

HEALTH  
PROFESSIONS  
COUNCIL

# RECOMMENDATIONS ON THE DESIGNATION OF RESPIRATORY THERAPY

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Application by the  
BC Society of Respiratory Therapists

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## FOREWORD

This report is in response to an application by the BC Society of Respiratory Therapists for designation under the *Health Professions Act*, RSBC 1996, c. 183. Under the *Health Professions Act*, the Health Professions Council is a three-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health Planning about the regulation of health professions. This report is the result of an investigation of the profession of respiratory therapy by a three-member panel of the Health Professions Council.

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## EXECUTIVE SUMMARY

In its review of the application for designation of the BC Society of Respiratory Therapists (the applicant), the Health Professions Council (Council) applied the Public Interest Criteria as directed by the *Health Professions Act (HPA)*. The Council reviewed the information provided by the applicant and information gathered during the research, written consultation and public hearing phases of its investigation.

The Council has concluded that the designation of respiratory therapy under the *HPA* is in the public interest and recommends that a self-regulatory college be established to regulate the profession.

The Council first determined that the practice of respiratory therapy meets the definition of "health profession" set out section 1 of the *HPA*.

The Council then reviewed the services provided by respiratory therapists in light of the risk of harm criteria in section 5(1) of the *Health Professions Act Regulation (the HPA Regulation)*. Finally, the Council considered the discretionary criteria set out in section 5(2) of the *HPA Regulation*. After considering these factors, the Council determined that a self-regulating college for the profession should be created. The Council then went on to consider the appropriate scope of practice, reserved acts and reserved titles for the profession of respiratory therapy.

The Council makes the following recommendations to the Minister of Health Planning:

1. that respiratory therapy be designated as a health profession under the *Health Professions Act*;
2. that the following scope of practice statement be granted to members of a college of respiratory therapists:

The practice of respiratory therapy is the assessment and treatment of cardio-respiratory and associated disorders through the performance of therapeutic interventions and operation of cardio-respiratory equipment to maintain or restore ventilation for prevention and treatment of illness, health promotion and maintenance.

3. that the following definition be adopted by the Minister of Health Planning for the term "order":

Direct orders

A “direct order” is a prescription or order for care written by an individual prescriber for a particular patient for a specific treatment(s) or intervention at a specific time.

#### Medical directives

A "medical directive" is a prescription or order for a treatment or intervention that may be performed for a range of patients who meet certain conditions.

In addition to meeting the requirements of a valid order, medical directives must include:

- the specific conditions which must be met for the medical directive to apply;
  - any specific circumstances or criteria which must exist;
  - any contraindications for implementing the medical directive;
  - the identity of the individual authorizing the medical directive; and
  - appropriate date and signature of the administrative authority approving the medical directive.
4. that members of a college of respiratory therapists be granted the following reserved acts:
1. Making a diagnosis of a cardio-respiratory disorder or condition as the cause of the signs or symptoms of an individual.
  - 2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by inhalation to an adult patient: oxygen/air mixture by mask, cannula, or catheters.
  - 2(e) Performing the physically invasive or physically manipulative act of putting an instrument
    - (ii) beyond the point in the nasal passages where they normally narrow,
    - (iii) beyond the pharynx, and
    - (vii) into an artificial opening into the body, for purposes of suctioning.

2(e)(vii) Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s) into an artificial opening into the body for purposes of changing tracheostomy cannulas.

5. that members of a college of respiratory therapists be granted the following reserved acts only when the act is ordered by a health practitioner who is authorized by legislation to perform the act:

2(a) Performing the physically invasive or physically manipulative act of procedures on tissue below the dermis: arterial puncture/capillary puncture.

2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by inhalation: oxygen to preterm neonates, infants and children under 12 years of age; heliox, nitric oxide and other gases to all patients.

2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by mechanical ventilation: oxygen/air mixture.

5(a) Administering by inhalation or instillation a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, or as prescribed by regulation.

6. that members of a college of respiratory therapists be granted the reserved title "Respiratory Therapist".
7. that the college to be established for respiratory therapy be named the "College of Respiratory Therapists".

# RECOMMENDATIONS ON THE DESIGNATION OF RESPIRATORY THERAPY

## I. APPLICATION AND PROCESS OF INVESTIGATION

### A. GENERAL BACKGROUND

The applicant BC Society of Respiratory Therapists (the applicant) was formed in 1964, as the Canadian Society of Inhalation Therapy Technicians, BC Division. It changed its name in 1968 to the BC Society of Respiratory Technicians, in 1977 to the BC Society of Respiratory Technologists, and finally to the BC Society of Respiratory Therapists in 1983, when it was incorporated under the *BC Society Act*. The Canadian Society of Respiratory Therapists (CSRT) is the national association.

The applicant states that the following statutes outside BC are relevant with respect to respiratory therapists (RTs) in other jurisdictions:

- Alberta: *Health Professions Act – Respiratory Therapists Regulation*
- Manitoba: *Registered Respiratory Therapists Act*
- Ontario: *Regulated Health Professions Act*
- Quebec: *Code des Professions – Les Actes Medicaux Delegates*

The applicant submits that there are approximately 550 practitioners in the province, 398 (or 72 per cent) of whom are registered with the applicant. No practitioner is incorporated. 470 practitioners work in institutional settings (acute care and educational), 80 in private practice, community health and sales.

### B. PROCESS OF INVESTIGATION

The applicant submitted an application for designation of respiratory therapy as a self-regulating health profession under the *HPA*. The application was received in February 1991. A revised application was sent to the Council in July 2000.

The Council conducted an investigation pursuant to section 9 of the *HPA*. It conducted a written consultation in September 2000. A summary of the responses to the consultation on the applicant's application is found in Appendix A. All respondents are referred to by the name used at the time of their response.

The Council held a public hearing on 17 May 2001. A list of participants is found in Appendix B.

## II. STATEMENT OF ISSUES

In accordance with the requirements of the *HPA*, the Council identified five issues involving the regulation of the practice of respiratory therapy. In assessing the public interest in the regulation of this profession, the Council considered:

- (1) whether the practice of respiratory therapy meets the definition of “health profession” in section 1 of the *HPA*;
- (2) the extent to which the practice of respiratory therapy may involve a risk of physical, mental or emotional harm to the health, safety, or well-being of the public according to section 5(1) of the *HPA Regulation*; and
- (3) whether designation of a college of respiratory therapy would be in the public interest having regard to the criteria of sections 5(1) and 5(2) of the *HPA Regulation*;
- (4) where granting of reserved acts to members of a college of respiratory therapists is recommended, whether these reserved acts should be granted as independent reserved acts or whether the reserved acts should be performed “on the order” of another health professional; and
- (5) the need for clarification of the Council’s definition of “indirect order” as outlined in the Council’s report, *Safe Choices: A New Model for Regulating Health Professions in British Columbia*.

### III. RECOMMENDATIONS

Pursuant to section 10(2) of the *HPA*, the Council recommends to the Minister of Health Planning:

1. that respiratory therapy be designated as a health profession under the *Health Professions Act*;
2. that the following scope of practice statement be granted to members of a college of respiratory therapists:

The practice of respiratory therapy is the assessment and treatment of cardio-respiratory and associated disorders through the performance of therapeutic interventions and operation of cardio-respiratory equipment to maintain or restore ventilation for prevention and treatment of illness, health promotion and maintenance.

