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*Editorial*

# Why We Need a College of Intensive Care Medicine (UK)

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In 2004, as a young consultant intensivist, I wrote an editorial entitled 'Anaesthetist or Intensivist' [1]. I argued that thinking of yourself as an intensivist, and being perceived as such by other specialities, is important for good, timely patient referrals to improve outcomes. I argued that an intensivist is someone appropriately trained in intensive care medicine; their background training, be it medicine, anaesthesia or surgery was irrelevant. The editorial provoked responses varying from suggesting I grow up, to agreeing but calling for patience. Now, as an old consultant intensivist, some of the points I made then, apply now to why we need a College of Intensive Care Medicine. Those who called for patience were right.

The inauguration of the College of Intensive Care Medicine (UK) on July 1st 2026 was a momentous day for the speciality, not a destination but a point in the maturation of a speciality whose evolution has been driven by wars and pestilence. Wars, in the form of Crimea which drove the development of specialist nursing and the formation of hospital wards, the First World War which drove advances in airway management, and subsequent wars which have driven fluid management and renal support. Pestilence in the form of pandemics: polio, influenza, HIV, and SARS-CoV-1 and SARS-CoV-2, have brought advances in medicine, mechanical ventilation and microbiology as well as driving intensive care specialisation.

Intensive care medicine (ICM) in the UK has, to its great benefit, maintained a broad entry in residents' training, including medicine - acute, emergency, renal and respiratory, as well as anaesthesia. After decades of work by individuals arguing that ICM should be recognised as requiring specialist training, the General Medical Council recognised ICM as a separate speciality in 2010, with its own Certificate of Completion of Training (CCT). Intensivists could therefore have a single ICM CCT on the GMC register. The recognition that ICM requires its own training programme to improve patient outcomes confirms why we need our own College.

How can the diversity of training backgrounds among residents and consultant intensivists be properly recognised other than by bringing us together under one roof? Without our own College, an increasing number of intensivists who weren't also anaesthetists were paying member subscriptions without true representation. A nod to "No taxation without representation". Those practising intensive care can now, if they so wish, be members of the College of Intensive Care Medicine and be genuinely represented without requiring any additional College membership.

According to our 5000 members, advocacy is the most important reason why they want a College. To properly advocate for ICM, to do so without compromise, and on behalf of all members, we need to be unified. Having our own College allows us to do this better than we could as a Faculty of the Royal College of Anaesthetists, where compromise was inevitable. As a charity registered in England and Wales and separately in Scotland, we have a duty to speak up for the issues that are most important to our members across all four nations. Our charitable objects include not only training and educating our members but also, as important, educating patients and the public. As a College, we can concentrate our energy and resources on what ICM can and should do, as well as on what it can't do. Our vision is to lead excellence in ICM, with all patients cared for in UK intensive care units having their care directed by an intensivist. This means a consultant intensivist who has completed training, passed the relevant examinations, and holds a CCT in ICM—the model envisaged by those who advocated so strongly for a CCT programme, and whose efforts led to the GMC recognising the speciality. Becoming a College has brought maturity by strengthening our governance and defining our vision, mission and values.

The COVID-19 pandemic brought intensive care and intensivists into the limelight. The Covid Inquiry recognised that the UK has too few staffed intensive care beds and that infrastructure in many units is unfit to deliver 21st-century care [2]. With the limelight now shifted elsewhere, we need a College of Intensive Care Medicine that can advocate on an equal footing with other medical Colleges on behalf of all our multidisciplinary staff, our speciality and our patients through their whole illness journey, including recovery after critical illness. The Module 3 Report of the Covid Inquiry made recommendations that will require intensive care to direct and implement. A College of Intensive Care Medicine will enable this or we risk going into the next pandemic in the same situation as in 2019.

The speciality of ICM has developed and matured. Gone are the days when only ventilated patients were admitted to intensive care units, with a preponderance of surgical pathologies and with supportive care delivered by anaesthesia. Intensivists now lead the diagnosis and treatment of pa-

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tients with critical illness in 'closed' units and are essential in many areas of modern healthcare, including trauma, infectious diseases, cardiac arrest, cardiogenic shock, and organ transplant. They also provide vital life-saving support for many other specialties' treatments and interventions, such as haematology, oncology and immunology. Good data are absolutely fundamental to the delivery of intensive care and the improvement of patient outcomes. In the UK, this has been led for decades by ICNARC (Intensive Care National Audit and Research Centre) and SICSAG (Scottish Intensive Care Society Audit Group). Outcomes in intensive care have improved, and we are more likely to admit and intervene earlier, with sepsis recognition, Outreach and Martha's rule pointing to the direction of travel.

