

## Innovations in Practice

# ***When life looks like easy street, there's danger at your door: Why the respiratory therapy profession should evolve***

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### Abstract

#### Background

Healthcare systems are rapidly transforming in response to demographic pressures, changing funding models, technological advances, and new models of care. As a result, professions must adapt in parallel to remain relevant. In Canada, respiratory therapy stands at an inflection point. Respiratory Therapists (RTs) provide essential and complex care across diverse clinical settings, yet the profession remains anchored in traditional roles. Questions remain about whether RTs are evolving in step with broader system changes, and what may be lost if they do not.

#### Methods

This paper originates from a panel at the 2025 Canadian Society of Respiratory Therapists annual conference. We used narrative methodology and composite narrative techniques to synthesize the reflections of four clinician–researcher panelists into a unified account. Drawing on clinical, professional, policy, and research perspectives, we co-constructed a narrative that highlights shared insights, tensions, and opportunities in the profession.

#### Results

We identified multiple sources of tension. RTs engage with evidence daily, yet most of this evidence comes from other health professions. This reliance constrains the development of RT-specific frameworks, guidelines, and research agendas. Additionally, scholarship in respiratory therapy often remains undervalued and narrowly defined, treated as an optional activity rather than a core part of professional identity. Finally, structural, cultural, and organizational barriers, further restrict the integration of evidence and scholarship into routine work.

#### Discussion

Moving forward requires deliberate action to embed scholarship and evidence generation within the respiratory therapy profession. We suggest that strengthening research literacy at entry-to-practice, creating formal roles for clinical scholars, recognizing scholarly work within career structures and innovation incubators and interprofessional collaborations can position RTs as co-creators of solutions to health system challenges. By embracing these suggestions, the profession can evolve in step with health system change, enhance its influence, and secure its relevance in the future of healthcare.

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## BACKGROUND

Healthcare in Canada and globally is changing. The healthcare landscape is shifting in response to demographic changes, system pressures, changes in funding models, evolving models of care, and shifting patterns of disease burdens.<sup>1-3</sup> As a result of such changes, there is growing recognition that healthcare professions must also adapt and evolve to meet the diverse needs of patients in a complex health system.<sup>4,5</sup> In Canada, Respiratory Therapy is one of such professions that current stands at the precipice of change. We, the authors, believe that respiratory therapists (RTs) continue to play a vital role in delivering care to patients across diverse clinical environments. Simultaneously, we recognize that that urgent questions remain about whether the profession is evolving in step with broader systemic changes taking place in Canadian health systems today, and what could be at stake if the profession fails to evolve alongside these changes.

This paper originates from a panel discussion held at the Canadian Society of Respiratory Therapists (CSRT) 2025 annual educational conference, where we provided our reflections on the current state and future directions of certain components of the respiratory therapy profession. To frame this reflection, we drew from the Red Queen hypothesis from evolutionary biology,<sup>6,7</sup> an allegory derived from Lewis Carroll's *Through the Looking-Glass, And What Alice Found*.<sup>8</sup> In this metaphor, the Red Queen tells Alice, "Now, here, you see, it takes all the running you can do, to keep in the same place." The implication is that, in a rapidly changing environment, species must continuously adapt simply to maintain their current position in the ecosystem. Fail to keep pace, and the species goes extinct as the environment around them adapts and evolves without them. Applied to respiratory therapy, this metaphor underscores an existential challenge: as healthcare systems evolve in response to demographic and system pressures, changes in funding models, new models of care, technological innovations, and policy reforms, the profession must also evolve to fit and survive in this new ecosystem, or risk becoming obsolete.