3. that the following definition be adopted by the Minister of Health Planning for the term "order":

Direct orders

A "direct order" is a prescription or order for care written by an individual prescriber for a particular patient for a specific treatment(s) or intervention at a specific time.

Medical directives

A "medical directive" is a prescription or order for a treatment or intervention that may be performed for a range of patients who meet certain conditions.

In addition to meeting the requirements of a valid order, medical directives must include:

- the specific conditions which must be met for the medical directive to apply;
- any specific circumstances or criteria which must exist;
- any contraindications for implementing the medical directive;
- the identity of the individual authorizing the medical directive; and
- appropriate date and signature of the administrative authority approving the medical directive.

4. that members of a college of respiratory therapists be granted the following reserved acts:

1. Making a diagnosis of a cardio-respiratory disorder or condition as the cause of the signs or symptoms of an individual.

2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by inhalation to an adult patient: oxygen/air mixture by mask, cannula, or catheters.

2(e) Performing the physically invasive or physically manipulative act of putting an instrument

(ii) beyond the point in the nasal passages where they normally narrow,

(iii) beyond the pharynx, and

(vii) into an artificial opening into the body, for purposes of suctioning.

2(e)(vii) Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s) into an artificial opening into the body for purposes of changing tracheostomy cannulas.

5. that members of a college of respiratory therapists be granted the following reserved acts only when the act is ordered by a health practitioner who is authorized by legislation to perform the act:

2(a) Performing the physically invasive or physically manipulative act of procedures on tissue below the dermis: arterial puncture/capillary puncture.

2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by inhalation: oxygen to preterm neonates, infants and children under 12 years of age; heliox, nitric oxide and other gases to all patients.

2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by mechanical ventilation: oxygen/air mixture.

5(a) Administering by inhalation or instillation a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, or as prescribed by regulation.

6. that members of a college of respiratory therapists be granted the reserved title "Respiratory Therapist".
7. that the college to be established for respiratory therapy be named the "College of Respiratory Therapists".

## IV. RATIONALE FOR THE RECOMMENDATIONS

### A. DESIGNATION

In order to proceed under section 10 of the *HPA* to recommend the designation of respiratory therapy as a health profession under the *HPA*, the Council must determine that the applicant's profession comes within the definition of "health profession" as set out in section 1 of the *HPA* and that designation is in the public interest pursuant to section 5 of the *HPA Regulation*.

#### 1. Definition of "Health Profession"

Section 1 of the *HPA* defines a health profession as:

*. . . a profession in which a person exercises skill or judgment or provides a service related to*

*(a) the preservation or improvement of the health of individuals, or*

*(b) the treatment or care of individuals who are injured, sick, disabled or infirm.*

Clearly, this is an extremely broad definition that encompasses many health related services.

The applicant states that RTs perform some or all of the following:

- (a) Perform diagnostic tests, such as arterial blood analysis and cardiopulmonary function tests;*
- (b) Operate and monitor respiratory equipment to administer treatments such as oxygen, oxygen-air mixtures, humidified air, or medications;*
- (c) Perform artificial respiration and external cardiac massage;*
- (d) Maintain and test diagnostic and therapeutic equipment;*
- (e) Supervise and train student or other respiratory therapists;*
- (f) Participate in research related to cardiac and pulmonary disorders.*

The applicant submits the following with respect to the definition of "health profession":

*The Respiratory Therapist is a health professional who is able to utilize his/her specialized training to provide a range of services in the client's home, residential facility and acute care institution.*

...

*The Respiratory Therapist works closely with the physician and other members of the health team to develop the most effective method of achieving the patient's therapeutic objectives. The majority of professionals are involved with the direct provision of therapy, or diagnostic evaluation of clients, the remaining therapists work to support these individuals through teaching, administration, research and staff development.*

In the Council's view, RTs perform health service functions related to cardio-respiratory disorders. The Council is satisfied that the profession of respiratory therapy meets the definition of "health profession" as set out in section 1 of the *HPA*.

## **2. Public Interest Criteria**

When examining an application for designation the Council considers the public interest criteria set in section 5(1) and (2) of the *HPA Regulation*. The section 5(1) criteria relate to risk of harm and must be considered by the Council while the section 5(2) criteria are discretionary and may be considered by the Council.

### **a) Introduction to the Application Process**

Prior to analysis of the application and the Public Interest Criteria, the Council will discuss general concepts relevant to reviewing an application for designation, including scope of practice statements, "*exclusive scope of practice*" and reserved acts.

The Public Interest Criteria contained in section 5(1) of the *HPA Regulation* provide the context in which the Council will analyze the risk of harm in the practice of respiratory therapy. While the Council may also consider the section 5(2) criteria in making its designation decision, these criteria do not address risk of harm.

Section 5 of the *HPA Regulation* states:

*5.(1) For the purposes of s.10(1) of the Act, the Council must consider the extent to which the practice of a health profession may involve a risk of physical, mental or emotional harm to the health, safety or well being of the public, having regard to*

- (a) *the services performed by practitioners of the health profession,*
  - (b) *the technology, including instruments and materials, used by practitioners,*
  - (c) *the invasiveness of the procedure or mode of treatment used by practitioners, and*
  - (d) *the degree to which the health profession is*
    - (i) *practised under the supervision of another person who is qualified to practise as a member of a different health profession, or*
    - (ii) *practised in a currently regulated environment.*
- (2) *The council may also consider the following criteria:*
- (a) *the extent to which the health profession has demonstrated that there is a public interest in ensuring the availability of regulated services provided by the health profession;*
  - (b) *the extent to which the services of the health profession provide a recognized and demonstrated benefit to the health, safety or well being of the public;*
  - (c) *the extent to which there exists a body of knowledge that forms the basis of the standards of practice of the health profession;*
  - (d) *whether members of the profession are awarded a certificate or degree from a recognized post-secondary educational institution;*
  - (e) *whether it is important that continuing competence of the practitioner be monitored;*
  - (f) *the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulate the profession in the public interest;*
  - (g) *the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors which in the view of the council may affect the viable operation of the college;*

- (h) *whether designation of the health profession is likely to limit the availability of services contrary to the public interest.*

If after considering the section 5 criteria the Council decides that the profession should be designated, the Council will determine an appropriate scope of practice statement for the profession. The Council's 1994 *Terms of Reference* for the review of scopes of practice of regulated health professions direct the Council to define scopes of practice and to encourage shared scopes of practice among qualified health practitioners. These same principles apply to the Council's mandate to define scopes of practice for health professions for which designation is recommended. The term "*exclusive scope of practice*" is no longer used.

The Council will next determine which aspects of the scope of practice have been shown to present a significant risk of harm. These will be defined as reserved acts, as directed in section 10(3)(b)(v) of the *HPA* and they may be shared with other regulated health professions whose members are qualified to perform such acts.

There is a distinction between analyzing risk of harm for the purposes of section 5(1) and for reserved acts. The section 5(1) analysis is broadly based and looks at the extent of the risk of physical, mental or emotional harm to the health, safety or well being of the public in the practice of the profession. This analysis looks generally at the services performed by practitioners, the technology used, the invasiveness of procedures or treatments and the degree of regulation or supervision of practitioners, as directed in section 5(1)(a), (b), (c) and (d). The Council will determine whether the profession should be designated on the basis of this analysis together with the analysis of the criteria contained in section 5(2) of the *HPA Regulation*.

