Diabetes Care: "State of the Union"

With this issue, I have completed my first full year as Editor in Chief for *Diabetes Care*. I have attempted with each editorial to give a different perspective on the issues to date and really try to inform, educate, and, if nothing else, simply provide acknowledgment that I do appreciate and understand the issues of interest to our readership, authors, and reviewers. So, what does one do to celebrate 1 year at the helm? My first thought was to take on the mindset of a CEO of a large corporation and, as required of the position, provide an update to the stockholders through an annual report. In that way, I could provide the required information about our activities, performance, and projected direction. Clearly, *Diabetes Care*, as the main clinical journal of the American Diabetes Association (ADA)—an organization whose reach and influence could be argued to rival a major corporation—would clearly qualify for such an approach. Alternatively, I could use the practice that arose from a command given to the president as outlined in the Constitution of the United States that the president "…shall from time to time give to the Congress Information of the State of the Union, and recommend to their Consideration such Measures as he shall judge necessary and expedient…" (1). In thinking about it, I believe the latter approach has promise. Specifically, we know in these addresses that the president always opens with a statement on the strength or weakness of the nation and says something to the effect of "My fellow citizens, the state of our union is strong." After considering these words, I felt a State of the Union approach was very appropriate for *Diabetes Care*. So, let's get started.

Ladies and gentlemen, the state of *Diabetes Care* is strong!!

I make my statements that *Diabetes Care* remains at the top of its game based on assessed factors that judge the success and impact of a journal. Specifically, the journal's latest impact factor, considered to be a measure of a journal's prestige and influence, is the highest it has ever been. With an impact factor of 8.1, *Diabetes Care* continues to be the highest-ranked journal with a focus on diabetes treatment and care (2). Both *Diabetes* and *Diabetes Care* also lead diabetes research publications in Thomson Reuters Eigenfactor score, a measure of the overall value provided by articles in a given journal, and Article Influence score, a measure of a journal's prominence based on per-article citations. Given the lag time between publications and the assessment of these factors, neither I nor our current editorial team would—nor should—claim responsibility for this success. I outlined in my first editorial (3) that "the success of *Diabetes Care* has clearly been due to the hard work, dedication, vision, and expertise of the outstanding editors and associate editors who have preceded me in this role." Our goal for the current editorial team is to affect "a strategy to continue the momentum and make changes only as required to allow the journal to thrive." With this editorial, I would like to review some of the notable highlights of the past year at the journal.

One of our primary aims for the past year was to proactively seek high-quality, state-of-the-art reviews by leaders in the field. As readers, you are well aware of the results to date. A few of the outstanding reviews appearing this past year that have addressed key topics have been the review by Suissa and Azoulay (4) commenting on the time-related biases in observational studies of drug effects, particularly related to metformin and cancer; the thoughtful review on individualizing targets for high-risk patients with type 2 diabetes and cardiovascular disease by Riddle and Karl (5); and the timely review in the December issue on standardization of hemoglobin A_{1c} (HbA_{1c}) by Sacks (6), which set the stage for the journal's new requirement of dual reporting for HbA_{1c}. Future reviews planned for publication will evaluate the status of personalized medicine approaches and propose to define and identify ways through which reliable observations of gene-environment interactions can be translated into the public health setting. Other reviews will provide comprehensive assessments of the relationships between gastric emptying, postprandial glycemia, and incretin hormones. In addition, we have been very pleased with our Bench to Clinic Symposia contributions. For example, Corkey (7) and Pories and Dohm (8) provided arguments supporting the hypothesis that hyperinsulinemia is the underlying cause of type 2 diabetes, the possibility of improving metabolic health by suppressing hyperinsulinism, and the role of environmental agents in this process. Other contributions, such as the article from Schneider and Sobel (9), offer us perspectives on a "journey" from the laboratory to the clinic that evaluates the fibrinolytic system in relation to the pathogenesis of coronary artery disease and the precipitation of myocardial infarction. These cutting-edge narratives will continue in 2013 with a planned submission, among others, that will report on in-depth assessments of the mechanisms and management of diabetic painful distal symmetrical polyneuropathy. One initiative I have really enjoyed is the point-counterpoint debates, which included self-monitoring of blood glucose testing and its value in individuals not on insulin (featured in this issue of *Diabetes Care* [10,11]) and the use of glycated protein assays and their relevance to the care and management of individuals undergoing dialysis (12,13). For 2013, we are hopeful to have debates on the use, benefits, and risk of insulin versus incretin therapy for hospitalized patients and also a separate debate and update on the safety, concerns, promise, and potential of these agents. My hope is that *Diabetes Care* will become *the* featured journal for such debates that represent controversial clinical management and clinical research issues.