The establishment of the College of Intensive Care Medicine comes at a difficult time for all medical colleges, but at a time of fundamental importance to the NHS. The medical colleges play a pivotal role in the education, training and examination of the present and future generation of doctors, and they provide better value and higher standards than the alternatives. The Colleges also play a crucial role in advising and implementing policy. The Westminster government's 10-year Health Plan for England [3] has called for three shifts in England: Analogue to Digital, Hospital to Community and Sickness to Prevention.

As the College of Intensive Care Medicine, we are very well placed to support the shift from Analogue to Digital. The College strongly supports digital transformation and has advocated for years for it, not least in relation to small and remote units that need support from the centre. Access and the ability to share real-time patient data are crucial to this.

The shift from Hospital to Community does not, at first sight, appear to be one of intensive care's priorities, but 'Life after Critical Illness' [4] and maximising return of function and quality of life is a major shift that has taken place in intensive care medicine and one that is vital for patients and their families. A move away from defining success in intensive care admissions as survival to defining it as survival with a quality of life at home in the community is one we seek to deliver through Follow-Up and Rehabilitation.

The third shift is from Sickness to Prevention. As a College representing our members, preventing critical illness or reducing its severity speaks to our commitment to outreach, our strong support for vaccination programmes, and our fundamental role in organ donation, which can transform the lives of recipients and reduce the need for in-patient care, including intensive care. Many admissions to intensive care are repeat admissions; better psychological and medical prevention after intensive care admissions could reduce or eliminate the need for further admissions. The GiRFT Report [5] for Adult Intensive Care summarises the scale of readmissions and, therefore, the potential to reduce them.

Lastly, ICM lies right at the forefront of legal and ethical issues in medicine and in wider society. As a College, our independent voice is vital to the discussion that desperately needs to take place about where we want our care to be delivered at the end of our lives, and what care we want. The cost of healthcare in the last year of life is staggeringly high [6]. As intensivists, it is common for us to receive referrals for intensive care in which prior discussions about what is most important to a patient would have prevented admission. Once intensive care admission has taken place, such discussions are often too late, frequently occur without the patient's participation as they are incapacious, impose an unnecessary burden on patients and their families and increase costs to the NHS. By forming the College of Intensive Care Medicine, we are best placed to lead discussions about what intensive care can and cannot do to achieve the outcomes that patients desire.

## Key Points

• To advocate for all our college members within the wider health and social care environment.

• To lead in Intensive Care Medicine across the four nations with courage, compassion and excellence.

• To advance the knowledge of intensive care medicine with patients and the public.

• To develop and maintain the highest professional standards in intensive care medicine.

• To lead on the necessary societal discussions on what intensive care medicine can and can't do as we approach the end of our lives.

## Availability of Data and Materials

Not applicable.

## Author Contributions

All elements of the study and subsequent write-up were carried out by the author [JPJ]. The author read and approved the final manuscript. The author has participated sufficiently in the work and agreed to be accountable for all aspects of the work.

## Ethics Approval and Consent to Participate

Not applicable.

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## Conflicts of Interest

The author declares no conflicts of interest.

## References


[1] Anaesthetist or intensivist? Hospital Medicine. 2004; 65: 516–518. https://doi.org/10.12968/hosp.2004.65.9.15977

[2] The Rt Hon the Baroness Hallett DBE. Module 3 Report – The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom. 2026. Available at: https://covid19.public-inquiry.uk/documents/module-3-full-report/ (Accessed: 19 March 2026).

[3] GOV.UK. 10 year Health Plan for England: fit for the future. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future (Accessed: 19 March 2026).

[4] The Faculty of Intensive Care Medicine. Life After Critical Illness. 2021. Available at: https://www.ficm.ac.uk/sites/ficm/files/documents/2021-12/LACI%20Life%20After%20Critical%20Illness%202021.pdf (Accessed: 19 March 2026).

[5] NHS England. GiRFT Adult Critical Care. Available at: https://gettingitrightfirsttime.co.uk/medical_specialties/adult-critical-care/ (Accessed: 19 March 2026).

[6] Nuffield Trust. Public expenditure in the last year of life. 2025. Available at: https://www.nuffieldtrust.org.uk/research/public-expenditure-in-the-last-year-of-life (Accessed: 19 March 2026).