After it is determined that the profession should be designated, a more narrowly focused risk of harm analysis is conducted to determine whether the health profession will be granted one or more reserved acts. The Council emphasizes that it is not necessary for a health profession to be granted any reserved acts in order to be designated. However, once the decision to designate is made, the Council will look at whether there are acts or activities within the profession's scope of practice which present such a significant risk of harm that they must be designated reserved acts, as directed in section 10(3)(b)(v) of the *HPA*. In *Safe Choices: A New Model for Regulating Health Professions in British Columbia* (*Safe Choices*) issued by the Council in March 2001, reserved acts have been restricted primarily to physical acts which carry a significant risk of harm.

These distinctions between the two risk of harm analyses are valid and important; however, they are often misunderstood by applicants. Additionally, there is significant overlap between the two, particularly when discussing the services performed by practitioners, the technology utilized and invasiveness of procedures employed. In the following analysis of

RT practice, the Council looks generally at the services performed by RTs in order to analyze the risk of harm for purposes of designation, using the section 5(1) criteria. When discussing the areas of services performed, technologies employed or invasive procedures, the Council will discuss the general risk of harm for purposes of the section 5(1) analysis. In the Reserved Acts section of this report, the Council will specifically address whether any acts or activities present the significant risk of harm required of a reserved act, as directed under section 10(3)(b)(v) of the *HPA* and the Council's *Terms of Reference*.

The Council's *Safe Choices* will form the basis of the reserved act analysis. Where an act or activity is currently listed as a reserved act, the Council will determine whether members of the applicant profession are trained and qualified to perform such act. Where the applicant requests a reserved act not included on the current reserved act list incorporated in *Safe Choices*, the Council will conduct a risk of harm analysis to determine if a new reserved act is warranted or a current reserved act should be expanded or adapted.

## **b) Section 5(1) Risk of Harm Criteria**

In the following pages the Council applied the public interest criteria set out in section 5 of the *HPA Regulation* in order to determine whether designation of the profession of respiratory therapy is in the public interest.

### **(1) Section 5(1)(a): the services performed by practitioners of the health profession**

The applicant states that RTs perform the following services:

- *Provide diagnostic and therapeutic services for patients with impaired pulmonary function*
- *Operate ventilators, incubators, manual resuscitators and other life-support equipment*
- *Are responsible for maintaining airway pressure, humidity, blood gas levels and respiratory rate*
- *Monitor patients' progress and equipment function*
- *Perform basic pulmonary function tests to assist physician in diagnosis of respiratory illness*

The applicant states that the services performed by RTs “*are continually evolving with the introduction of new therapies and technology.*”

### **(2) Section 5(1)(b): the technology, including instruments and materials, used by practitioners**

The applicant provides a list of equipment used by RTs. It states that the list is not exhaustive and includes equipment such as:

- Stethoscopes
- Ventilators
- Oxygen administration devices
- Gas analyzers
- Oxygen delivery systems
- Oxygen blending devices
- Suction regulators and catheters
- Negative pressure devices and regulators
- Metabolic cart
- Sleep monitoring equipment

**(3) Section 5(1)(c): the invasiveness of the procedure or mode of treatment used by practitioners**

The applicant identifies a risk of harm from improper performance by RTs. It states that the extent of risk ranges from minor (i.e., minor pain) to significant (life threatening). The applicant states that designation of respiratory therapists would protect the public from incompetent, impaired or unethical practice.

The applicant states that procedures performed by RTs involve varying degrees of risk to the patient. The applicant provides the following examples of procedures with the associated risks and consequences:

- a) *Cardiopulmonary resuscitation:*
- *Endotracheal tube misplacement*
  - *Mainstem bronchus intubation*
  - *Inadequate/inappropriate ventilation, oxygenation*
  - *Aspiration*
  - *Fractured ribs, lacerated liver, punctured lung*
  - *Traumatic damage to the viscera*
- b) *Arterial puncture or catheterization*
- *Pain*
  - *Arterial laceration*
  - *Arterial thrombosis*
  - *Infection*
  - *Inadvertent venous sampling, resulting in misleading sampling results*

- c) *Mechanical ventilation*
  - *Improper control/alarm settings leading to inadequate or excessive ventilation, oxygenation or airway pressure*
  - *Risk from improper operation include: patient discomfort, barotrauma, inadvertent and unnoticed patient disconnect or ventilator circuit leak, artificial airway obstruction*
  - *Delivery of inappropriate medical gas concentration to patients. i.e. inhaled nitric oxide, halothane, isoflurane, and oxygen.*
  
- d) *Endotracheal intubation:*
  - *Intubation of the esophagus*
  - *Broken teeth*
  - *Laryngeal or tracheal trauma*
  - *Pulmonary infection*
  - *Aspiration*
  - *Mainstem bronchus intubation*
  
- e) *Airway suctioning*
  - *Hypoxemia/hypoxia*
  - *Cardiac dysrhythmia*
  - *Mucosal damage*
  - *Atelectasis*
  
- f) *Aerosol therapy*
  - *Infection*
  - *Fluid overload*
  - *Bronchospasm*
  - *Cardiac dysrhythmias*
  
- (4) Section 5(1)(d)(i): the degree to which the health profession is practised under the supervision of another person who is qualified to practise as a member of a different health profession**

The applicant states that RTs are not directly supervised by other health care practitioners when providing services within their scope of practice. With respect to supervision of RTs by physicians, the applicant submits the following:

*Direct supervision by a physician is required when a therapist (who is competent) is asked to perform tasks or interventions for patient safety that are outside the scope of practice for respiratory therapists but have not yet been*

*delegated. These may include types of medication administration and invasive procedures.*

The Council heard submissions at the public hearing that RTs practise independently as well as with direction from another health practitioner. The levels of supervision will be discussed in the Reserved Acts section of this report.

**(5) Section 5(1)(d)(ii): the degree to which the health profession is practised in a currently regulated environment.**

RTs in BC are currently not regulated under any legislation. Most respiratory therapy practice occurs within a regulated institutional environment, either a hospital or clinical laboratory. The main employers of RTs are acute care hospitals who typically require RTs to be graduates of an accredited program and certified by the Canadian Board of Respiratory Care. Many RTs are employed part-time by a number of institutions. RTs also practise in home care settings. In the Council's view, institutional or administrative structure cannot generally be relied upon to regulate professional practice and standards. The administrative structure of the institution does not exist to supervise the professional practice of independent health professionals. A health care professional can only be supervised in his or her practice by another qualified health care professional.

