

garding the magnitude of underreporting intake of socially undesirable sucrose-containing foods. These assumptions would never be reliable. Thus, we recommended caution when interpretation of results from this part of our study.

The last point raised by Buyken and Liese was that alcohol intake may predict glycemic index of the diet and hence affect the estimates of glycemic index and glycemic load. The reported associations are relative changes in the continuous variable homeostasis model assessment of insulin resistance (HOMA-IR) expressed as HOMA ratios with corresponding 95% CIs. After adjustment for alcohol in the multiple analyses, glycemic index demonstrated an insignificant association with HOMA-IR (HOMA ratio 0.99 [95% CI 0.97–1.02];  $P = 0.60$ ) and glycemic load demonstrated a significant inverse association with HOMA-IR (HOMA ratio 0.99 [0.98–1.00];  $P < 0.01$ ).

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## Eliminating Inpatient Sliding-Scale Insulin: A Reeducation Project With Medical House Staff

Response to Baldwin et al.

We applaud Baldwin et al.’s (1) efforts to improve the management of inpatient hyperglycemia and to advance resident knowledge about best care practices. However, we would welcome additional data to support the authors’ assertion that the effect on medical house staff education was sustained. The data reported were only from the 8-week study period, when an attending endocrinologist rounded with residents twice each day on all study patients. There are no data from a subsequent time period for comparison. In addition, the authors suggest that their inpatient intervention was associated with a sustained improvement in diabetes care. Are follow-up data available regarding the quality of glycemic management since July 2003 when sliding-scale insulin (SSI) use was discontinued? Outpatient HbA<sub>1c</sub> values in a subset of the study group were noted to improve 12 months after discharge; however, there are no control group data presented. It is therefore difficult to know if the HbA<sub>1c</sub> improvements were independently associated with the intervention or with other factors related to subsequent patient care.

One of the stated goals of the study was for medical residents to “feel comfortable managing blood glucose without the use of SSI” (1). How was this measured? As part of a larger study in our community teaching hospital, we asked internal medicine resident physicians ( $n = 37$ ) to rate their knowledge, perceived competence, and formal education concerning management of hyperglycemia in the hospital. The responses were taken on a five-point Likert scale, ranging from “strongly disagree” to “strongly agree.” Most (31 of 37, 84%) felt knowledgeable about managing

glucose control in diabetic subjects admitted to the hospital with acute medical conditions other than diabetic ketoacidosis. Similarly, the majority (28 of 37, 76%) agreed or strongly agreed that they understood the routes of insulin administration and how insulin works. However, fewer than half (15 of 37, 41%) indicated that inpatient management of diabetes was explicitly taught during residency training. Nearly all (36 of 37, 97%) wanted additional training in hospital diabetes management. With these baseline data, we will be able to assess the effects of our inpatient diabetes management program on resident physicians’ education, knowledge, and perceptions. Clearly, education and training of resident physicians is a key to success in caring for diabetic patients in teaching hospitals. We concur with Baldwin et al. that teaching medical residents to improve hospital diabetes care is essential.

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## Eliminating Inpatient Sliding-Scale Insulin: A Reeducation Project With Medical House Staff

Response to Peterson et al.

We thank Peterson, Charney, and Rennert (1) for their interest in our study (2). We share and applaud their interest in improving the level