From the Endocrinology and Nutrition Unit and the Psychiatry Unit, Hospital Clinic, University of Barcelona, Villarroel, Barcelona, Spain.
Address correspondence and reprint requests to J.I. Conget, MD, Endocrinology and Nutrition Unit, Hospital Clinic, University of Barcelona, Villarroel 170, Barcelona 08036, Spain.

REFERENCES
1. Rubin RR, Peyrot M, Saudek CD: Effect of diabetes education on self-care, metabolic control, and emotional well-being. *Diabetes Care* 12:673–79, 1989
2. Mazzuca SA, Moorman NH, Wheeler ML, Norton JA, Fineberg NS, Vinicor F, Cohen SJ, Clark CM Jr: The diabetes education study: a controlled trial of the effects of diabetes patient education. *Diabetes Care* 9:1–10, 1986
3. Swedo SE, Rapoport JL, Leonard H, Lenane M, Cheslow D: Obsessive-compulsive disorder in children and adolescents: clinical phenomenology of 70 consecutive cases. *Arch Gen Psychiatry* 46:335–41, 1989
4. American Psychiatric Association Committee on Nomenclature and Statistics: *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, DC, Am. Psychiatr. Assoc., 1980
5. Pollock SE: Human response to chronic illness: psychologic and psychosocial adaptation. *Nurs Res* 35:90–95, 1986
6. Williams G, Pickup J, Keen H: Psychological factors and metabolic control: time for reappraisal? *Diabetic Med* 5:211–15, 1988

Reply

We appreciate the support Conget et al. (this issue, p. 901) offer for our finding that intensive diabetes education generally improves emotional well-being (1), and we agree that, in exceptional cases, intensive intervention might produce adverse emotional effects in individuals with preexisting psychological problems. However, we question whether the case Conget et al. describe is an illustration of such effects. In addition, we differ with Conget et al. concerning the implications of these exceptional cases for diabetes education and treatment.

If we assume that diabetes education produced the psychological problems of the patient Conget et al. describe, we risk confusing symptomatology with causation. The young man's obsessive-compulsive disorder expressed itself in part as disturbances in the realm of his diabetes self-care, but this does not establish the fact that his disorder was caused by interventions in this realm. We note that obsessive-compulsive disorders most commonly emerge during late adolescence (2), the young man's disorder expressed itself in several realms, and several factors might have contributed to the exacerbation of this man's underlying problems. Although the young man's symptoms were relieved after treatment with clomipramine and termination of diabetic self-control, it should not be assumed that changes in regimen caused changes in the patient's psychological state. Clomipramine is widely used in Europe for the treatment of obsessive-compulsive disorders, and this medication might have been the essential factor in improving the patient's emotional status.

Conget et al. assume that it is possible to predict who will experience severe adverse emotional effects from diabetes education. Based on this assumption, they recommend eliminating those at high risk before the educational process is begun. Unfortunately, even if it were possible to accurately identify such people, this action would withhold a potentially beneficial educational program from some patients. For example, Conget et al. report improved metabolic control for the patient they describe.

We prefer another approach—close monitoring of participants during and after the educational intervention. If an underlying psychological disorder is revealed, the patient can be referred for assessment, counseling, or pharmacological treatment. If the patient is disturbed by something he/she hears during the educational program (e.g., the possibility of complications), his/her fears can be addressed. If there are questions about the appropriate level of regimen intensity for an individual patient, changes in regimen can be titrated, the patient's response can be monitored, and adjustments can be made accordingly.

Conget et al. remind us that diabetes education does not produce universally beneficial results and that some patients require special attention. We agree. Furthermore, we believe that research should be directed toward estimating the number of patients who may be at risk and improving our ability to identify and protect these patients.

RICHARD R. RUBIN, PhD
MARK PEYROT, PhD
CHRISTOPHER D. SAUDEK, MD

From the Diabetes Center, Division of Endocrinology, Department of Medicine, Johns Hopkins University School of Medicine and the Center for Social and Community Research, Loyola College, Baltimore, Maryland.
Address correspondence and reprint requests to Richard R. Rubin, PhD, 500 W. University Parkway 1-M, Baltimore, MD 21210.