At the public hearing, the Council requested specific information about employer practices with regard to RTs. Subsequent to the public hearing, the Health Employers Association of BC (HEABC) responded to the Council's questions:

- (i) What qualifications do employers require for respiratory therapists;*
- and*
- (j) are there any on-going education programs and/or further assessments of qualifications?*

The HEABC responded:

***Required Qualifications***

*... For the classification of "Respiratory Therapy" the qualifications that are required include graduation from an approved program in Respiratory Therapy and registration with the B.C. Society of Respiratory Therapy.*

*... On-going education and re-assessment of qualifications vary between employers. ... Respiratory Therapists, along with many other employees, ... have completed the basic Cardio-Pulmonary Resuscitation (CPR) certification course prior to employment or shortly thereafter. Some employers require or offer the Advanced Cardiac Life Support (ACLS)*

*certification or training. These certifications require recertification at various intervals in order to remain valid. All employers offer some amount of on-going education to respiratory therapists in the form of seminars, new product demonstrations, education workshops and various medical/health services rounds and reviews.*

*Several employers also indicated that upon hire a Respiratory Therapist is assessed and obtains individual approval (from either a department head or an anaesthetist) before they can perform intubations, arterial punctures and/or the insertion of arterial lines, despite the fact that these skills are considered entry to practice skills that are taught proficiently in the education preparation. The employers we contacted also reported that a similar approval is necessary prior to performing more advanced skills, such as the insertion of central lines. We understand that administration of drugs and/or anaesthetic agents is performed pursuant to a physician order or protocol. Most employers reported that they conduct annual or bi-annual performance appraisals for Respiratory Therapists. [Emphasis added.]*

In May 2000, the Minister of Health forwarded a coroner's report to the Council for consideration in its review of respiratory therapy. The report made several recommendations to the Minister of Health. The Council has particularly noted and considered the following recommendation:

- 1. That consultation take place with the B.C. Society of Respiratory Therapists, with a view to expediting the creation of a regulatory body for the licensing of Respiratory Therapists in British Columbia.*

***Background for Recommendation #6:*** *It was surprising to learn during the course of this investigation that there is no College or other licensing body for Respiratory Therapists in British Columbia. This creates a situation where Respiratory Therapists are under no obligation (except as demanded by individual employers) to adhere to any established standards of practice or to meet educational or work requirements for continuing competence in their field. Nor are employers required to ensure that their employees upgrade skills or maintain minimum levels of competence. Although it was not a direct factor in [patient's name] death, the Respiratory Therapists at GPC [George Pearson Centre] were not familiar with equipment (specifically the Bivona tracheostomy tube) being used at Vancouver Hospital, even though this is not unusual equipment in an acute care setting.*

*Ontario, Manitoba, Alberta, and Quebec have licensing bodies for Respiratory Therapists, and perhaps their standards and licensing requirements could be*

*used as a resource to help expedite the formation of a licensing body in British Columbia.*

The Council is concerned with the lack of consistent standards of practice and monitoring of continuing competency across the practice of respiratory therapy.

**c) Conclusion regarding section 5(1) criteria**

The Council concludes that there is a significant risk of harm in the practice of the profession. RTs may use highly sophisticated and invasive technology. There is considerable independent practice which is likely to increase with services provided in home care settings. The Council also notes the potential variation in employers' requirements for continuing competency. The Council concludes that the risk of harm is not adequately addressed by voluntary membership in the professional association and reliance on employers' monitoring of continuing competencies and requirements for assessment of qualifications.

**d) Section 5(2): Discretionary Public Interest Criteria**

When examining the services of the health profession being considered for designation under the *HPA* the Council must consider the section 5(1) criteria above. The Council may also consider the section 5(2) criteria. While consideration of the section 5(2) criteria is not mandatory, the practice of the Council has been to consider all of the section 5(1) and (2) criteria.

**(1) Section 5(2)(a): Profession has demonstrated that there is a public interest in ensuring the availability of regulated services**

The applicant has demonstrated that a significant risk of harm to the public arises from the techniques and procedures employed in the practice of RT. Services are widely available throughout the province, both in acute care settings as well as home care. More respiratory therapy services will likely be provided in unregulated home care settings in the future.

There is currently no direct regulation of the respiratory therapy profession to protect the public.

The Council has received and considered a coroner's report dated February 2000 which specifically recommends regulation of RT be expedited. In the Council's view the information provided by the applicant demonstrates that ensuring availability of regulated respiratory therapy services is in the public interest.

**(2) Section 5(2)(b): the extent to which the services of the health profession provide a recognized and demonstrated benefit to the**

## **health, safety or well being of the public**

In the Council's view it is clear that diagnostic and therapeutic respiratory therapy services provide a recognized and demonstrated benefit to the health of the public.

### **(3) Section 5(2)(c): the extent to which there exists a body of knowledge that forms the basis of the standards of practice of the health profession**

The University College of the Cariboo in Kamloops provides the only RT training program in BC. Requirements for admission include completion of secondary school, with satisfactory performance in Math 12, Chemistry 12, Biology 12, English 12, and Physics 11. Academic training takes four semesters over two years and covers the curriculum established by the Canadian Society of Respiratory Therapists (CSRT). Clinical internship takes place over 48 weeks. RTs study human anatomy and physiology; pathophysiology; biomedical technology; and all aspects of cardiopulmonary health care.

The applicant maintains a Standards of Practice manual which guides its members regarding expectations for practising RTs in the following areas:

*specialized body of knowledge; intervention and application of knowledge; professional accountability; safe practice and applied technology; assessment, planning; and evaluation.*

The manual also includes a Statement of Ethics and Professional Conduct.

It is clear that there exists a body of knowledge that forms the basis of the standards of practice of the health profession.

### **(4) Section 5(2)(d): whether members of the profession are awarded a certificate or degree from a recognized post-secondary educational institution**

The only respiratory therapy training program in BC is at the University College of the Cariboo in Kamloops. It is a three-year program and is fully accredited by the Canadian Medical Association (CMA) Conjoint Committee on Accreditation of Educational Programs in Respiratory Therapy.

The applicant requires its members to have graduated either from a Canadian respiratory therapy program accredited by the Conjoint Committee on Accreditation of Educational Programs in Respiratory Therapy, or from a US respiratory therapy program considered by the CSRT to be equivalent to accredited Canadian programs. There are 17 CMA accredited training institutions in Canada, and many diploma and degree programs in the US. Members

must also have passed the National Registry Examination in Respiratory Therapy offered by the Board of Canadian Respiratory Care, or the equivalent examination offered in the United States, and members must hold a valid Certificate of Registry from the CSRT or a Certificate of Registration deemed equivalent by the CSRT.

**(5) Section 5(2)(e): Whether it is important that continuing competence of the practitioner be monitored**

In the Council's view, monitoring continuing competency is important in the practice of any profession which involves a risk of harm to the public.

The University College of the Cariboo offers a continuing education program for RTs; however, the program is not mandatory.

The applicant's Code of Ethics states that "*no member shall endeavour to extend his practice beyond his competence...*" and that "*each member shall accept responsibility for referring incompetence and illegal or unethical conduct to the proper authorities and the Society.*" However, BCSRT membership is voluntary and there is no clear structure in place for an RT to report incompetent, unethical or impaired practice. Furthermore, there is no mechanism for a member of the public to report incompetence or unethical practice.

Given the potential risks to the public and the continuing changes in technology and equipment used by practitioners, the Council believes that the public interest will be served if respiratory therapists should be monitored for continuing competence by a regulatory body.

