State of the Journal, June 1998

On 1 July 1998, it will have been 2 years since the Indianapolis team began reviewing manuscripts submitted to *Diabetes Care*. It is a good time to assess the state of the journal and of the new initiatives that the associate editors and I outlined in our first editorial (1).

The number of manuscripts submitted to *Diabetes Care*, and the number of paid subscribers, continues to grow. During the past 12 months we processed a total of 965 submissions, of which 790 were original scientific observations, 20 were editorials, reviews, or commentaries, and 137 were letters from our readers. The number of pages in the journal has been increased to accommodate this increase in submissions. We continue to have the largest paid subscription base of any diabetes peer-reviewed research journal, over 12,000 and growing. *Diabetes Care* has also become a well-established international journal, with over 77% of our submissions coming from outside the U.S. In the coming year we will publish four multi-authored supplemental issues based on clinical symposia. The topics covered in these supplements will include the financial and societal burdens of diabetes; the pathophysiology, diagnosis, and treatment of gestational diabetes and of diabetic renal disease; and the pharmacological treatment of type 2 diabetes. *Diabetes Care* continues to be the journal of record for position statements, technical reports, and standards of care of the American Diabetes Association.

We are often asked by present and potential contributors what we want. No one expressed the question so well as a graduate student who explained to our editorial office manager, "I want you to tell me exactly what you want the first time so that I won't have to waste time with revisions."

Occasionally we get an animal study or an in vitro study not involving a clinical intervention, which we send back with a note suggesting our sister journal, *Diabetes*. Overall, though, we are quite pleased with the mix of articles we receive. We would encourage more submissions regarding the costs and benefits of improved care, particularly in a managed care environment. In these times of fiscal constraint in which the value of what we do is being questioned, we need solid studies validating what we do in terms of outcomes, patient satisfaction and quality of life, and cost. There is a particular need for studies on the costs and benefits of recommended standards of care. We are pleased with the role that *Diabetes Care* has played in the discussion of these issues, and we encourage additional research in these areas.

What we do not want are manuscripts in which the data are mostly a re-look at published findings with perhaps a little twist. With the scientific literature growing at 3–4 million articles per year, we do not want to waste our readers' time with old wine in new bottles. There also has been a recent trend to send us genetic association papers. Given the technology and the large numbers of possibilities, we could publish several of these each month. However, we note the observation made by Drs. Goldstein and Brown in their editorial in the *Journal of Clinical Investigation* in 1997 (2):

> In 1986, a group of investigators described a polymorphic restriction-endonuclease site in the gene encoding apolipoprotein A-1, a component of plasma high density lipoproteins, that appeared to be associated with a higher risk for heart attacks. This opened the floodgates. Over the next 10 years, more than 500 papers reported an association between either heart attacks or hyperlipidemia and a common polymorphism in one of eight different lipoprotein-related genes. To date, none of them has been robust, none has proved to be diagnostically useful, and none of them has provided new insights into the pathogenesis of hyperlipidemia or atherosclerosis.

Thus, while we encourage linkage studies (that is, association studies within families), we are unlikely to publish them unless they employ genome screens such as those described by Valle et al. in this issue (3).

How are we doing with our new initiatives? With regard to our goals for review and publication times, we have not quite achieved our 30- and 90-day targets. The average time from receipt to initial decision is 35 days. The average time from final decision to publication is 96 days. (Table 1 summarizes the six most common author-generated reasons for delays in review or publication.) In addition to our efforts to accelerate the average review and publication times, we have established a fast track for papers likely to have a significant and immediate effect on clinical care. Unless there are significant revisions that delay such an article, we will shorten the time from acceptance to publication to an average of 66 days. Whereas we have initiated such a fast-track review process, if you feel that you are submitting or reviewing such a paper please indicate that in the letter of submission or in your review. We reserve the right to disagree. Among the other changes we introduced, those in the look of the journal have been well accepted, especially our cover art. The categorization of articles also has been well accepted. Thus, these features will continue.

Two additional initiatives are planned. First, we have expanded our World Wide Web page (www.diabetes.org/ diabetescare) to offer subscribers the full text of all articles. The Web site has been a tremendous success. We are averaging over 160,000 hits per month, and the curve shows no sign of leveling off. *Diabetes Care* is an international journal, and this Web site serves a vital function for our overseas readers.

Our second new initiative will be to expand our very active letters section by dividing it into two parts beginning in August. The first section will be "Observations." This will include letters describing clinical observations that may stimulate correspondence or clinical studies that in and of themselves do not warrant a full publication. Be warned that these are not peer reviewed and are published only to stimulate our readers. The dialogue between our readers and contributors will continue in the second section, "Comments and Responses."

I cannot discuss the state of the journal without acknowledging and thanking our

Table 1—*Most common author-generated delays in review or publication*

1. Did not include disks with revisions.*
2. Omitted copyright and duality forms.
3. Did not send enough copies to allow for peer review.
4. Printed on both sides of a page.
5. Did not include fax numbers or gave incorrect ones.
6. Did not include a list of potential reviewers.

*Does not apply to initial submissions, except letters.

literally thousands of colleagues who conduct the research, write (and rewrite) the manuscripts, review the articles, and give us editorial guidance. This also is a truly global effort. We made the decision when we took over the journal that an international journal requires an international review and editorial team. The American Diabetes Association has agreed with us and has generously supported our very large international telephone and Federal Express bills. This effort has contributed greatly to our success in the international arena. Of our more than 2,500 reviewers, nearly half are from outside the U.S. Finally, the associate editors and I need to acknowledge that we received the journal in great shape and wish to thank our predecessors for giving us a journal that we could continue to expand in size, scope, and impact.

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