Report Card

The editorial team is now half-way through our 3-year commitment. Although our term officially began 1 January 2002, assignment of new manuscripts started 1 July 2001 during a 6-month transition period with the outgoing editorial team completing evaluation of already submitted manuscripts and the incoming team taking over new submissions. I would like to share some aspects of the journal at this midway point with the readership of *Diabetes Care*.

The impact factor, a measure of the frequency with which the "average" article in a journal has been cited in a particular year, is often used to compare the "clout" of a journal in its field. It is calculated as the number of current citations to articles that were published in the journal during the previous 2 years divided by the total number of articles published in the journal during that same period. *Diabetes Care's* impact factor increased in 2002 from 5.0 to 5.5, ranking it 11th among 90 endocrine journals.

In the calendar year 2002, 1,441 new submissions were received. If the recent monthly submission rates represent future trends, ~1,800 new submissions will be uploaded in 2004, representing a 25% increase over 2002. Additionally, the vast majority of these papers are resubmitted after reviewers suggest revisions. The time to initial decision on new manuscripts currently averages ~31 days. Your editorial team certainly is busy.

The current acceptance rate is over 40%. Our goal is to reduce this to ~30%. A decreased acceptance rate will improve the quality of *Diabetes Care*. Articles describing original research are judged by three criteria: *1*) Is it of high scientific quality? *2*) Does it contain new (or relatively new) information? And *3*) does it have clinical relevance, if not now, at least in the near future? A large challenge is to hold the line on papers that represent good science and have clinical relevance but mostly confirm what is already in the literature.

I have instituted several changes in *Diabetes Care* (and failed to realize several others). Short summaries on the more important articles are provided between the table of contents and the first article. "Key Global Literature," a summary of four to five articles pertinent to diabetes appearing in other journals is a new feature appearing at the end of each issue. This section is authored by Associate Editor Vivian Fonseca. From time to time, debates of controversial issues relevant to clinical diabetes are published in a "Point-Counterpoint" format. A classified advertising section in which individuals as well as institutions may place position-available or position-wanted notices has been added (although, so far, few have taken advantage of this opportunity). A new section called "Metabolic Syndrome/Insulin Resistance Syndrome/Pre-Diabetes" was initiated with the November issue to bring attention to the increasing amount of new information in this important area. In concert with the *New England Journal of Medicine*, *JAMA*, *Annals of Internal Medicine*, and *Archives of Internal Medicine*, I tried, unsuccessfully, to require senior authors to briefly designate the contributions of each fellow author. The purpose was to reduce the increasing number of authors who do not meet the criteria for authorship recommended by the International Committee of Medical Journal Editors (*BMJ* 291:722, 1985).

Finally, we are reintroducing the section "Brief Reports" to replace "Letters: Observations." "Letters: Comments and Responses," which are comment letters citing previously published articles and cited author responses, will remain. There are two reasons for "Brief Reports" reappearing. The most important being that the requirement of only 500 words without tables or figures for a letter often did not allow authors enough space to adequately describe their contribution. The "Brief Reports" format allows 1,000 words with one table or one figure. Secondly, and of less importance, a "Brief Report" carries more weight with academic promotion committees than a publication in "Letter: Observations." Even though abbreviated, these are original contributions to the literature.

An increasing challenge is to enlist the aid of good reviewers. There are fewer and fewer of them available because many senior people are going into industry or retiring and a dearth of younger people are going into research. This means that senior people are busier than ever and lack the time to provide this vital service to the research enterprise. We routinely must invite 10–15 potential reviewers per manuscript to get one or two to agree to review. The majority of invitees do not even bother to respond. We are reinstituting the policy of thank you letters to the top active reviewers. In addition, a token of appreciation will also be awarded to those few that have excelled above and beyond the call each year.

As the editorial team marks the halfway point in their editorship, *Diabetes Care* remains the most widely read clinical diabetes journal (with nearly 15,000 subscribers). Our further aim is to improve *Diabetes Care's* scientific quality. Currently, other journals publish some of the good clinical diabetes papers. It is our goal to attract these same investigators by raising the standards for, and improving the quality of, published papers in *Diabetes Care*, an outcome to which the editorial team is committed.

As in the past, *Diabetes Care* remains your journal. It is through the combined efforts of author, reviewer, and editorial team that *Diabetes Care* has been able to achieve its advances.

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