

Letter to the Editor

Reflections on leadership and professional growth in respiratory therapy

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Keywords: Respiratory Therapy, Leadership, Professionalization, Organizations

<https://doi.org/10.29390/001c.129001>

Canadian Journal of Respiratory Therapy

Vol. 61, 2025

Dear Editor,

As a founding member of the Canadian Society of Respiratory Therapists (CSRT) some 60 years ago, I am extremely proud of the evolution of the profession of respiratory therapy and the CSRT as an organization. Recently, in May of 2024, I was invited to attend the sixtieth anniversary conference of the CSRT in Banff, Alberta. This was a truly heart-warming experience for me as I met with students and practicing RTs in a delightful setting. I was struck with the professionalism demonstrated by all the attendees present. My personal interaction with these professional and well-educated people caused me to reflect about the evolution of the profession. This editorial is a result of these reflections, and I congratulate all those who make our profession what it is today.

In the early 1960s, most people working in inhalation therapy, as it was then known, were oxygen orderlies or former army medics. Any training they received to practice inhalation therapy was acquired on the job and there was no certification process. In 1960, Robert (Bob) Merry, a former army surgeon's assistant and head of the Inhalation Therapy Department at the Royal Victoria Hospital in Montréal, had a vision to form a Canadian Society of Inhalation Technicians to oversee the emerging groups of technicians across Canada. At the time, Montréal was a chapter in the American Respiratory Therapists Association. To that end, he wrote a discussion paper for dissemination to supporting physicians and working technicians. He outlined three major objectives for a Canadian Society of Inhalation Therapists¹:

1. *To further the education of all technicians working in our field in order that everyone may give up-to-date, efficient services.*
2. *To police our own group and increase both the character and discipline of the Inhalation Therapist.*
3. *To establish an area of responsibility for an Inhalation Therapist in order that he does not exceed his authority or neglect it.*

It is interesting to note the language of the day, given that at the time, no women worked in the field! This is thankfully not the case anymore.² More significantly, this highlights the desire to evolve into a self-regulated profession, which is a significant milestone in the profession's growth.

Considerable effort by many persons across Canada followed and in December of 1964 the Office of the Secretary of State approved the application for National Charter and Letters Patent incorporating the Canadian Society of Inhalation Therapy Technicians. Our request to use the term *therapist* was refused, as a person with such a title should hold a university degree. Following government approval, the major functions of the Society then became to identify persons working in the field across Canada, to establish a certification process, create an acceptable area of professional responsibility, develop a standardized curriculum and provide a systematic mechanism of approval of training programs.

As I reflect from the progress in the 1960s, two things jump out at me. First, is the vastly improved technological equipment used by the RT. In the early sixties ventilators were pressure-cycled machines, such as the Bird Mk 7 or Bennett PR2. These had no alarm systems, so therapists had to closely observe the patient at all times. The spirometer I used for pulmonary function testing was a volume displacement spirometer hand built at the Royal Victoria Hospital. At that time, volume-cycled ventilators were just being introduced and had rudimentary alarm systems. The Bennett MA1 was considered the state of the art for ventilators in the late 1960s. A particular therapy at that time was Intermittent Positive Pressure Breathing (IPPB) as a method of provision of aerosol medication. Oxygen was administered by nasal cannula and piped oxygen was only then becoming a standard for hospitals.

The second thing that struck me was the great variation in the role of the RT. For example, in the early years at the Vancouver General Hospital, the RTs were called oxygen orderlies and delivered the oxygen tanks and equipment to the nursing staff and serviced and sterilized equipment. This was comparatively different to Alberta where they were called Inhalation Therapists and gave direct patient care. Manitoba, Ontario and Atlantic Canada were also more involved with patient care, but the degree of involvement depended on the scope *allowed* by the physicians. Part of the reason for the great variation in the role was because the training for the RT was on-the-job training, hence reflected the scope of practice of that particular region. Only when educational programs became formalized, and an accreditation process was introduced did the role of the RT become more consistent across Canada.

Recently I visited local hospitals and observed the RTs role today. I was impressed to see that the RT was considered a highly respected member of the clinical patient care staff. During these visits it became clear to me that the COVID-19 pandemic and the essential patient care provided by RTs during the crisis gave further credence to the importance of the role of the RT. However, the profession faces challenges, including workforce shortages, burnout rates,³ evolving healthcare demands, and emerging technologies. To meet these demands, RTs and their organizations must stay adaptable and forward-thinking as healthcare grows increasingly complex. RT training programs have advanced significantly. Many are of three-year duration and some institutions are four-year degree granting programs. This has raised the proficiency of the new graduates, but it is of considerable importance to ensure that other health care workers and administrators are fully aware of the competencies that RTs possess and bring to their work. This will require the CSRT to continue advocacy efforts promoting understanding of the important role of the RT.

As I look at the role of the CSRT as an organization, I see many changes from the original vision. At its inception, the CSRT (in partnership with the Canadian Medical Association) provided the national examination, program accreditation, a national curriculum and a Canada wide journal. At that time, no provincial legislation existed that governed the profession. Today, some of these responsibilities have been distributed so that the CSRT can focus on its national leadership responsibilities. For example, most provinces have enacted legislation governing the practice

of Respiratory Therapy and Accreditation Canada accredits most Respiratory Therapy programs across Canada. Taken together, this evolution of the CSRT from standards oversight to leadership position has positioned the RT profession well with a unified national voice that effectively provides representation amongst decision-makers.

The CSRT now provides numerous support services for RTs as well as opportunities for networking, mentorship, and knowledge sharing– the basis for a strong community. Recently, the Canadian Society of Association Executives recognized the CSRT as a Centre of Excellence. This is of particular importance to members as it demonstrates the work being done, and the services provided by the CSRT, have been determined by an external benchmarking body as being of a very high standard. The CSRT, and by virtue the RT profession, are now at a point in history where it is providing important leadership beyond that of the profession. The RT profession is being heard.

Upon reflection, I am proud of the progress made by the profession and the role the CSRT had in making that progress possible. From the early days of oxygen orderlies to the highly trained RT of today, vast changes have indeed taken place. Bob Merry would glow with pride as his vision has become reality. I offer my sincere congratulations to all of you who make Respiratory Therapy your profession.

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Submitted: January 23, 2025 EST. Accepted: January 23, 2025 EST. Published: February 04, 2025 EST.



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