The changing face of the modern respiratory clinician

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Shareable abstract (@ERSpublications)
This issue of *Breathe* examines both the integral role multidisciplinary care has in managing respiratory disease, and the changing faces of the respiratory clinicians providing that care.
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Much has changed in respiratory medicine since the turn of the century. Our knowledge of the immunobiology of respiratory illness has transformed. Elegant, targeted pharmacotherapies have become available to our patients. Previously niche clinical areas such as sleep medicine and pleural disease have been established as distinct subspecialties. But a less discussed change within the specialty has been an evolution in our understanding of what a respiratory clinician is. 20 years ago, someone identifying as a respiratory clinician was highly likely to be a respiratory *physician* (and the chances were that they were a male respiratory physician). Clinical nurse specialists had been around to some degree since the late 1970s [1], and most people were probably aware that physiotherapy was pretty important for people with respiratory disease, but the scope of practice and degree of autonomy these clinicians had was vastly different from today. Meanwhile, entire professions now considered integral parts of the multidisciplinary team (MDT) were seen as having – at best – tangential connections with the delivery of respiratory care.

This issue of *Breathe* is all about the respiratory MDT, and the myriad professional identities of the modern respiratory clinician. Pharmacists are a good example of this. Those of us training as respiratory physicians in the early 2000s were probably dimly aware of pharmacists as possibly having some role in providing inhalers for our patients. If you worked in cystic fibrosis, you may have known them as the nice people who deciphered antibiotic prescriptions. As outlined in a forthcoming review from Clements and co-workers, contemporary respiratory pharmacy now encompasses everything from adherence assessment to dose titration, with pharmacists established practitioners across the full gamut of respiratory subspecialties. Similarly, speech and language therapists now take a leading role in the respiratory MDT, in particular working alongside nursing, physiotherapy and medical colleagues in the management of inducible laryngeal obstruction and breathing pattern disorders, as described by Ludlow *et al.* [2].

The importance of multidisciplinary care is perhaps longer established in some diseases than others. The management of respiratory failure in patients with amyotrophic lateral sclerosis/motor neurone disease (ALS/MND) is by definition multidisciplinary, requiring collaboration between clinicians from respiratory medicine and neurology. A fascinating review by Berlowitz *et al.* [3] explores the complexity of respiratory care, and the need for multidisciplinary working, in people with ALS/MND. While the review has a focus on respiratory supports such as noninvasive ventilation and cough assist devices, it also illustrates the inherent benefit of a multidisciplinary approach to the management of people with complex care needs.

In other disease areas the merits of multidisciplinary input are increasingly appreciated. Many of the headlines about idiopathic pulmonary fibrosis and other progressive fibrotic interstitial lung diseases over the past few years have focused on pharmacotherapy [4]; however, as discussed in the review by Oliveira *et al.* [5], it is clear that these patients can greatly benefit from input by colleagues from clinical nutrition, clinical psychology and palliative care, alongside the more established roles played by chest physicians, nurses and physiotherapists. This issues' Journal Club also focuses on treating pulmonary fibrosis, but with a focus on new and potentially exciting antifibrotic medications [6].

Some situations require the involvement of non-respiratory colleagues in order to achieve successful outcomes for our patients. In our Ask the Expert piece, Barca-Hernando and Jara-Palomares [7] describe how the use of catheter-directed therapies by interventional radiology colleagues can salvage the situation in patients with pulmonary embolism, particularly those for whom systemic thrombolysis is contraindicated or has been unsuccessful. A forthcoming review on the role of the MDT in asthma includes a discussion on the utility of involving specialists in ENT, bariatric medicine and mental health in the management of people attending difficult asthma clinics. Even our forthcoming Lung Function Corner article from Bayat and co-workers has a multidisciplinary theme, highlighting the potential for functional imaging studies to compliment traditional measurement of lung function in assessing pulmonary physiology in people with respiratory illness.

Finally, mycobacterial disease enthusiasts are also well served in this issue of *Breathe*, with three Viewpoint articles looking at contemporary aspects of tuberculosis (TB) care. Ramos *et al.* [8] highlight the importance of a multidisciplinary approach to TB prevention and treatment. Saluzzo *et al.* [9] examine exciting developments in shortening TB treatment duration, while Adepoju and Onyezue [10] underline the importance of the development and deployment of a new, effective TB vaccine in mitigating the devastating global effect of this disease.

Overall, this issue of *Breathe* helps illustrate both the integral role multidisciplinary care has in managing respiratory disease, and the changing faces of the respiratory clinicians providing that care.

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