

Celebrating the creation of the College of Intensive Care Medicine

On 1 July 2026, the Faculty of Intensive Care Medicine (FICM) – of which the RCP was one of eight parent colleges – officially became the College of Intensive Care Medicine (CICM). To mark this event, the new CICM president, Dr Jack Parry-Jones FRCP FCICM, shares his reflections on the changing landscape of intensive care medicine and why this brand new college has so much value for physicians.

It is a pleasure, as president of the new College of Intensive Care Medicine (CICM), to write an article for *Commentary*.

All the medical colleges face significant challenges in a post-COVID world – financial, governance and political – but there are also very good reasons why colleges continue to exist, and also very good reasons why we need a college dedicated to intensive care medicine. Our new college council's vision is for us to 'lead excellence in intensive care medicine' with a mission to deliver that by developing professionals across a diverse intensive care medicine (ICM) workforce, advocating for the specialty and our members, listening to public, patient and family voices, and supporting a sustainable and dynamic college. Our college's values – which in the current world are so important – are compassion, courage and excellence. We need to live up to and work to these values.

Some colleagues and I recently wrote a short definition to try and encapsulate what, and who, we believe a modern intensivist really is. We came up with the following:

'An intensivist is a physician with specialist training in intensive care medicine who possesses the expertise required to direct the multidisciplinary care and organ support for critically ill patients. This includes caring for patients at risk of developing multiple organ failure, overseeing diagnoses, admission, treatment, organ support, discharge and recovery across a broad spectrum of critical illnesses while also providing holistic support for patients and their family. This supportive care includes those who don't respond to treatment and transition to end-of-life care. An intensivist is cognisant of the ethical and legal framework in which we work, is sensitive to religious and cultural beliefs, and is mindful of changes in societal and professional expectations of what is felt to be realistically achievable.'

Intensive care has evolved significantly in the UK, to the point that being a stand-alone specialty with our own college became increasingly obvious and important.

Intensive care is often said to have started in 1952, with the polio epidemic in Copenhagen. There is good evidence to say that it started much earlier but it is convenient, however, to have that start point. The world's first intensive care society started in the UK around 20 years later. The Faculty of Intensive Care Medicine (FICM) formed in 2010; at that time, in the UK almost all intensivists were also still anaesthetists. Those days are long gone. Instead, we now have increasing numbers of either single-specialty intensivists, or intensivists with a medical specialty – be that respiratory, emergency, renal or acute medicine.

Intensivists who are also anaesthetists have decreased, to the point that intensivist representation solely within the Royal College of Anaesthetists (RCOA) was no longer optimal, particularly as intensivists who weren't also anaesthetists had no representation. How should non-anaesthetic intensivists get the recognition and representation that they deserve, other than by inclusion in their own college; a college which can recognise all people doing ICM as equal, and advocate for and represent them as equals?

Intensive care as a specialty is a broad church; we want to welcome people whatever their background. This is apparent when you consider that the FICM was formed with eight parent colleges: the RCP, RCoA, Royal College of Emergency Medicine, Royal College of Paediatrics and Child Health, Royal College of Surgeons, Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Royal College of Physicians and Surgeons of Glasgow.

Diversity of medical training on entry to the specialty of intensive care is a great strength. All those completing their ICM training, however, should have reached a common recognised standard with their certificate of completion of training (CCT) in ICM, or its equivalent via the portfolio pathway. All those with an ICM CCT should have the same job opportunities – and nowadays, all critically ill patients should have their care directed by a qualified intensivist.

One of the great things about doing intensive care is its huge variety; each clinical day is different.

Good technical skills are required but it is also

truly general medicine, with the need for a good understanding of infectious diseases, immunology, haematology, rheumatology, endocrinology, cardiology, respiratory, renal, gastroenterology, hepatology, palliative care, rehabilitation medicine etc. You also need a good understanding of the surgical specialties, including trauma, orthopaedics, and obstetrics and gynaecology. Medical training, with its emphasis on diagnosis, treatment and supportive care, is a great entry point for ICM – and if you are planning a career in research there are also ample opportunities.

Technical skills and a good broad medical knowledge on their own are not enough. Communication skills are essential, and that includes communication within the wide multidisciplinary team (MDT) that the consultant intensivist leads, communication with other specialties often involved in the patient's care, and communication with their family and friends. Knowledge, skills and experience in the diseases that we diagnose and treat, and the supportive care that we deliver to patients and their family, lead to better judgement.

With judgement comes the management of risk, about which there has been much debate recently. As doctors, of whatever chosen path, we all need to learn to manage risk better for our patients and ourselves; we need to deliver good training environments, with the right amount of supervision to do this. How we manage risk changes over time; in training and with consultant experience. Judging which patients to admit to intensive care, what tests and radiological investigations are needed and, possibly, the point where further intervention is more burdensome than meaningful can be challenging – but we can make a beneficial difference to patients and their families in life and in death. These

judgement calls are common in ICM, which is at the forefront of medical ethics and medical law – especially since many of our patients lack mental capacity to make decisions for themselves.

For patients who survive critical illness, there is often a prolonged recovery period over months to years. In the past 20 years, it has become increasingly clear that, as intensivists, we have a significant role to play in intensive care follow-up and rehabilitation as part of the MDT. A return to outpatient clinics seems a strange thing for some to enjoy, but I personally really enjoy seeing patients, often with their family, helping them to understand their illness and its treatment, and seeking to improve their journey of recovery. Again, we can make a real difference to people's lives.

Visit the [CICM website](#) to find out more about the work of the new college and look out for the upcoming summer 2026 edition of 'Critical eye', the CICM membership magazine, which will include an article by RCP president Professor Mumtaz Patel.

Listen to Dr Jack Parry-Jones' 2025 FitzPatrick lecture, 'The history of intensive care medicine – a specialty moulded by infection' on the [RCP Player](#).

This feature was produced for the August 2026 edition of [Commentary magazine](#). You can read a [web-based version](#), which includes images.

