but did not slow the increasing number of consultant and staff grade appointments being made to MAUs.

Many of the physicians who presented to the working party decided to meet again. The Royal College of Physicians facilitated this and the Acute Medicine Group was formed. This group met again in Edinburgh, and the Society for Acute Medicine was established. One of the first actions of the newly formed society was to sound out the attitudes of emergency medicine and critical care medicine to our ambitions. It fell to me to speak with friends and notaries in emergency medicine. The response at that time, some three years ago, was that many emergency physicians were pleased to see medicine taking a greater interest in acutely ill patients, some said not before time, and generally there was a feeling of goodwill. There was a smaller group, often of those with experience or knowledge of the American or Australasian style of emergency medicine, who had themselves similar ambitions to ours for the initial care of emergency medicine admissions. I suspect that the situation is similar today.

So who should provide the initial care for the acutely ill medical patient? I don't think that there is necessarily a single answer, for a number of reasons. Different hospitals will have consultant staff in both emergency and general medicine who have differing ambitions and enthusiasms for the early management of ill patients. Recent experience has shown that trusts are keen to recruit consultant physicians in acute medicine, but the early enthusiasts are all in post and the newly developed training schemes will not produce their first graduates for another three years, and even then the numbers will be few. It perhaps matters less who does the job than that it is done well. Best care will demand close working between all those involved and this will include practitioners of acute medicine, emergency medicine, and critical care medicine, who will need to develop uniform management strategies that are well founded, well disseminated, and used when any discipline is caring for similar patients. The Royal College of Physicians has recognised this and produced two reports[7 8] on the interface between acute medicine and the two specialties.

Recently the Royal College of Physicians reviewed its thoughts on acute medicine and its most latest report, *Acute medicine: making it work for patients*[9] shows a substantial change in thinking, due in no small part to the efforts of Professor Black, now the President of the College and Dr George Cowan, Medical Director of the Joint Committee for Higher Medical Education (JCHMT). Rather than suggesting that consultant posts in acute medicine were undesirable, it now recommends a minimum of three such posts in every hospital by 2008. Moreover, throughout the document there is evidence of a change in philosophy regarding the organisation of care for the acutely ill medical patient, with emphasis on cooperation between acute medicine and emergency medicine. There are suggestions of consultant appointments in acute medicine having commitments to accident and emergency departments, high dependency units, and intensive care units. Perhaps most significantly there is a recommendation that ''clear pathways are developed to facilitate higher specialist training in Acute Medicine for doctors with a background in Emergency (A&E) Medicine and Critical Care, who have appropriate basic specialist training, but do not necessarily have the MRCP(UK) Diploma''.[7] While this is in keeping with the change in G(I)M training towards competency based standards, it does mark a significant departure from previous practice and it remains to be seen how practicable it is to determine equivalent competence and experience.

So the past few years have been an interesting time. If all works well I hope we will all be winners, with specialist acute care and improved inter-departmental organisation resulting in the most important thing of all, a better experience and quality of care for our patients.

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New for 2005

Changes and thanks

Jim Wardrope, Pete Driscoll

EMJ goes monthly and important changes in requirements for patient consent.

The *EMJ* will become a monthly publication in January 2005. This is a major step in the development of the journal. We thank all those who have worked so hard to achieve this aim, especially the great support from the British Association for Emergency Medicine, the British Association for Immediate Care (BASICS), the Faculty of Pre-hospital Care, and BASICS Scotland. This change will allow us to be more topical, more reactive, and quicker at publishing accepted papers, a particularly worrying problem for the journal and authors.

In advance of this change we have reviewed our policies and procedures. These can be viewed in full on http://emj.bmjjournals.com/misc/ifora/jnlguidelines.shtml. One significant change is that we now require patient consent for case reports or small

case series where there is patient identifiable information. All other research requires ethical approval and we feel that this is important step in protecting patient privacy. There may be times when consent is not possible but these will be few in number. This change will apply to case reports submitted after 1 January 2005. A copy of a consent form can be obtained from http://emj.bmjjournals.com/misc/ifora/patconsent.shtml.

We have also updated the instructions for reviewers. A heartfelt thanks to all our reviewers who give time and brainpower freely to assist the journal. Your hard work is much appreciated (see page 717). We believe the quality of papers in the *EMJ* has significantly increased and the review process is part of this quality improvement.

If you do review for the *EMJ* could you read the new instructions for reviewers on http://emj.bmjjournals.com/misc/ifora/. The changes are not major but are in response to some ideas you have suggested.

Finally, we would like to thank Claire Jura for her work for the *EMJ*. For three years she has been the editorial assistant for the journal, the ever patient voice on the *EMJ* telephone and a great supporter of the editorial team. Recently she was promoted within the BMJ Group and has been replaced by Craig Raybould. We welcome Craig to the *EMJ* team.

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