While other health professions have begun to evolve by virtue of expanding their scopes of practice and producing evidence to support these changes,<sup>9-14</sup> respiratory therapy has largely remained anchored in traditional roles. Although RTs provide complex and essential care across diverse settings and patient populations, the profession is still in the early stages in its evolution and professionalization, particularly in advancing its own research agenda, developing conceptual frameworks that describe or explain the nature of respiratory therapy practice, and articulating unique contributions through profession-led scholarship to understand and empirically demonstrate the value and effectiveness of the profession and the clinical interventions that RTs provide.<sup>15,16</sup>

This paper invites a critical conversation about the need for respiratory therapy to evolve to ensure its relevance in the changing healthcare landscape and to maximize its impact on patient care. In this conversation, we focus on three

key areas: evidence generation and use, scholarship, and certain barriers that hinder integrating evidence. Through this lens, we argue for a renewed professional imperative: to move beyond the comfort of established routines and invest in a future defined by adaptability, leadership, and evidence-informed practice. While these are not the only areas that may contribute to a profession's evolution, they fall within our expertise and are supported in the literature as important drivers of professional growth.<sup>17-20</sup>

## METHODS

This paper integrates principles of narrative research, specifically the use of composite narratives as a methodological approach. Composite narratives are used in qualitative research to synthesize multiple individual accounts into a single, storied voice that preserves and conveys shared meaning.<sup>21-23</sup> This composite narrative blends the personal, professional, and research-informed reflections of the four authors, who served as panelists at the 2025 CSRT annual conference.

Following the panel, we collaboratively reconstructed the discussion by developing a set of guiding questions informed by both the predetermined conversational questions that shaped the panel and the talking points that emerged during the session (Appendix 1). Each author then individually reflected on these guiding questions, and these reflections formed the basis of an interpretive synthesis. The first author (MZ) conducted an initial synthesis by weaving together shared ideas and constructing a preliminary narrative structure. This draft was then reviewed, refined, and expanded through multiple rounds of collective reflection and feedback among all authors. The synthesis involved interpretive reflection to identify key concepts, which were then grouped under thematic headings that structure the paper and illustrate the composite narrative.

The resulting narrative does not represent a transcript of the panel or a traditional qualitative analysis involving coding transcripts. Rather, the presented composite narrative reflects a negotiated synthesis of professional insights, shaped through multiple rounds of review and feedback from all authors to ensure conceptual alignment, authenticity of voice, and fidelity to each author's original reflections. This approach is grounded in a constructivist paradigm, emphasizing co-created meaning rather than producing generalizable findings. It was intended to surface tensions, opportunities, and directions for growth in the respiratory therapy profession by drawing on our collective expertise across clinical practice, policy, education, and research.

MZ brings the perspective of a clinician-researcher who has recently transitioned from frontline practice to academia, with a program of research focused on the professionalization of respiratory therapy, the role of scholarly practice in healthcare, and the evolving nature of evidence in complex healthcare systems. JN brings the perspective of a clinician-researcher working in Canadian and international health policy, focused on issues of health system strengthening, health equity, and the response to emerging

public health threats. RS brings the perspective of a clinician-researcher with a provincial practice leadership role in respiratory therapy representing all practice areas, with a focus on collaborative problem-solving across disciplines, departments and service streams, with an emphasis on system-wide data sharing to support real-time, evidence-informed decision-making. ER brings a multifaceted clinician-researcher perspective that integrates the pragmatic translation of bedside clinical insight into innovations in practice, rigorous scientific appraisal, and a commitment to advancing equitable, evidence-informed respiratory care through her leadership at the professional journal and a research institute.

## DISCUSSION

### EVIDENCE USE VERSUS EVIDENCE GENERATION IN RESPIRATORY THERAPY

RTs consistently engage with evidence in their day-to-day practice, but it must be acknowledged that most of this evidence is generated by other health professions. Foundational knowledge that informs respiratory therapy often originates outside the profession,<sup>24,25</sup> and the resulting guidelines or protocols may not always reflect the unique expertise, settings, or roles of RTs. This dependence on externally developed evidence is thought to be a limiting factor in the growth and professionalization of the respiratory therapy profession.

