THE THREE FIRST’S in DIABETES CARE,
21 YEARS BEFORE DCCT

“Well to advocate and perform blood glucose self monitoring”
“Well to use a blood glucose self monitoring and bolus/basal insulin dosing to achieve tight control”
“Well to publish a paper on reversing complications by tight control”

Being the first for anything in the medical field is not the easiest. As you will see, it took a great commitment and a desire to help others to achieve what Dr. Bernstein achieved.

We are proud to be friends with Dick would like to thank him for providing us with the materials to write this feature. We know you will find it interesting and informative.

We have made it a 3-week series, discussing the 3 first’s. Included is the actual article on how tight control can prevent complications, that was finally accepted by Diabetes Care and also the rejection letters from NEJM, ADA, AMA and Lancet which stated that:

“No physician or patient would ever be interested in such a time consuming program of using a device to check blood glucose multiple times a day and adjusting insulin doses”

Part 1 will be, “First to advocate and perform blood glucose self monitoring”
Part 2 will be, “First to use a blood glucose self monitoring and bolus/basal insulin dosing to achieve tight control”
Part 3 will be, “First to publish a paper on reversing complications by tight control”

If you have any comments, please email us at publisher@diabetesincontrol.com

PART 3

“First to publish a paper on reversing complications by tight control”

I submitted the article and its revisions to many medical journals over a period of years — a period during which I was continually improving in health, and continually proving to myself and my family, if to no one else, that my methods were correct. The rejection letters I received are testimony that people tend to ignore the obvious if it conflicts with the orthodoxy
of their early training. Typical rejection letters read in part:

“Studies are not unanimous in demonstrating a need for ‘fine control’ (the New England Journal of Medicine), or “How many patients would use the electric device for measurement of glucose, insulin, urine, etc.?" (Journal of the American Medical Association). As a matter of fact, since 1980, when these “electric devices” finally were made available to patients, the worldwide market for blood glucose self-monitoring supplies has come to exceed $3 billion annually. Look at the array of blood glucose meters in any pharmacy, and you can get an idea of just how many patients use, and will use, the “electric device:"

Trying to cover several routes simultaneously, I joined a few lay diabetes organizations, in the hope of moving up through the ranks, where I could meet physicians and researchers specializing in the disease. This met with mediocre success. I attended conventions, worked on committees, and met many diabetologists. In this country, I met only three physicians who were willing to offer their patients the opportunity to put these new methods to the test.

Meanwhile, Charlie Suther was traveling around the country to university research centers with copies of my unpublished article, which by now had been typeset and privately printed at my expense. The rejection by doctors of the concept of blood sugar self-monitoring, even though essential to blood sugar control, was so intense, however, that the management of his company had to turn down the idea of making meters available to patients until many years later. His company and others could clearly have profited from the sale of blood glucose meters and test strips. However, the backlash from the medical establishment prevented it on a number of counts. It was unthinkable that patients be allowed to “doctor” themselves. They knew nothing of medicine — and if they could, how would doctors earn a living? In those days, patients visited their doctors once a month to “get a blood sugar:' If they could do it at home for 25 cents (in those days), why pay a physician? But almost no one believed there was any value to normal blood sugars anyway. In some respects, blood glucose self-monitoring remains a serious threat to the incomes of many physicians who specialize in the treatment of the symptoms of diabetes and not the disease. Drop into your neighborhood ophthalmologist's office and you will find the waiting room three-quarters filled with diabetics, many of whom are waiting for expensive fluorescein angiography or laser treatment.

With Suther's backing in the form of free supplies, by 1977 I was able to get the first of two university-sponsored studies started in the New York City area. These both succeeded in reversing early complications in diabetic patients. As a result of our successes, the two universities separately sponsored the world’s first two symposia on blood glucose self-monitoring. By this time I was being invited to speak at international diabetes conferences, but rarely at meetings in the United States. Curiously, more physicians outside the United States seemed interested in controlling blood sugar than did their American colleagues. Some of the earliest converts to blood glucose self-monitoring were from Israel and England.

By 1978, perhaps as a result of Charlie Suther’s efforts, a few additional American investigators were trying our regimen or variations of it. Finally, in 1980, manufacturers
began to release blood glucose meters for use by patients.

This “progress” was entirely too slow for my liking. I knew that while the medical establishment was dallying there were diabetics dying whose lives could have been saved. I knew also that there were millions of diabetics whose quality of life could be vastly improved, so in 1977, I decided to give up my job and become a physician — I couldn’t beat ‘em, so I had to join ‘em. This way, with an M.D. after my name, my writings might be published, and I could pass on what I had learned about controlling blood sugar.

After a year of premed courses and another year of waiting, I entered the Albert Einstein College of Medicine in 1979. I was forty-five years old. During my first year of medical school I wrote my first book, Diabetes: The Glucograf Method for Normalizing Blood Sugar, enumerating the full details of my treatment for Type I, or insulin-dependent, diabetes.

In 1983 I finally opened my own medical practice. By that time, I had well outlived the life expectancy of an “ordinary” Type I diabetic. Now, by sharing my simple observations, I was convinced I was in a position to help both Type I and Type II diabetics who still had the best years of their lives ahead of them. I could help others take control of their diabetes as I had mine, and live long, healthy, fruitful lives.

Recently for this anniversary issue, I asked Dr. Bernstein for his recollection regarding the acceptance of his article “Virtually Continuous Euglycemia......

May 8, 2002
Dear Steve

One of these letters is from DIABETES HEALTH CARE, which was the working title for DIABETES CARE prior to initial publication, the ultimate publication of “Virtually Continuous Euglycemia.” .....in the journal DIABETES CARE, occurred in 1980 via a flukey set of circumstances. In 1978, Sheldon Bleicher M.D. and I began a research project using his Patients and my blood sugar control methods in an attempt to reverse early retinal leakage in diabetics by normalizing blood sugars. We were indeed able to demonstrate the successful accomplishment of our goal.

The Ames Division of Miles Laboratories had provided us with the 3' lb. blood sugar meters that I describe in my book and blood sugar test strips, all gratis. Because of the favorable, outcome of the study, Ames sponsored a symposium on blood sugar self monitoring under the auspices of Dr. Bleicher and the New York Downstate University. A select group of diabetologists from around the country was invited to attend. Since my agreement with Dr Bleicher was that my name would be cited in any publications and I would be allowed to present the methodology to any symposia, I was allowed to present this paper at the meeting. The firm that was responsible for Ames publicity negotiated an arrangement with Jay Skyler, editor of DIABETES CARES to publish all of the papers presented at the
symposium. Since I had read this paper at the symposium, it was automatically published even though it had been rejected in 1971.

It is worth noting that the ADA continued to reject blood sugar self-monitoring as a viable methodology until a joint meeting with the American Association of Diabetes Educators in 1986. At that time, self-monitoring was approved, only for insulin users, thereby keeping out 90% of diagnosed diabetics.

Richard K. Bernstein, M.D., F.A.C.N., F.A.C.E.

Rejection Letters Follow:
Study to follow letters