**(6) Section 5(2)(f): the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulate the profession in the public interest**

The applicant is the only group representing respiratory therapists in BC. It has been representing RTs since 1964, first as the Canadian Society of Inhalation Therapy Technicians, BC Division, then since 1968 as the BC Society of Respiratory Technicians, since 1977 as the BC Society of Respiratory Technologists, and finally as BCSRT since 1983, when it was incorporated under the *BC Society Act*. Of the 550 practitioners, 72 per cent are members of the applicant. The current BCSRT code of ethics and professional conduct sections set out professional conduct standards and complaint and disciplinary procedures. The applicant also maintains a Standards of Practice manual which sets out in detail standards of practice expectations of RTs by the applicant. In the Council's view, the BCSRT leadership has expressed a commitment to regulate RT in the public interest.

**(7) Section 5(2)(g): the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having**

**regard to factors which in the view of the Council may affect the viable operation of the college**

The application includes a proposal for establishing a college and a funding mechanism. The applicant has been allocating funds for some time in anticipation of a self-regulating college. With 550 members the size of membership would make a college viable.

The Council is satisfied that there exists within the profession the means to establish a college and that a self-regulating college is a viable option for the profession.

**(8) Section 5(2)(h): whether designation of the health profession is likely to limit the availability of services contrary to the public interest**

Since most respiratory therapists in the province are members of the applicant, it is unlikely that designation would limit the availability of services contrary to the public interest. According to the applicant the remaining 28 per cent who are currently non-registrants would generally qualify for membership.

**e) Conclusion Regarding Section 5(1) and 5(2) Criteria**

The Council has reviewed the information gathered during the investigation in light of the public interest criteria. It is satisfied that designation of the profession would be in the public interest. The significant risk of harm associated with the practice of the profession is such that regulation is in the public interest. Institutional requirements do not adequately regulate the practice of RT. The Council also noted the increasing number of professionals working outside institutional settings.

There is demonstrated leadership within the profession committed to regulating the profession in the public interest, and a college is viable for this profession. The core training and education of members of the profession influenced the Council in its decision. The Council also noted that the majority of respondents support designation of the profession of respiratory therapy. The Council recognizes that the applicant has improved professionalism and standards of practice within the profession over an extended period of time. They have successfully moved the profession toward self-regulation.

**The Health Professions Council recommends that the practice of respiratory therapy be designated as a health profession under the *Health Professions Act*.**

**B. DISCUSSION OF THE REGULATORY MODEL**

Once designation has been recommended, the Council may make further recommendations regarding the profession. These are set out in section 10(3)(b) of the *HPA* and include recommendations regarding the name of a college, the title of practitioners of the profession, scope of practice, reserved acts, and any limits on scope of practice. The Council feels that some discussion of the reserved acts and scope of practice model of regulation is important to an understanding of these recommendations.

Prior to the enactment of the *HPA*, the method of regulating health professions in British Columbia was an exclusive scope of practice system. Under this system, the various health professions were granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, was entitled to perform acts within the profession's scope of practice unless they were specifically granted an exemption.

The Seaton Commission and various other reports such as the Foulkes Report (1974) criticised this method of regulating health professions and suggested a new model. This new model is reflected in the Council's *Terms of Reference* for its scope of practice review of the existing professions, and in the *HPA*. The system is based on non-exclusive scope of practice statements and narrowly defined reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession or shared amongst several qualified professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exemptions) only those acts which present a significant risk of harm will be reserved.

### **C. SCOPE OF PRACTICE STATEMENT**

According to the Council's *Terms of Reference* for the scope of practice review and its *Policy Guidelines*, the purpose of the scope of practice statement is to describe what the profession does, the purpose for which it does it and the methods it uses. The statement itself does not grant the profession an exclusive scope of practice.

Nonetheless, the statement is important because it defines the area of practice in relation to which the governing body must establish registration requirements and standards of practice. It defines the parameters of the profession for members of the profession, employers, courts and educators and it informs consumers about the service practitioners are qualified to perform. *Safe Choices* indicates that "*a scope of practice statement will define an individual profession's activities in broad, non-exclusive terms.*"

The applicant proposes the following scope of practice statement:

*The practice of respiratory therapy involves the application of technical therapeutics and cardio-respiratory equipment for the purpose of health promotion, maintenance, restoration, or palliation and illness or injury prevention of cardio-respiratory disorders.*

The majority of respondents agree with the proposed scope of practice statement.

The Licensed Practical Nurses Association of BC (LPNABC) states the proposed scope of practice adequately describes the practice of respiratory therapy. At this time, LPNABC does not foresee any limitations to be imposed on the service provided by respiratory therapy. The BC Medical Association (BCMA) states there were no responses from members of its profession disagreeing with the proposed scope of practice statement. The BC Society of Clinical Perfusionists (BCSCP) states that the proposed scope of practice appropriately reflects the areas of current clinical practice of RTs. Simon Fraser Health Region (SFHR) states it is in general agreement with the proposed scope of practice and comments that the focus is primarily the respiratory system with lesser involvement with the cardiac system.

The Registered Nurses Association of BC (RNABC) states it would be useful to include a definition of “*technical therapeutics*”. It further states that the use of the term “cardio-respiratory” may be confusing, since the focus of the respiratory therapist is the respiratory system and the equipment related to it.

The Health Employers Association of BC (HEABC) suggests the term “*application of technical therapeutics and cardio-respiratory equipment*” be reworded as “*performance of therapeutic interventions and the operation of cardio-respiratory equipment*”.

The Health Employers Association of BC (HEABC) states that its understanding of current respiratory therapy practice is to generally monitor, evaluate and treat patients with respiratory and cardiopulmonary disorders. In some facilities, RTs also provide respiratory/cardiopulmonary assistance or intervention to patients undergoing surgery requiring anaesthetic, sometimes working in an anaesthetic assistant role. In this regard, HEABC does not see the need to create a new and separate professional body for the role of anaesthetic assistant, as this can be regulated within the scope of existing and currently pending professional standing applications.

RTs in Alberta will be regulated under the *Health Professions Act* (Alberta’s *HPA*), RSA 2000, c. H-7 once regulations are finalized which has not occurred at the date of this report. Part 10 of Alberta’s *HPA* contains profession-specific schedules for each college established under Alberta’s *HPA*. Schedule 26 sets out the scope of practice of RTs:

*Practice*

3. *In their practice, respiratory therapists do one or more of the following:*
- (a) provide basic and advanced cardio-respiratory support services to assist in the diagnosis, treatment and care of persons with cardio-respiratory and related disorders, and*
  - (b) provide restricted activities authorized by the regulations.*

In Ontario, the practice of respiratory therapy is defined as:

*... the providing of oxygen therapy; cardio-respiratory equipment monitoring and the assessment and treatment of cardio-respiratory and associated disorders to maintain or restore ventilation.*

After considering the respondents' comments and having regard to the Ontario and Alberta scope statements the Council concludes that the following statement most accurately describes the practice of RT.

**The Health Professions Council recommends the following scope of practice be granted to members of a college of respiratory therapists:**

**The practice of respiratory therapy is the assessment and treatment of cardio-respiratory and associated disorders through the performance of therapeutic interventions and operation of cardio-respiratory equipment to maintain or restore ventilation for prevention and treatment of illness, health promotion and maintenance.**

## **D. RESERVED ACTS**

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those acts which present a significant risk of harm to members of specific professions who are qualified to perform them. The Council has developed a list of reserved acts first set out in its *Shared Scope of Practice Model Working Paper (Working Paper)*. The *Working Paper* was developed, in large part, as a result of the Council's review of information provided by the various professions during the scope of practice consultation process.