The absence of respiratory therapy-specific frameworks, models of care, and a coordinated research agenda to guide practice, inform policy and support evolving role expansion is concerning. While RTs regularly contribute to clinical decision-making, few are currently positioned to lead research, shape clinical guidelines, or generate system-level evidence. This suggests that much of the practice of respiratory therapy remains reactive and shaped by the priorities and agendas of others (i.e., professions, policymakers), rather than being a proactive driver of its own knowledge base.

We acknowledge that multiple studies have shown the benefit of respiratory therapist-driven protocols for an array of respiratory illnesses and interventions, including mechanical ventilation, oxygen therapy, asthma care, and others.<sup>26-28</sup> This kind of evidence—which critically evaluates and provides an evidentiary basis for much of the day-to-day care provided by RTs—is an example of what is needed to ensure that the care provided by RTs can meet patients' needs and drive efficiencies and improvements in respiratory therapy. Beyond this, there is also a need for more evidence on the models of care, such as standardized respiratory therapist-to-patient ratios and the integration of RTs into new roles in practice, such as primary care. These data and analyses are important to understand how to deploy RTs safely and effectively at the top of their scope of practice.

As health systems are increasingly demanding evidence to justify changes to scopes of practice, role definitions, and care models, the need for profession-specific data becomes

more urgent. Although rich administrative and clinical data exist in some provinces, they remain largely underutilized in capturing the current contributions of RTs, both in routine practice and in emerging roles. This data could be instrumental in identifying unmet needs where RTs might improve access to care or enhance the quality of respiratory services.

There is also a broader challenge: generating local evidence is important but so is ensuring its wider dissemination. Many RTs are engaged in innovative practice and quality improvement work, yet these activities often remain undocumented or unpublished, making it difficult to inform broader system change or demonstrate the profession's value. Put another way, high-quality interventions and models of care developed in one setting are not being shared in a structured or coordinated way, limited their spread to other contexts. If RTs are not recognized as leaders and innovators within their own profession, they risk being marginalized in clinical decision-making and excluded from shaping the future of healthcare delivery.

Taken together, the discussion pointed to a pressing need for respiratory therapy to define its own research priorities, strengthen its capacity for research and scholarship, and claim a more active role in shaping the evidence base that informs the care that RTs provide.

### REFINING AND VALUING SCHOLARSHIP IN RESPIRATORY THERAPY

There is a need to reflect and revisit how scholarship or scholarly practice is understood and valued within respiratory therapy. While scholarship is often associated with traditional academic activities such as publishing in peer-reviewed journals, scholarly practice emphasizes the integration of inquiry, reflection, and knowledge sharing into professional roles. Recognizing that both are vital, we address them together in this paper rather than as separate or competing concepts. While the limited number of respiratory therapy-led research studies remains a concern, scholarly practice can take many other valuable forms. These include mentoring students or new staff, helping to update clinical policies, sharing knowledge through presentations or workshops, engaging in continuing education, interprofessional or industry collaboration on research and innovation, and participating in professional or regulatory organizations, and public outreach and advocacy to enhance Canadians' knowledge of respiratory health and to improve access to respiratory care.<sup>29</sup>

Respiratory therapy has often been viewed as a technical profession, focused primarily on tasks and procedures. Because of this, enacting scholarly practice is often undervalued in clinical settings, especially those not directly tied to immediate patient care. Many of these efforts, such as engaging in reflective practice or professional development, tend to happen informally or outside of paid work hours, as similarly noted in other professions.<sup>30,31</sup> As a result, they are not always recognized or supported as important parts of being a RT, contributing to a culture where research and inquiry are considered peripheral to practice rather than essential to it.

