As I begin my 4th year as Editor-in-Chief of Diabetes Care, I remain proud of the achievements of our editorial team and the tremendous success of the journal. In addition, as I take on additional roles in the American Diabetes Association (ADA), I am conscious of the importance of the ADA’s mission in providing the highest quality scientific information to the world. In that regard, we are pleased that the journal remains very high in the rankings in terms of readership, subscriptions, and citations, despite a large number of new journals in the field. The journal’s impact factor remains high, and it continues to be rated as fourth among journals in endocrinology and metabolism. With the large number of international editions in several languages, Diabetes Care is clearly established as the leading clinical and clinical research journal worldwide in the field of diabetes.

Last year we were concerned about a small decline in the number of articles submitted to us. I am pleased that this trend was reversed in 2009. I hope it means more support for clinical research as we continue in our quest to find a cure for diabetes and improve the lives of people who suffer from this condition. Unfortunately, for many the increase in submissions also means a lower acceptance rate, now around 18%. Many good papers will inevitably be rejected because we may be forced to give higher priority to other competing papers. We continue to have a broad range of clinically relevant papers that will rapidly impact practice and clinical research in the field.

Despite our success, we need to look for ways to make Diabetes Care better and stronger, not only its scientific content but also in issues relating to ethics, policy, and societal priorities. The ADA Publications Policy Committee continues to issue important guidelines in respect to these matters, and I will only touch on some of these issues with my own personal views (which are not necessarily the policies of ADA).

We must be transparent at all levels (authors, reviewers, and editors) in relation to conflicts of interest—whether they are real or perceived. We have a separate review/editorial process for handling papers when an associate editor is an author or has a conflict. Given that health care is in many ways a business, research is dependent on funding; in our system, the development of new treatments will always be linked to profits. Substantial clinical research that is most likely to impact patient care is funded by industry. Because of this, some conflict of interest is inevitable. My personal view is that it is not necessarily a bad thing since individuals with the greatest level of expertise are more likely to be consulted by those who have a commercial interest in developing new treatments. Must we shy away from such conflicts completely as some of our colleagues suggest? Not if we all have the common goal of improving the lives of our patients, whether or not a few profit from such success more than others. Despite some controversy about the value of new drugs and their side effects (whether based on anecdotes or good data), diabetes control has improved dramatically in the last 10–15 years as we have advanced from having 2 drugs to prescribe to over 10 drugs today. What is important is that we must be transparent in declaring such conflicts so that readers can determine for themselves whether there is a possible bias in reporting results and their interpretations. Guidelines on trial registration, publication policies, etc., have been established and continue to evolve and be refined. It is also important to recognize that conflicts are not exclusively financial and professional factors, such as competition for grant funding, career advancement, etc., which may also represent an important but intangible conflict—an issue the purists seem to ignore.

Frequently in the news is the issue of “ghostwriting” articles, particularly when the author is supported by the pharmaceutical industry. Again, transparency would eliminate all such accusations. We recognize that large multicenter trials, where authors are often in different cities or even countries, may require an appropriate person to be paid to coordinate efforts in analyzing data and preparing the final paper. Nevertheless, such efforts need to be declared and these coauthors and writers given credit for their work. It is particularly important that the lead authors on any paper play a significant role in the preparation of the first draft and that all authors play a role in the finalization of a paper prior to submission.

Who is an author and how many do we need on a paper? This is a frequent question that arises in relation to papers from multicenter studies. The definition of authorship has been very clearly laid out numerous times in the literature, and I will not repeat the criteria here. Clearly, it is imperative that each named author plays a significant role in at least one aspect of the study (design, conduct, analysis, and interpretation). At Diabetes Care, we limit the number of authors to 12, and it is extremely rare that a paper needs more than that number to be true “authors.” On the other hand, recognition needs to be given to the many other players in multicenter trials. Toward that end, we have now developed links to our online appendix so that every person listed in the online appendix is also listed as an author on PubMed.

Finally, we continue to have a shortage of reviewers who are both qualified and willing to help us make decisions about papers. More importantly, our reviewers help shape the final version of what we ultimately publish to the highest possible level, which is what our readers expect. In 2009, there were only 1,313 active reviewers from a list of 5,295 potential reviewers who agreed to assist in the review process. Once again, I feel the need to remind all of our readers, particularly previous Diabetes Care authors, of their responsibility to participate in the peer review process. We ask that reviewers be constructive in their criticism allowing authors to revise their papers to much higher standards for resubmission either to us or elsewhere. Constructive criticism will therefore greatly enhance the standards of all journals and help investigators firm their ideas in a more lucid manner. We have revised our instructions to reviewers asking for brief bulleted constructive points to be given to authors rather than long diatribes. We now offer...
reviewers continuing medical education (CME) credits and hope that it will serve as an incentive for potential reviewers.

Our associate editor team has undergone some changes over the past year. We thank Marian Rewers and Ann Nettles for their long and valuable service and welcome Richard Pratley, Carla Greenbaum, and Katie Weinger. We also thank and say goodbye to editorial board members George L. Bakris, Verdain Barnes, Paresh Dandona, Andreas Festa, Linda B. Haas, Michele Heisler, Frank Hu, Takashi Kadomaki, Lawrence Lavery, and Merrn Pendergrass and welcome our new board members.

We have an outstanding team helping me to make this good journal better. Diabetes Care functions uniquely and well in a virtual world from an office in Indiana linked to the ADA offices in Virginia. Our editorial team of Lyn Reynolds, Shannon Potts, Jane Lucas, Rita Summers, and Amanda Nixon now work with not only Diabetes Care but also Diabetes, thus fulfilling the ADA’s important role in the dissemination of the best basic and clinical scientific information in an efficient and user-friendly manner. Every small step makes our good journal outstanding.

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