*, July 1948.
- ⁷ Heffner, G. P., and Miller, A. P.: West Virginia's first camp for diabetic children (a report on Camp Kno-Koma). *West Virginia M. J.* 47, January 1951.
- ⁸ Sweeney, J. S.: The South's first full summer camp for diabetic children and observations on the use of NPH insulin. *South M. J.* 44:1157, December 1951.

The Committee on Scientific Exhibits

REPORT TO THE COUNCIL OF THE AMERICAN DIABETES ASSOCIATION, 1951-1952 INTERIM MEETING JANUARY 19, 1952

The Committee held its first meeting for this year on January 6, 1952. Four of the six members were present, including one ex-officio member, and it is felt that much that was useful was accomplished.

Two major subjects were considered. The first was the preparation of an exhibit for scientific meetings and other professional audiences, and the second was the development of a lay exhibit. The latter project had earlier been assigned to the Subcommittees on Scientific Exhibits and on Health Information, neither of which now exist. The scientific exhibit was discussed because

it was thought desirable to develop something new for the 1952 Annual Session of the American Medical Association.

THE SCIENTIFIC EXHIBIT

The Committee decided that an exhibit entitled "Vascular Complications of Diabetes" would be both instructive and timely, and suggested a five-panel display to fit a booth built to American Medical Association specifications and consisting of a 12-foot back wall and two