This limited view has broader implications. As health systems increasingly demand data and evidence to support decisions about staffing, funding, and scopes of practice, professions that don't produce these data and evidence may be left out of important health system adaptations, such as the expansion of scopes of practice or the entry into new practice environments. For RTs, the inability to clearly demonstrate and quantify their value and effectiveness in a given area, particularly when other professions can, makes it difficult to argue for an expanded scope of practice or greater presence in a practice environment. Although many RTs are finding creative ways to adapt their roles to meet evolving system needs, much of this work remains undocumented and remain unrecognized by those who shape health policy. Without sharing these efforts more widely (e.g., publications or reports) it becomes harder to influence policy or support the profession's development. RTs may be excluded from key policy and planning discussions simply because their contributions have not been documented or disseminated. For example, while primary care represents a growing area of practice for RTs, recent reforms and investments in Ontario aimed at expanding scopes of practice and implementing new models of care have not explicitly included RTs. In contrast, others (e.g., pharmacists, nurses, paramedics) have seen their roles and centrality in the health system expand.<sup>52</sup> This omission overlooks the potential for RTs to play a significant role in initiatives such as asthma and chronic obstructive pulmonary disease (COPD) management, among other roles that could reasonably fall within an independent scope of practice of RTs.<sup>33-35</sup> Encouraging a broader, more inclusive definition of scholarly practice is essential for ensuring that RTs are recognized as contributors to knowledge, not just users of it. Shifting this perception will require cultural change, institutional support, and leadership that values non-traditional scholarly contributions.

#### SUGGESTED BARRIERS TO INTEGRATING EVIDENCE INTO EVERYDAY PRACTICE

RTs face a range of challenges regarding their engagement in scholarly activities and applying evidence in day-to-day practice. These barriers are not unique to the profession; in fact, there exists a body of literature in the fields of knowledge translation and implementation science replete with documented barriers and facilitators to healthcare professionals' efforts to integrate evidence into practice.<sup>36-40</sup> These challenges are systemic, cultural, and individual, reflecting broader issues within the healthcare system. For RTs, addressing them will require both a deep understanding of the existing evidence in the field and the targeted documentation of context-specific barriers and enablers within respiratory therapy practice.

Although interest in research and evidence use is growing among RTs, many lack access to the infrastructure, support, and training needed to engage meaningfully with scholarly work. A common issue is the inconsistent integration of scholarship into respiratory therapy education. Not all training programs emphasize topics like research literacy, research methods, knowledge translation, or dis-

semination skills. Similarly, scholarly engagement is often framed as optional rather than essential.<sup>41-44</sup> This fosters a perception that research stands as distinct from, rather than inherently embedded in, clinical practice.<sup>45</sup> For many RTs, scholarly engagement remains an added responsibility, something pursued informally or "off the side of the desk," rather than a recognized and supported part of their professional role.

Workplace conditions add to these challenges. Clinical environments are marked by staff shortages, heavy workloads, and limited resources, and it can be difficult to justify dedicating time to activities that are not directly tied to patient care. Even in departments where scholarly engagement by RTs is supported, that support can wane without sustained leadership investment, protected time, or visible pathways for career advancement.

Cultural and psychological factors also play a role. Many RTs may lack confidence in their ability to critically appraise evidence or question existing practices, especially if the organizational culture does not encourage inquiry or innovation. Even when RTs are motivated and skilled, acting on that knowledge can be difficult if there is no structural support or if raising concerns is seen as disruptive. Such difficulty perpetuates a perspective that RTs are the technicians rather than change agents, in contrast to professions that more actively assert their roles in shaping policy and practice.

The necessary conditions for engaging in scholarship and evidence-informed practice are often missing. Applying evidence effectively requires not just knowledge, but also the time, tools, mentorship, and a culture that values and rewards critical thinking. Creating space for learning and reflection, fostering leadership that embraces change, and normalizing the act of questioning routine practices were all seen as necessary for moving forward.

Moreover, it is important to recognize that the clinical work of RTs can be physically, intellectually, and emotionally challenging. RTs routinely provide care to critically ill and medically complex patients in acute care, primary care, and other settings, where the demand for services outstrips the availability of these services. Consequently, many RTs experience moral distress and negative psychological consequences as a result of their work,<sup>46,47</sup> and we acknowledge that engaging in scholarship and other forms of scholarly practice requires time and energy that may not always be readily available.