REFERENCES
1. Rubin RR, Peyrot M, Saudek CD: Effect of diabetes education on self-care, metabolic control, and emotional well-being. *Diabetes Care* 12:673–79, 1989
2. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, DC, Am. Psychiatric Assoc., 1987

Pediatric Primary Care for Children With IDDM

Henry (1) recently reported the results of a self-report survey of practicing pediatricians in Michigan regarding their routine ambulatory care of children with insulin-dependent diabetes mellitus (IDDM). We published similar data gathered from pediatricians practicing in Virginia (2) and present a comparison of the findings from these two studies. Survey response rates were similar in both studies (66% [1] vs. 77% [2]). Use of human in-

sulins (78% [1] vs. 65% [2]), twice-daily injections (96 vs. 72%), and blood glucose monitoring (56 vs. 62%) were not different compared with the use of glycosylated hemoglobin determinations (39 vs. 73%). Henry reports that physicians who completed their training before 1975 were more likely to use insulin of animal origin and obtain random and fasting blood glucose levels during office visits. We were unable to detect any differences in the care practices of pediatricians completing residencies before 1978 compared with younger respondents. However, both studies suggest that data collected from physician self-reports may not be accurate. In particular, we noted that respondents who graduated from medical school before 1976 and those who graduated at a later date both reported that medical school and residency training most strongly influenced their current diabetes-care practices. Because the care practices reported above were not available before 1980, it was not possible for these to have influenced their use. Thus, it is important to recognize that self-reports of behavior may not always be valid and that survey findings should be qualified.

WILLIAM L. CLARKE, MD
ANDREA L. SNYDER, MS

From the Department of Pediatrics and the Diabetes Clinical Research Institute, University of Virginia Health Sciences Center, Charlottesville, Virginia.
Address correspondence and reprint requests to William L. Clarke, MD, Box 386, Department of Pediatrics, University of Virginia Health Sciences Center, Charlottesville, VA 22908.

REFERENCES

1. Henry D: Primary pediatric care for children with type I diabetes. *Diabetes Care* 12:595–96, 1989
2. Clarke W, Snyder A: Influence of educational activities on pediatricians' diabetes care practices. *J Med Educ* 63:67–68, 1988

Reply

Clarke and Snyder make the important point that self-reports of behavior may not always be valid. However, pediatricians completing training before 1975 may be more likely to obtain fasting blood glucose levels and prescribe animal insulins and less likely to obtain glycosylated hemoglobin determinations every 3–4 mo if medical school and residency training strongly influenced their diabetes-care practices as mentioned by Clarke and Snyder in their letter. Two studies suggest that pediatric diabetes-care practices are slowly changing (1,2) from previous survey results (3). Nonetheless, a need remains to educate both health-care providers and patients on the level of care needed (4,5).

DOUGLAS N. HENRY, MD

From the Department of Pediatric Endocrinology, University of Michigan, Ann Arbor, Michigan.
Address correspondence and reprint requests to Douglas N. Henry, MD, Department of Pediatric Endocrinology, University of Michigan, Ann Arbor, Michigan.

REFERENCES

1. Henry DN: Pediatric primary care for children with type I diabetes. *Diabetes Care* 12:595–96, 1989
2. Clarke W, Snyder A: Influence of educational activities on pediatricians' diabetes care practices. *J Med Educ* 63:67–68, 1988
3. Lorenz R, Pichert J: Diabetes related goals, practices, and beliefs of practicing pediatricians. *J Med Educ* 57:630–34, 1982
4. *Physician's Guide to Insulin-Dependent (Type I) Diabetes: Diagnosis and Treatment.* Sperling MA, Ed. Alexandria, VA, Am. Diabetes Assoc., 1988
5. American Diabetes Association: Position statement: standards of medical care for patients with diabetes mellitus. *Diabetes Care* 12:365–68, 1989

Change in Army Policy

In the editorial "Diabetics Need Not Apply," Fisher (1), comments on a meeting with senior military officers to review the U.S. Department of Defense (DOD) policy on the exclusion of accession to active duty based on family history of diabetes. He then states that, although he received favorable responses from us, the regulation has not been changed.

Fisher's editorial is not accurate and is of particular concern and frustration to us. After the meeting at the offices of the American Diabetes Association (ADA), a thorough literature review was conducted by all three branches of the service, and recommendations were made. On reviewing our recommendations, the Assistant Secretary of The Army for Manpower and Reserve Affairs requested that DOD change the policy in December 1988. In anticipation of final DOD approval, the Office of the Army Surgeon General notified the Army Waiver Authorities to immediately begin waiving applicants with parental history of diabetes in January 1989. In May 1990, the change was published in U.S. Army Regulation 40-501.

We did everything possible to be responsive to the concerns of Fisher and ADA. Every effort was made to expedite this change. We would appreciate a correction in a subsequent issue of *Diabetes Care* that clarifies that the military has made the changes promised. We will continue to work closely with ADA and any organizations concerning issues related to soldiers with diabetes mellitus.

MICHAEL J. KUSSMAN, MD, FACP
STEPHEN C. CLEMENT, MD

From the Office of the Army Surgeon General, Falls Church, Virginia.
Address correspondence and reprint requests to Office of the Army Surgeon General, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

REFERENCES

1. Fisher JN: Diabetics need not apply (Editorial). *Diabetes Care* 12:659–60, 1989