One of our major accomplishments of the past year was holding the 1st Annual *Diabetes Care* Symposium at the American Diabetes Association's 72nd Scientific Sessions in Philadelphia, Pennsylvania, in June 2012. This event was incredibly successful as it represented a competition among submitted papers with the end result being a high-level symposium that featured studies representing innovative concepts and evolving clinical management strategies. Over 150 manuscripts were submitted for the competition and only six were selected for eventual presentation. These six manuscripts were published in a special symposium section in the July 2012 issue of *Diabetes Care*. Based on this success, I am thrilled to report that the ADA has decided to feature this symposium yearly at the annual Scientific Sessions, and our 2nd Annual

Diabetes Care Symposium is on track to be presented at the 73rd Scientific Sessions planned for 21–25 June 2013, in Chicago, Illinois.

We have held two Editor's Diabetes Expert Forums, which represented a general consensus of a certain topic by the world's thought leaders. Opinions from both forums are in the process of being compiled in manuscript form and submitted for review. The topics initially discussed were the current state and potential surrounding personalized treatment of type 2 diabetes and the timing, use, and other considerations of insulin given the new formulations, new oral agents, and use of incretin therapy. In addition, we initiated a new series in *Diabetes Care* called "Profiles in Progress" with the first narrative appearing in the December 2012 issue. These narratives specifically recognize a researcher or provider in the field of diabetes whose contributions and discoveries were so noteworthy and remarkable that the findings truly changed the landscape of diabetes management forever. Dr. Samuel Rahbar, who discovered that HbA_{1c} is elevated in people with diabetes, was featured in the first narrative. At this time, and in moving forward, we would welcome suggestions from our readership to feature individuals they feel should be recognized in this series.

Other highlights during the year were not specific to *Diabetes Care*, but to publications from the ADA in general. The reader is referred to the editorial in the July 2012 issue (14) for the specifics, but these advances were *1*) the release of the Diabetes Core Update as a free monthly podcast; *2*) the availability of *Diabetes Care* and its sister journals as mobile-optimized websites for viewing on smartphones and other mobile devices; *3*) the availability of the ADA Journals app, providing users with the ability to download, search, view, and save abstracts and full-text articles; *4*) completion of the online PDF archives of *Diabetes Care* dating back to the first issue in 1978; and *5*) the availability of the ADA Journals Facebook (/DiabetesJournals) and Twitter (@ADA_Journals) profiles. Readers now have many options available that allow them to keep up with the current developments in diabetes research, treatment, and education.

Finally, one of the bigger changes that we made this past year was our decision, beginning on 1 January 2013, to require submissions to *Diabetes Care* to dual report HbA_{1c} in both percent and International System (SI) units. The rationale behind the change was outlined in detail in the December 2012 issue (15). In this regard, the readers are strongly encouraged to read the timely state-of-the-art comprehensive review on HbA_{1c} by Sacks (6) that appeared in the December 2012 issue. This review outlines the history of HbA_{1c} development and standardization and provides the rationale and reasoning that supported our decision for the HbA_{1c} dual-reporting requirement. Given that the conversion of one unit into the other is not a simple conversion, Sack's review is even more important and provides information on HbA_{1c} that most readers may not be aware. We feel that dual reporting is an important step for *Diabetes Care* that will allow clinicians, patients, and investigators from around the world to continue to compare the results reported in the journal with articles previously published in past issues of *Diabetes Care* or in future articles from various sources for which one or the other unit is solely reported.

Thus, with the above narrative, I feel that that "the state of *Diabetes Care*" is strong and will continue to be so given the incredible support team in place. Clearly, it remains a team approach, and the journal would not be in existence if it was not for the quality manuscripts received from authors and the in-depth and comprehensive critiques from our invited reviewers. It is also based on the efforts of the Associate Editors who have been given the charge to "keep the hurdle high" for manuscript acceptance. As we try to inform authors when we are not able to accept a manuscript, *Diabetes Care* continues to receive more quality manuscripts than it is possible to publish. *Diabetes Care* received approximately 2,700 new submissions and 1,000+ revisions in 2012. This means that approximately 3,700 papers crossed the desks of the ADA's Editorial Office in 2012. According to our current milestone report, approximately 80% of these papers were rejected. Needless to say, many of these papers were very interesting and very good, but unfortunately they did not meet our publication priorities at the time. Whereas most authors appreciate the constructive feedback from reviewers, it is now part of my job as Editor in Chief to address letters from authors that are, for lack of a better term, "less than kind" in their opinions of the decisions. But, despite the letters from upset authors questioning my expertise, competence, and in some cases, sanity, I strive to remain objective. Our charge at *Diabetes Care* is to ensure that every manuscript that is accepted will advance the field, does not simply confirm well-known findings, is novel, and truly deserves to be one of the manuscripts we are honored to publish.

I continue to have tremendous support in my role as Editor in Chief, not only from actions taken, resources provided, and decisions made by the ADA that offer a strong and consistent message to me and the editorial team that our journal and its role is important, but also the continued support and work done by the Editorial Office in Indianapolis, Indiana. So, given my role as Editor in Chief of *Diabetes Care*, my message to the authors, readers, reviewers, and to the ADA is that after 12 months at the helm, I can confidently state the following, "Ladies and gentlemen, the state of *Diabetes Care* is strong!!"

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