Taken together, these reflections highlight that integrating scholarly and evidence-informed practice in respiratory therapy will require more than individual motivation. It demands structural investment, leadership support, and cultural change to create environments where inquiry is encouraged and scholarly contributions are valued as a core part of professional identity.

#### LOOKING AHEAD: A VISION FOR THE RESPIRATORY THERAPY PROFESSION

Despite these challenges, there is a cautious optimism grounded in the belief that the profession is already beginning to evolve. The very fact that conversations about ev-

idence generation, use, and scholarship are taking place is a positive sign that the profession is ready to shift its focus from maintaining the status quo to actively shaping its own future.

Over the next decade, there is an assumption that research and evidence are more fully integrated into clinical practice, not treated as separate activities, but embedded into how RTs think, work, and lead. Advancements in and uptake of Electronic Medical Record (EMR) technology will likely provide easier access to comprehensive, system-wide data on patient outcomes, enabling sustained and integrated quality improvement for the profession. In this future, RTs are not just consumers of evidence but active contributors: co-creating research questions, leading quality improvement projects, contributing to clinical guidelines, and collaborating with academic researchers. By embedding RTs as equal partners in inquiry and guideline development, the profession shifts from being implementers at the margins to co-owners of the evidence base. This integration narrows the practice–research gap, results in more contextually relevant guidelines, and elevates the profession’s influence on innovation and policy. Such partnerships ensure that both clinicians and scholars bring their unique expertise to shared inquiries that reflect the realities of respiratory therapy practice.

There should also be a broader understanding of what counts as evidence. Rather than privileging one type of evidence (e.g., quantitative versus qualitative evidence), RTs should embrace all forms of evidence, including practice-based knowledge, patient experiences and values, and professional judgment. This would lead to recognizing that context matters and “good evidence” would be defined not only by its methodological rigour but also by its relevance and ethical application in real-world care.

Equally important is a cultural shift in respiratory therapy, from compliance to curiosity. Rather than viewing scholarship as optional or extra, the next generation of RTs should see it as a natural and expected part of their professional identity. This transformation will require structural changes: investment in education, leadership that values innovation, and the creation of clear career pathways for RTs who want to engage in research and scholarship. Without a willingness to question outdated practices, integrate quality improvement evaluation practices, and engage with new knowledge and technology (e.g., artificial intelligence), the profession risks becoming stagnant or even obsolete. Staying relevant will depend on being intentional to embrace innovation and developing the capacity to generate evidence that can align policy, funding, and education to support a more evidence-informed profession.

#### SUGGESTIONS FOR ADVANCEMENT

The respiratory therapy profession is at an important juncture. Its continued relevance and influence in an evolving healthcare system will depend on choices made both individually and collectively. While challenges outlined in this paper, such as limited research infrastructure, under-recognition of scholarship, and barriers to evidence integration remain, they are not insurmountable. Taking deliberate ac-

tion will be essential for the profession to thrive in a system that increasingly values adaptability, innovation, and evidence-driven practice. We wish to conclude these narratives by offering a series of suggestions that may help address some of the challenges outlined throughout this paper. These are not intended as prescriptive solutions, nor are they drawn from systematic reviews or large-scale trials. Rather, they emerge from our shared experiences as RTs, educators, quality improvement personnel and researchers who have encountered these issues in practice. We offer them as starting points for discussion, adaptation, and further exploration within the profession.

One potential area for growth lies in strengthening research literacy at the entry-to-practice level. While national competency frameworks acknowledge the importance of evidence-informed practice, how these competencies are interpreted and operationalized across programs likely varies. Understanding the breadth of this variability to identify opportunity to enhance curricula to more explicitly integrate skills such as research appraisal, knowledge translation, and inquiry-based learning may help foster greater confidence and engagement among new RT graduates.