The list of reserved acts has evolved and expanded during the Council's continuing scope of practice review. In March 2001 the Council issued *Safe Choices*. Appendix C is the most recent list of reserved acts contained in *Safe Choices*, and as amended subsequently.

*Safe Choices* will form the basis of the reserved act analysis. Where an act or activity is currently listed as a reserved act in the Council's Reserved Acts List, the Council will determine whether members of the respiratory therapy profession are trained and qualified to perform such act and whether it is within the RT scope of practice. Where the applicant requests a reserved act which is not included on the reserved act list incorporated in *Safe Choices*, the Council will conduct a risk of harm analysis to determine if a new reserved act is warranted or a current reserved act should be expanded or adapted to include that which is requested by the applicant, should it present a significant risk of harm.

The applicant proposes that the following reserved acts be granted to its members (explanations by the applicant are italicized):

1. Making a respiratory therapy diagnosis by determining the cause of the subjective symptoms and objective signs relating to the cardiopulmonary system of the individual.
  - *RTs initiate this act independently when assessing any client/patient prior to initiating any treatment, assessing efficacy of treatment or assessing client/patient clinical status.*
  - *Take patient history*
  - *Conduct a complete physical assessment as treated to respiratory therapy*
  - *Interpret laboratory and radiological data*
  - *Develop treatment plan*
2. Performing the following physically invasive or physically manipulative acts:
  - (a) procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;
    - *arterial punctures*
    - *capillary punctures*
    - *intravenous line insertion*
    - *arterial line insertion*
    - *central line insertion*
  - (b) administering a substance, other than a drug, by injection, inhalation, irrigation or instillation through enteral or parenteral means;
    - *oxygen*
    - *oxygen/air mixtures via positive pressure (i.e., Noninvasive positive pressure ventilation, invasive positive pressure ventilation)*
    - *oxygen under hyperbaric conditions*
    - *heliox*
    - *nitric oxide*
    - *nitrous oxide*
    - *anaesthetic agents*

- *Pulmonary Function Testing gas mixtures*
  - *Inhalation medication administration*
- (c) putting an instrument, hand or finger(s),
- i. beyond the point in the nasal passages where they normally narrow,
    - *nasopharyngeal airway*
    - *suction catheter*
    - *esophageal airway*
    - *nasal endotracheal tube*
    - *bronchoscope*
  - ii. beyond the pharynx,
    - *suction catheter*
    - *oropharyngeal airway*
    - *laryngoscope*
    - *bronchoscope*
    - *oral endotracheal tube*
  - iii. into an artificial opening into the body.
    - *Tracheostomy devices*
3. Compounding or administering by any means a drug listed in Schedule 1 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.
    - *RTs administer many types of drugs listed in this category such as bronchodilators, surfactant, pentamidine, etc.*
    - *Refer to CSRT Occupational Profile page 61 – 63: F) General Therapeutics – provide humidity and aerosol therapy*
  4. Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.
    - *Bronchoprovocative testing*
    - *Skin scratch allergy testing*
  5. Cardiac stress testing conducted for medical diagnosis and treatment planning.

With respect to the reserved act of cardiac stress testing, the applicant in its revised submission in July 2000 stated:

*In some labs the Respiratory Therapist is responsible for providing Holter Scanning, ECG, cardiac stress testing, exercise tolerance testing.*

## **1. Summary of general comments on reserved acts made by respondents**

The proposed reserved acts generated lengthy and detailed responses. Some respondents made general comments.

The Licensed Practical Nurses Association of BC (LPNABC) states the proposed reserved acts are appropriate.

The Registered Nurses Association of BC (RNABC) states that clarifying some of the proposed reserved acts would be helpful. RNABC notes and approves the Council's approach of not listing the various activities that can be carried out within a particular reserved act. RNABC states that if the Council intends to specifically list activities for RTs within a particular reserved act, it would like clarification that these activities are not prohibited to registered nurses. Further, RNABC states that there needs to be more clarification on which reserved acts are to be self-initiated by RTs and which should be delegated to them.

The Council wishes to emphasize that its recommendations will provide for the sharing of many of the reserved acts. Thus, in conducting its review of any of the reserved acts of a profession, the Council is not deciding which acts would be reserved exclusively to that profession. It is possible and indeed likely that acts reserved to a profession will also be reserved to other professions. However, each profession may perform the reserved acts granted to it only within the context of its defined scope of practice.

The BC Nurses' Union (BCNU) has two concerns for the proposed reserved acts: first, RTs do not perform certain proposed reserved acts, and second, the way the proposed reserved acts have been framed:

1. *Performing certain proposed reserved acts* - BCNU states RTs do not insert arterial lines or central lines, and they do not administer anaesthetic agents or use bronchoscopes.
2. *Framing the proposed reserved acts* - BCNU questions whether RTs are capable of independently initiating the proposed reserved acts, and whether they should be required to hold a special license or follow a prescribed protocol when performing these reserved acts. BCNU makes reference to its submission to the Council regarding the scope of practice review of registered nursing where it outlined five different situations that would arise in relation to reserved acts.

For this review of RT, BCNU proposes that the Council apply the same regulatory framework it proposed for the registered nurses scope of practice review. This will be discussed in the reserved acts analysis at page 35.

The BC Medical Association (BCMA) comments that the proposed reserved acts do not specify under what conditions these acts are allowed to be done and under whose orders.

It further states it does not seem reasonable to grant to RTs the following procedures: central line insertion, bronchoscopy, insertion of tracheostomy devices, and allergy challenge testing.

The Health Employers Association of BC (HEABC) makes the following specific comments on the reserved acts that the applicant proposes be granted to RTs and additional reserved acts that might be considered by the Council to be appropriately undertaken by RTs in certain circumstances. HEABC understands that RTs routinely establish intravenous lines and currently administer some medications by intravenous, intramuscular, subcutaneous, endotracheal and topical routes. It states that given the Council's qualification of this reserved act with the phrase "*other than a drug*", it suggests that the following additional reserved acts would be appropriately granted to RTs:

*Performing the physically invasive or physically manipulative act of administering a substance other than a drug, by irrigation or instillation through enteral or parenteral means.*

*Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*

Simon Fraser Health Region (SFHR) states that the acts proposed are appropriate to be granted to RTs, with the following exceptions:

- physically invasive or physically manipulative acts of procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth
  - *capillary punctures*
  - *arterial line insertion*
  - *central line insertion*
- administering a substance by injection or inhalation
  - *oxygen under hyperbaric conditions*
  - *nitrous oxide*
  - *anaesthetic agents*
- putting an instrument, hand or finger(s), beyond the point in the nasal passages where they normally narrow
  - *nasal endotracheal tube*
  - *bronchoscope*
- beyond the pharynx

- *laryngoscope*
- *bronchoscope*
- *oral endotracheal tube*

According to SFHR, these acts are delegated functions from a physician and ongoing skill assessment is needed to determine and maintain competence.

