Member Story – Professor Martyn Partridge

Professor Martyn Partridge is Emeritus Professor of Respiratory Medicine at Imperial College London.

Professor Partridge served as BTS President 2007-2008. He is one of the 500 founding members of the Society.

Here he offers us his reflections on the work of the Society since its founding day and where he sees it heading in the future.

40 years with BTS

In 1982 I was transiting from a Senior Registrar post at University College Hospital (Senior Registrar is old speak for a grade between Specialist Registrar and Consultant), to a Consultant post at Whipps Cross Hospital.

At the time we were living with our 3 children aged 5 years and under in a two bedroomed flat in Fulham and as well as selling the flat we were looking for a house to buy in Loughton and a school for our eldest daughter to attend. To be honest therefore, I doubt that the merger of two specialist societies and the launch of the BTS was top of my list of pressing problems at the time!

However as a member of both of the constituent associations I do recall voting on the issue in both, and irresponsibly thinking that a reduction in number of societies meant less opportunity to attend scientific meetings!

The next few years spent working in a hospital where 50 admissions per weekend per duty consultant was not unusual, (and where we gave our own chemotherapy to patients with small cell lung cancer under the auspices of the London Lung Cancer Study group), passed in a flash but I lasted 19 happy years there before moving to Imperial. Starting in the mid 1980's, and for at least a 30 year period, I enjoyed undertaking many "jobs" for the BTS.

For any younger readers let me assure you that in my experience volunteering for a medical charity or for your specialist society or for a Health Department advisory role is very much a gain for the individual, often to a greater extent than the organisation gains. "Gain" not in financial terms but gain in meeting new colleagues, learning new skills whether in fund raising or public relations, thinking strategically, and generally giving one a different opportunity to promote good respiratory care away from the ranch.

So what BTS activities which I was involved in do I think were successful, in what did I fail, and which do I wish were successful but the jury is still out?

The first British Asthma Guidelines published in 1990 initiated decades of subsequent activity on wide ranging guidelines and position statements. The benefits in terms of someone else distilling advice from big bodies of evidence are obvious, but we should never underestimate their value as a learning tool for trainees and non specialists.

Specialism and a focus upon Respiratory Medicine by Nurses working in all parts of healthcare has been another sustained initiative and for me this followed the vision of 2-3 astounding nurses such as Greta Barnes (BTS Medal 2016) and Angela Heslop.

A first scoping meeting at the Royal College of Physicians in London in 1989, lead by the BTS, was followed by a Policy Statement suggesting that every Respiratory Medicine department should make such appointments.

The launch of BTS Short Courses also proved to be a long-term success although the one that gave me most satisfaction, on Palliative Medicine and Breaking Bad News, held in Lincoln in 1989 (see flier, Figure3) was repeated in 1993 but possibly not since. I hope that this subject and patient centred approaches do not lose prominence as essential parts of a training programme in Respiratory Medicine.

The BTS/NAC Lecturer scheme (*NAC equals old speak for Asthma + Lung UK*) came and went. The scheme offered Post Graduate Centre administrators, often desperate for a speaker for their weekly clinical meetings, a volunteer lecturer who's travel expenses were paid by the two charities. Only a modest success, it does remind one that current educational activities are aimed at those with a committed respiratory interest whereas we should also be educating those in other specialities who also look after those with lung disease, (and what about initiatives for medical students where current medical school exposure to good respiratory medicine is patchy to say the least).

Whilst I am still in regular contact with Dr Anila Basit from the Pakistan Chest Society who came to this country for a spell with Professor Anita Simonds, the BTS Overseas Fellowship scheme did not survive changes in BTS priorities and officers. The scheme enabled British trainees 3 weeks supported fellowship overseas and an overseas fellow 3 weeks in the UK.

The Profile of Respiratory Medicine: Whilst the BTS for many years supported the Lung and Asthma Information agency based at St Georges Hospital, its first publication to collect together all of the data on the Burden of Lung Disease was published in November 2001. The publication facilitated a meeting with the Secretary of State for Health lead by Professor Duncan Geddes and attracted a national award in the Health section of one scheme. Gina Coladangelo, Sheila Edwards and I collected the award at a glitzy ceremony at a Park Lane Hotel.

It is a pleasure to see the dignified and responsible actions that have been continued by the BTS to maintain the profile of our speciality but many believe that we still do not receive a fair share of the resources cake.

Integrated care nowadays usually means integration between health and social care, but the BTS and many members have also been inspirational in advocating integrated respiratory care twixt hospital and community. Taking specialist respiratory care nearer to the patient has tremendous advantages in terms of spreading messages about good practice, but is also good *green* healthcare saving unnecessary travel for patients. After an initial burst of enthusiasm and activity it is essential that this move must not be allowed to wither.

So what of the future? There are many challenges and many opportunities but super specialisation is a trend we should guard against.

I have enjoyed being an expert in the lingula and only regret that I did not choose the azygos lobe for there are fewer of them! Specialisation is necessary for rare diseases and when utilising techniques and expensive interventions that require regular exposure and practice, but we must guard against a situation where the patient with COPD who develops heart failure is not promptly diagnosed or where the patient with sleep apnoea or the patient with suspected lung cancer is kept waiting because that sub type of respiratory physician is on leave.

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The majority of Respiratory Physicians should be able to diagnose and manage the majority of patients with lung disease who require specialist care.

Keep up the great work BTS – a professional society to be really proud of.