We also see value in exploring the creation of formal roles for clinical scholars or scholars-in-residence<sup>48,49</sup> within RT departments, particularly for RTs who might hold or have a desire to obtain advanced academic training. These individuals could act as bridges between clinical practice and academia, supporting practice-based inquiry, facilitating the dissemination of new knowledge, and nurturing a culture of curiosity and reflection within the department. For such roles to succeed, they would require appropriate resourcing, institutional buy-in, and alignment with the department’s goals.

Additionally, efforts to recognize and reward scholarship or scholarly practice within clinical career structures could signal its value as a core component of professional identity. This might include adjustments to compensation models, protected time, or access to professional development opportunities such as conferences or project brainstorming retreats. These types of supports could encourage RTs to engage more actively in scholarship while remaining embedded in frontline care.

At a broader level, continued investment in RT-led research infrastructure would help strengthen the profession’s knowledge base. Targeted funding opportunities, academic mentorship, and institutional partnerships could create more sustainable pathways for RTs to lead or contribute to research. National coordination through a respiratory therapy research collaborative may further support these efforts by aligning priorities and facilitating collaboration between RTs with an interest in scholarship. Finally, we believe there is potential in developing interprofessional innovation incubators that bring RTs together with engineers, designers, and industry partners. These spaces could foster the co-creation of patient-centered technologies and open new avenues for RTs to contribute to health system innovation and design.

These suggestions will not come to fruition by chance. They require deliberate, coordinated, and ambitious action from individuals, institutions, and professional bodies alike. Their purpose is to spark reflection on how RTs might shape, rather than simply react to, the evolving healthcare landscape. By moving toward these kinds of initiatives, the profession has the potential to redefine the role of respiratory therapy, ensuring its relevance, sustainability, and impact on patient care for decades to come.

#### STRENGTHS AND LIMITATIONS

A strength of this paper is our use of a composite narrative approach to explore this topic. This method allowed us to integrate our diverse professional perspectives into a cohesive account that captures shared meaning while preserving individual nuance. The collaborative and iterative process used to co-construct the narrative enabled us to examine professional issues in respiratory therapy from multiple vantage points, including practice, policy, education, and research.

As noted in this manuscript, our discussion and findings are grounded in our personal, professional, and research-informed experiences within the Canadian healthcare context. They are not intended as a comprehensive or systematic review of the literature and should be interpreted with this in mind. While drawing on reflective accounts provides depth and authenticity, it may also limit the breadth of perspectives represented. Furthermore, because these reflections were written after the panel took place, they may have been shaped by hindsight, which may have influenced how experiences were recalled and described.

#### CONCLUSION

This paper reflects a collective call for the respiratory therapy profession to evolve in step with a changing healthcare system. Through a co-constructed narrative grounded in professional experience and collaborative reflection, we have identified persistent tensions in how evidence and scholarly practice are understood, valued, and enacted within respiratory therapy.

The profession stands at an inflection point. Healthcare systems are transforming under demographic pressures, increasing patient complexity, technological innovation, and new models of care. The Red Queen's warning is clear: "*It takes all the running you can do to stay in the same place.*"

If we remain anchored in tradition and reactive to change, we risk being left behind. But if we embrace scholarship, generate evidence, and lead in innovation, we position ourselves not *just* to keep pace but to help shape the future of healthcare. This is an invitation to do so. Respiratory therapy's evolution is not optional; it is essential.

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All authors have completed the ICMJE uniform disclosure form. ER is the editor-in-chief of the *Canadian Journal of Respiratory Therapy*, MZ is deputy editor of the *Canadian Journal of Respiratory Therapy*, and JN is editor emeritus of the *Canadian Journal of Respiratory Therapy*. None were involved in any decision regarding this manuscript. RS has no disclosures to report.

#### ETHICAL APPROVAL

Not required for this article type.

#### AI STATEMENT

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## SUPPLEMENTARY MATERIALS

### **Appendix 1**

Download: <https://cjrt.ca/article/147368-when-life-looks-like-easy-street-there-s-danger-at-your-door-why-the-respiratory-therapy-profession-should-evolve/attachment/310513.docx>

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