The Capital Health Region (CHR) states:

*... the list of procedures that come under the Reserved Acts section ... has ... the broadest and most ambitious scope possible, yet ... could have quite serious consequences. These are items that could generate a significant medical-legal problem for the practitioners.*

In its analysis which follows, the Council will address the issues raised by the respondents, in particular the qualifications of RTs to perform reserved acts within the RT scope of practice.

## **2. Analysis**

The Council has been charged with the responsibility to devise a reserved acts model which reflects current practice. In *Safe Choices*, the Council recommended granting certain reserved acts to be shared among various health professions. The role of the health professionals who are granted a certain reserved act may vary from profession to profession. Certain health professions will be able to initiate and perform reserved acts independently. Others will perform the same reserved act independently, however, the decision to initiate the reserved act will reside with another health profession, and the reserved act will be performed "on the order" of the profession with the authority to initiate and perform that reserved act. This distribution of responsibility reflects current practice. The Council recognizes that any profession whose members are granted a reserved act possesses the knowledge, skill, and ability to perform that reserved act without delegation or supervision, and is responsible for the competent delivery of that reserved act, whether or not it is initiated "on the order" of another health profession. The shared scope of practice model is based upon a framework of competent health professions who practice independently, yet collaboratively.

The Council has carefully reviewed the applicant's proposal for reserved acts and the information provided by the applicant to determine the context in which RTs perform these acts. The Council held discussions with the applicant, conducted an extensive review of guidelines and protocols in current use, and observed respiratory therapy practice in various settings.

### **a) Reserved acts outside the respiratory therapy scope**

At the outset, the Council notes that some of the reserved acts requested are beyond the scope of RTs. These are currently performed under supervision or delegation. In no case can an RT be ordered to initiate or perform a reserved act outside his or her scope of practice. These types of situations should be handled under the guidelines for delegation recommended by the Council in *Safe Choices*. The Council has been presented with documentation that in Ontario the lack of clarity surrounding the distinction between order-initiated reserved acts and delegated reserved acts has resulted in registered nurses being ordered to perform reserved acts not within the RN scope of practice. In the Council's view, it is clearly not in the public interest for a health professional to order another health professional to perform a reserved act for which the health professional receiving the order is not educated or trained. Such situations must be considered delegation and follow the Council's delegation guidelines.

With respect to the issue of limits to its scope of practice, the applicant proposes that some medical functions may be delegated to RTs as long as they do not contravene existing law or acceptable standards of medical practice. It goes on to define "delegation" as the *"transfer to perform a procedure which is controlled and to a person not otherwise authorized to perform the procedure."*

The Council uses the term "delegation" to mean what is often referred to in health care settings as a "transfer of function". This occurs when a reserved act outside the scope of a particular profession is delegated to a member(s) of that profession by a member of a profession which has been granted that act. When referring to a transfer of function in this report, the Council would like to emphasize it is not sanctioning particular institutional practices which may or may not meet the guidelines for delegation recommended in *Safe Choices*.

In *Safe Choices*, the Council discussed the issue of how activities otherwise restricted could be performed by individuals under some form of supervision or delegation. The Council considered this issue and recommended the following:

*The Health Professions Council recommends that a provision be enacted by the Minister of Health and Minister Responsible for Seniors which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:*

- *The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;*
- *The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health*

*professional's governing body;*

- *Where the person to whom the act will be assigned is a regulated health professional, his or her governing body must approve of the assigning of the reserved act;*
- *The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;*
- *The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;*
- *The assigning health professional must ensure that the person who will be performing the act accepts the assignment.*

The Council emphasizes that the issue of supervised or delegated acts arises only with respect to reserved acts. Thus, the general provision regarding supervision will not apply in respect of acts which are not reserved.

## **b) Reserved acts within the respiratory therapy scope**

RTs perform reserved acts within their scope of practice under a variety of circumstances. In many instances, the respiratory therapist is ordered by another health professional to perform the reserved act. In some cases, the RT can initiate a reserved act independently without the order of another health professional. In yet other cases, a RT who is practising at an advanced level may perform or initiate a reserved act after completing an advanced training program required by an employer. Under any of these circumstances, protocols or guidelines approved by the hospital may be utilized.

### **(1) order-initiated reserved acts**

In *Safe Choices* the Council dealt generally with the concept of order-initiated reserved acts, indirect orders, and patient specific orders. The Council defined “indirect order”:

*An “indirect order” is not client-specific. It includes protocols or clinical guidelines or medical directives and is a prescription for a procedure, treatment or intervention that may be performed for a range of clients who meet certain conditions. The indirect order identifies a specific treatment or range of treatments, the specific conditions that must be met and any specific circumstances that must exist before the indirect order can be*

*implemented.*

In January 2001 RNABC initially responded to the RT application for designation that: “RTs often practice with medical directives rather than patient-specific orders”. RNABC has requested that the Council clarify its meaning regarding the concept of orders beyond patient-specific orders. Professions such as RTs may also be affected by the use of these broad orders. RNABC subsequently submitted its response to the Council’s *Safe Choices* titled *Regulating Registered Nurses in the Public Interest* (see [www.rnabc.bc.ca/newnews/index.htm](http://www.rnabc.bc.ca/newnews/index.htm)) to the Ministry of Health Planning. At the same time RNABC also submitted this brief to the Council to be considered in the Council’s review of RT practice.

The RNABC states in its response at page 15:

*The HPC, through this recommendation, acknowledges the considerable independent decision-making exercised by registered nurses. Registered nurses frequently initiate reserved acts without a client-specific order. RNABC does not consider evidence-based protocols and clinical guidelines to be physicians’ orders. Many protocols are developed by an interdisciplinary team and used by all members of the team. Considering evidence-based protocols and clinical guidelines to be orders leads to confusion regarding responsibility for the activities carried out. Evidence-based guidelines and protocols are decision support tools. Practitioners who initiate and carry out activities outlined in an evidence-based protocol must have a full understanding of the consequences of the activities they are undertaking for each client. They must complete a full assessment and reach a diagnosis in order to determine that it is appropriate to implement the protocol. Therefore, if an intervention in the evidence-based protocol or clinical guideline is within the scope of practice of registered nursing, it would be the registered nurse’s responsibility to ensure that he or she is meeting the Practice Standards for the Initiation of Reserved Acts. If the activities within the evidence-based protocol are outside the scope of practice of nursing, then the HPC delegation provisions should apply and medical directives would be used.*

*The competencies required by a registered nurse to initiate reserved acts without an order are currently achieved in entry-level and post-basic specialty education programs. RNABC believes that initiation of a reserved act without an order requires that a registered nurse have specific competencies as outlined in the Practice Standards for Initiation of Reserved*

## Acts.

RNABC is also developing a regulatory framework to regulate the process under which employer-authorized post-graduate training for advanced competencies must meet RNABC Rules. A similar framework, in conjunction with *Practice Standards for Initiation of Reserved Acts*, could be developed by a college of respiratory therapists to monitor reserved acts performed at an advanced competency level within the respiratory therapy scope of practice.

