This month in *JICS*

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The Editor writes

A belated Happy New Year! This is a landmark issue for *JICS* as it is the first to be published by SAGE Publications and it marks the beginning of some exciting new changes for the Journal. Both the print issue and the website of the Journal have new looks and, as I have eluded to previously, our strategy remains to make the Journal and its contents as relevant and accessible as possible for our readers and authors alike. There is a new online submission process which will, I hope, make it easier to submit your work to *JICS* and to track its progress through our review system. As an added incentive to submit your work to the Journal, I am very pleased to announce that we will be offering an annual prize of £2000 to the author/s of the ‘best’ article within a certain category; this year, that category will be the ‘best original article’ published by the Journal during 2015. All original articles will be assessed by an independent panel (no authors will be able to participate in the panel assessment) with the winner/s being the author/s of the manuscript with the majority vote. The details for awarding the prize are yet to be arranged, but I hope this will be at the State-of-the-Art meeting in December this year.

From now onwards, all original articles, reviews and special articles will be published online about 30 days after acceptance of the manuscript with a unique digital object identifier (DOI) that will allow immediate citation of your work rather than having to wait for the article to come to print. I firmly believe that these measures will encourage and support our authors while providing our readers access to contemporaneous new evidence, comment and debate as soon as they come to fruition.

New in this issue is the first of what I hope will be a regular section of ‘Bench to Bedside’ articles. The aim of these articles is to showcase basic science research pertinent to critical care, but in a digestible format: the background behind the research (why it is needed), the results so far and how this is hoped to translate into improved patient care in the future. I believe it’s vital that clinicians understand these aspects of basic science so that they can contribute and support wherever possible. Likewise, academics must engage clinicians in explaining their research in order to nurture this support and clinical direction for their work. The academic world is under increasing pressure to show its ‘worth’ through publication

productivity and grant awards; the clinical world is pressured by financial constraints and a focus purely on clinical output. Both are frustrated by the diminishing recognition of their ‘value-added’ contributions, in particular the forays of one world into the other. For our specialty to flourish and for continued improvements in our understanding of disease mechanisms and patient care, we need academics, clinicians and a spectrum of those with interest and expertise spanning the two. There is a risk that the current climate will push academic and clinical words apart; to prevent this, we need to forge new links between the two, whilst maintaining and nurturing existing ones; above all, we must have dialogue, and it is this philosophy that has led to the current ‘Bed to Bedside’ articles. To kick off, Dr. Kate Tatham describes how the group in which she works is studying the mechanisms involved in lung transplantation and ex vivo lung perfusion. I have invited similar articles from other research groups around the country (and beyond) which will appear in future issues but would very much welcome uninvited submissions along this theme.

Also in this issue, we have a wonderful selection of original articles from which certain themes appear to have evolved: trauma, rehabilitation from critical illness and the impact of critical illness on subsequent quality of life. In addition, Dr. Black and colleagues provide a valuable insight into the dosing of renal replacement therapy in Scottish intensive care units (ICUs); in so doing, they provide an approach that can be easily replicated and adopted in our own ICUs. It is important to recognise that sometimes the process of a study is as important (if not more so) as the result itself. Not all results can be extrapolated widely; however, a well-conducted process of research or evaluation can provide a ‘recipe’ for reviewing specific processes and outcomes that can be widely adopted; in so doing, we can gain valuable local insight into ways for improving patient care. In a similar vein, Anna Knott and colleagues describe their data on barriers to rehabilitation in ICU; while the process described is easily adopted, the comments in Eve

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Corner's editorial guide further refinement and raise interesting questions of barriers versus contraindications. If you are unsure whether rehabilitation is important at all, then the report in this issue of the qualitative arm of the PIX study makes for humbling reading.

In addition, you will find a systematic review of the implications of raised troponin levels in patients with sepsis and no angiographic evidence of coronary artery disease. The issue of raised troponins during critical illness remains a favourite topic for discussion during ward rounds and will likely remain so into the future; I'm not sure what we will debate if we ever

develop a definitive biomarker of coronary vascular events – probably procalcitonin...

The above sit alongside the usual offerings of case reports, correspondence and opinion pieces; all of which will stimulate the brain cells and, I hope, your own contributions. It is worth emphasising that *JICS* (and the *ICS*) aims to represent all intensive care disciplines and professionals, and I hope the breadth of topics covered in this and other issues of the Journal reflect this. If you feel differently about this or any other *JICS* or ICU-related issues, then please put 'pen to paper' and let me know; 'you've got to be in it to win it' – and that includes the £2000 prize!