Affiliate Association on Oct. 12, 1956, was partly due to the announcement of its program through the pages of this *Journal* and announcements sent to the membership of the American Diabetes Association.

As the subscription list of DIABETES grows, it is reasonable to expect the readers to consult its pages for news of interest concerning scientific presentations dealing with diabetes in various parts of the country. Since the *Journal* is bimonthly, announcements of such programs must be sent not later than three or four months in advance of the expected program date.

REPORT OF THE COMMITTEE ON CAMPS

In 1925, within three years after the initial clinical use of insulin, the first camp for diabetic children was founded by the late Dr. Leonard F. C. Wendt in Michigan. Insulin gave the diabetic child not only the precious gift of prolonged life, but the physical stamina, nutrition and freedom from restricted routine which allowed him to participate in camping activities.

Following Dr. Wendt's pioneering spirit, a number of other equally courageous physicians opened camps for diabetics: John of Cleveland, Joslin and White of Boston, and Fischer and Green of New York City. By 1931 there were five well established camps for diabetic children throughout the country.

Twenty-six years later this number has grown to twenty-six. The capacity and scope of activities of the camps have increased each year. The Clara Barton Birthplace Camp, as an example, took twenty-eight girls in 1930. Today it can accommodate groups of over seventy girls for five periods of two weeks each. Camps are now located in every section of the country and it is safe to say that no diabetic child in the United States is more than one day's trip by auto, bus or train from a camp. The metropolitan areas of Boston, New York City, Philadelphia, Cleveland, Toronto, Chicago, Detroit, Indianapolis, St. Louis, Milwaukee, Dallas, Los Angeles, San Francisco, and Seattle have diabetic camps within commuting distance.

The American Diabetes Association has always encouraged the establishment of camps for diabetic children. At no time, however, has the Association endeavored to operate or foster any single camp. The Committee on Camps of the Association has been composed of members interested in furthering the cause of camping. This committee has reviewed and discussed pertinent problems. The meetings serve as a clearing house through which knowledge, experience and solutions of common problems are exchanged and passed along to the many camps. A Subcommittee on Medical Standards was appointed in 1955. Its report entitled "Suggested Medical Standards For Camps For Diabetic Children" presents a significant milestone in the guidance of camping for diabetics. The report is the result of an integrated study of a compendium of information from all established camps. As indicated, the "standards" are not meant to be binding in any way. Neither attempt at comparison, rating, approval, or disapproval has been made.

It will be apparent to anyone acquainted with diabetic camps that most camps have some of the ideal features intermixed with some of the minimal standards. Most camps have some features which surpass even the "ideal." Few, if any, camps provide only the minimal requirements. It can be hoped that the time will come when the advancement of diabetic camping reaches such a level that these ideal standards will be minimal standards and a new even higher set of "ideals" can be sought. This report can serve as a guide and stimulus to both established and embryonic camps. A number of the points made in the report are deserving of special comment.

Ideal entrance requirements are little more than ordinary good medical care of the diabetic child would dictate. The implementation of these requirements could serve as a means of educating all physicians in the proper routine care of diabetic children. It could also serve to emphasize the importance of periodic examinations, immunization and dietary evaluation. The great majority of our school systems require periodic medical examination and routine immunizations against diphtheria, pertussis and smallpox. It is thus well within the prerogative of a camp for diabetic children to require these, and, in addition, the other suggested procedures such as Salk vaccination, chest X rays and emotional evaluation. A careful screening program plus a preventative medical program could save an entire camp from a catastrophic epidemic.

The suggestion that a comment be made upon the emotional status of the child is of utmost importance. Emotional problems are common in the diabetic child. If the camp personnel can be alerted to specific problems of individual children they can prepare and, many times, save the individual or his whole cabin group from an unpleasant camp experience. In many instances the medical social worker of the camper's hospital can supply valuable psychological or behavioral information. A maladjusted camper can spoil the summer for him-

self and all of those around him.

Sponsorship of diabetic camps differs from camp to camp. Many camps are sponsored by Affiliates of the American Diabetes Association. Others are sponsored by local civic groups or individuals with civic or church support. The suggested "table of organization" is applicable and useful for any of these individuals or groups. Proper integration of physicians and lay people is of paramount importance. A physician cannot be a camp director nor recreation director. By the same token an experienced camp director cannot provide the medical supervision and planning required in a diabetic camp. It is, however, important that both the medical and lay personnel of a camp be well oriented as to each other's problems. This orientation is dynamic and can be achieved only through frequent meetings of all individuals participating in the program. Meetings prior to, during, and following the camp season are essential. In this way potential problems may be aborted, imminent problems solved and mistakes corrected for future operations. Ultimate authority as suggested should be vested in the medical director. He is medically responsible for the welfare of the children, and the unpleasant spectre of malpractice must always be kept in mind when operating this type of camp.

There is little question that every camp should have at least one resident physician. The advantages to the operation of the camp are obvious. Recognition of the advantages to the resident are not as widely recognized. There is no place other than at a summer camp for diabetic children that a young or (older) physician can have the opportunity of observing and caring for from 15 to 100 juvenile diabetics. Certainly, no hospital has more than 10 to 15 juvenile diabetics at any one time. In addition, each of these children is participating in a full, normal activity program which is impossible in the hospital. The resident is thus given the opportunity to observe the day to day problems of control in a group of active diabetic children. With one or more residents in attendance at a camp it is then incumbent upon the physician members of the camp committee to visit camp frequently to conduct "teaching rounds" for the residents. The privilege and responsibility of the physicians is then to impart their knowledge of diabetes to the resident staff. If this type of program is worked out in the camps, the universities and teaching centers may ultimately include a period in a diabetic camp as part of their residency program in internal medicine and pediatrics.

Dietary management is the keystone of any camp, diabetic or otherwise. Preparation and variety of foods are critically examined by all campers. The diabetic diet routine for a large camp, almost of necessity, requires the services of a well qualified dietitian. Clever meal planning is important in rounding out a pleasant and happy camp experience for the campers. If there is imagination in planning a great variety of food, the children soon forget that they are on a mandatory diet. A smaller camp's diet program could be run by remote control. Menus for the whole camp season could be set up by a trained dietitian prior to camp. A well trained staff of cooks and servers could then prepare and portion out the food. Again a dietitian is important for economic purchasing of foods and for keeping a cost accounting system in operation.

Counselor selection is of utmost importance and is of course the responsibility of the lay director. Once a good staff of counselors is obtained, it is the responsibility of the medical director to orient and train the counselors in the problems encountered in the care of a diabetic child. They must be briefed on: 1. Hypoglycemia, its causes, symptoms and immediate treatment. 2. Behavior problems commonly encountered. 3. Principles of diabetic control. 4. How to answer specific questions from the children and to whom to refer them for further answers. These and other points necessary for elementary understanding of diabetes in children should be taught to the counselors prior to the opening of camp.

In general, camping for diabetic children and adolescents is expanding throughout the United States. This is a logical and commendable trend. It must, however, be kept in mind that mere expansion in numbers is neither wise nor desirable. The existing facilities should be utilized to their reasonable capacity. Any group or individual contemplating a camp would be wise to study existing facilities within the area and make some estimate of the number of potential campers residing in the area. It may be possible in many cases to combine the efforts of two or more groups in one camp. A combination of this type would result in better facilities, personnel, and greater capacity.

By making continual surveys of diabetic camps, their growth and problems, it is hoped that the Committee on Camps will be able to continue to serve the diabetic population.

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