Professional Councils of the American Diabetes Association

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I am honored that the editors of *Clinical Diabetes* have asked me to provide the first contribution to their new "Council's Voice" column. My tasks: to explain the role of the professional councils of the American Diabetes Association (ADA) and why they are important, and to provide an overview of the Council on Clinical Endocrinology, Health Care Delivery, and Public Health, for which I serve as chair. Future articles in this space will offer information on other ADA professional councils.

Historically, professional councils have formed when various groups of ADA health care professional members perceived a need within the diabetes community. Currently, ADA professional members can join a council that focuses on either a single aspect of diabetes (e.g., the Council on Foot Care, the Council on Exercise, the Council on Diabetes in Youth, or the Council on Diabetes in Pregnancy) or one that has a broader focus on the mechanisms of metabolic disease, diabetes complications, health care delivery, or outcomes (e.g., the Council on Complications or the Council on Clinical Endocrinology, Health Care Delivery, and Public Health).

Many members elect to join more than one council, recognizing the importance of each to the ADA mission and to the advancement of their professional lives. Each of the councils offers an opportunity for greater involvement in ADA activities and leadership. Council members have served on policy-making committees; written technical reviews, position statements, and other publications; and acted as liaisons between the ADA and other health care organizations or the media. The professional councils also provide a way for members to influence the planning and organization of the ADA's annual Scientific Sessions.

The Council on Clinical Endocrinology, Health Care Delivery, and Public Health

Background

Since the early 1980s, this group, the largest and most diverse of the 12 professional councils, has served as a forum for the exchange of information and strategies to meet the needs of clinicians in the area of endocrinology. In addition, its mission has been to further the generation, evaluation, and dissemination of scientific knowledge about public health and health care delivery related to diabetes. Its goal has been to foster interdisciplinary research and education to effect optimum health planning and care for the diabetes community.

As of February 2003, the council had 2,656 members: 2,113 in the United States and 543 from around the world. Many are also members of at least one other ADA council. Approximately one-third of the council's members list their area of specialty as primary care (e.g., internal medicine, family practice, general practice, or nursing), whereas the other two-thirds are adult or pediatric endocrinologists.

The council's members are active in a variety of other professional organizations. An e-mail survey completed in early 2002 revealed that more than two-thirds of members are active in one or more of the following organizations: the American Association of Clinical Endocrinologists (AACE), the Endocrine Society, the American Association of Diabetes Educators, and the European Association for the Study of Diabetes.

Plans and Priorities

The survey also clarified several priorities for the council regarding both council structure and possible activities to plan to meet member needs. Members expressed support for a formal leadership structure (e.g., chair, chair-elect, scientific sessions liaison), to define a leadership track to further the business of the council and provide a greater opportunity to identify new leaders within the ADA. Survey respondents also requested that council planning include the development of awards, recognition, and social-networking events.

Finally, the survey helped the council identify three areas for targeted activities. The first is information sharing (e.g., council-specific quarterly summaries, information on the clinical practice of diabetes and health care delivery, and Scientific Sessions via Internet access). The second is networking, with an emphasis on specialist/generalist interactions targeting regional/geographical, national/international, and provider/patient opportunities. The third is research, including clinical practice initiatives and funding support.

Recent Programs

To support the council's efforts to better understand the breadth and scope of national health policy planning for care of people with diabetes, Robert A. Rizza, MD, vice president-elect of the ADA and chair of the Endocrinology Workforce Study[1] task force, agreed to be the featured speaker at the council meeting held during the ADA Scientific Sessions in New Orleans in June 2003. Dr. Rizza presented findings from the Workforce Study, a collaborative effort among several organizations to addres the need for endocrinologists until the year 2020. Paul Jellinger, MD, FACE, past president of AACE and current AACE-ADA liaison, provided additional comments and insights, followed by a general council discussion.

Council leaders are anxious to continue planning and organizing to support the group's mission. The council not only provides a professional home for the many endocrinologists, primary care physicians, and other health care providers, but also serves as an opportunity for networking and identifying specific interests that may lead to the formation of new councils that will better serve the needs of the ADA, its health care professional membership, and people at risk for or with diabetes.

If you are a member of the Council on Clinical Endocrinology, Health Care Delivery, and Public Health and we do not have your e-mail address, please contact me. If you are not a member of a council or of the ADA at all, let me tell you more about these opportunities.

REFERENCE

[1]Rizza RA, Vigersky RA, Rodbard HW, Ladenson PW, Young WF Jr, Surks MI, Kahn R, Hogan PF: A model to determine workforce needs for endocrinologists in the United States until 2020. *Diabetes Care* 26:1545–1552, 2003

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