Many RTs perform reserved acts using evidence based protocols, clinical guidelines or medical directives. The Council has reviewed a large number of RT protocols and guidelines currently in use throughout B.C., all involving reserved acts. In its review of protocols and guidelines at facilities including Royal Inland Hospital, Saint Paul's Hospital, Nanaimo General Regional Hospital, Vancouver General Hospital, Children's Health Centre, Simon Fraser Health Region, and Richmond Hospital, the Council learned that the requirement of an order is often the first requirement in the protocol. In others where there is no requirement for an order, protocols and guidelines are decision-support tools for RTs and others, such as registered nurses. The Council observes that all of these documents are employer-approved, not reviewed by any regulatory body, and are products of the current regulatory environment in which many procedures involving reserved acts performed by RTs are delegated or transfers of function from medical doctors.

In its review, the Council found that the use of medical directives to order a treatment which involves a reserved act within the RT scope is actually quite rare. The majority of protocols in place refer to a transfer of function (delegation of a reserved act) or to the use of a clinical practice guideline. The Council shares the RNABC concern that the use of the term "indirect order" to describe all of these situations may create confusion regarding professional responsibility for performance of reserved acts.

Clinical practice guidelines are decision-support tools for RTs (registered nurses and other health professionals in some cases) to utilize in initiation or performance of reserved acts, for example the administration of oxygen therapy. These guidelines may mention the concept of "order" only when the patient's condition falls outside certain parameters. In other words, in certain circumstances, RTs are currently able to operate without an order, follow a clinical practice guideline, and perform reserved acts, unless the patient's condition requires contacting a physician to obtain an order. In some cases, the reserved acts involved in practice guidelines may require advanced competencies within the RT scope, which will be discussed in the next section. Yet other protocols are meant to facilitate a "transfer of function" or delegation of a reserved act outside the scope of RT practice and for these, the Council's delegation guidelines apply.

The Council agrees with the RNABC that many protocols and guidelines are decision-making tools for practitioners and are not "indirect orders". The Council would like to clarify

its definition of “order” to include only direct orders and medical directives for an act or intervention within the RT scope. Some protocols are “medical directives” and may include references to an “order” which must exist prior to implementation of the protocol. This clearly fits within the context of “indirect order” as the Council used that term in *Safe Choices*. The order can be from a physician or from another health professional who is authorized by legislation to initiate or prescribe (order) the initiation of the reserved act.

The following definition of order is used by the College of Respiratory Therapists of Ontario:

### **Definition of Order**

#### *Direct orders*

*A direct order is a prescription or order for care written by an individual prescriber for a particular patient for a specific treatment(s) or intervention at a specific time.*

#### *Medical directives*

*A "medical directive" is a prescription or order for a treatment or intervention that may be performed for a range of patients who meet certain conditions. Over time, protocols have been developed that have led to the concept of "standing orders". The term "medical directive" is preferred because the health care professional implementing the directive must exercise judgement before doing so, while a standing order implies that no judgement on behalf of the performer is required.*

*In addition to meeting the requirements of a valid order, medical directives must include:*

- the specific conditions which must be met for the medical directive to apply;*
- any specific circumstances or criteria which must exist;*
- any contraindications for implementing the medical directive;*
- the identity of the individual authorizing the medical directive; and*
- appropriate acknowledgement (date and signature) of the administrative authority (e.g., Medical Advisory Committee) approving the medical directive.*

The Council emphasizes that an “order” includes both “direct orders” and “medical directives”. Either of these can be given by a health professional who has been granted the authority to prescribe or initiate the reserved act involved.

A “medical directive” which essentially orders a health professional to perform an act or intervention that is within his or her scope must be clearly drafted to ensure accountability of all professionals involved. Two questions must be asked:

- 1) is this act within the scope of practice (whether at a basic or advanced level) of the performing professional who is responsible for deciding to implement the medical directive following the clear guidance of the directive. The individual drafting the medical directive must be certain the directive falls within the scope of the person directed.
- 2) If the reserved act involved is outside the scope of the performing professional it cannot be the subject of a medical directive because a health professional cannot direct another health professional to perform an act outside their scope. This situation is considered delegation and must follow the Delegation Guidelines outlined in *Safe Choices*.

**The Health Professions Council recommends that the following definition be adopted by the Minister of Health Planning for the term “order”:**

**Direct orders**

**A “direct order” is a prescription or order for care written by an individual prescriber for a particular patient for a specific treatment(s) or intervention at a specific time.**

**Medical directives**

**A “medical directive” is a prescription or order for a treatment or intervention that may be performed for a range of patients who meet certain conditions.**

**In addition to meeting the requirements of a valid order, medical directives must include:**

- **the specific conditions which must be met for the medical directive to apply;**
- **any specific circumstances or criteria which must exist;**
- **any contraindications for implementing the medical directive;**

- **the identity of the individual authorizing the medical directive; and**
- **appropriate date and signature of the administrative authority approving the medical directive.**

In its response to the Council's 30-day consultation on the final draft of this report, RNABC was concerned about the Council's definition of "direct order". Specifically, RNABC commented that "as it is written, i.e., 'at a specific time' appears to preclude the administration of medication given on an 'as needed' basis." In the Council's view, "at a specific time" includes medication given on an "as needed" basis.

### **c) Advanced competencies within the respiratory therapy scope**

The Council acknowledges the need to recognize development of advanced competencies within a profession's scope of practice through specialized training. With regard to monitoring advanced competencies, the Council carefully considered the Ontario College of Respiratory Therapists *Professional Practice Guidelines* (see [www.cрто.on.ca](http://www.cрто.on.ca)). The Council also reviewed the RNABC regulatory framework in its submission on "regulation of the process" and "regulation of the person". The BCNU submission, which follows, was also considered by the Council, which found it of assistance in distinguishing certain types of advanced practice within RT scope.

In the Council's view, all of these standards or proposals reflect the necessity of a framework for advanced practice competency assessment by a regulatory body with legislative authority to apply its regulatory mechanisms across all employers.

In its response to the RT application for designation, the BCNU suggests the Council adopt the following proposal and states:

*As part of the HPC's review of scope of practice review for registered nurses, the BCNU submitted a proposal that identified five different situations that would arise in relation to reserved acts. In brief, those situations are:*

- 1) *No reserved act granted: a health professional could perform the reserved act, but only if another health practitioner who is authorized to perform the act delegates the performance of the act to the first professional in accordance with the HPC's delegation guidelines; the reserved act cannot be self-initiated.*
- 2) *Order-initiated reserved act: A health professional could perform the reserved act, but only if a different health practitioner authorized by legislation to perform the act first orders the act be initiated; again, the reserved act cannot be self-initiated.*

- 3) *Licensed reserved act: A health professional could initiate and perform the reserved act, but only if that professional holds an applicable license granted by the College. The College would have the legislative authority to establish the educational standards for advanced practice leading to a licence, and accredit the educational programs or employer in-service programs, which meet those standards.*
- 4) *Protocol-based reserved act: A health professional could initiate and perform the reserved act, but only if that professional has the prescribed competencies and follows the protocol approved by the College. The College could either develop its own protocols (in consultation with employers, other regulatory bodies, etc.) or approve protocols that had been prepared by agencies with a recognized expertise in the particular subject area.*
- 5) *Autonomous reserved act: A health professional could initiate and perform the reserved act independently and autonomously.*

The Council found the BCNU response useful for analyzing the performance of reserved acts by RTs and others. Description of five different scenarios in which reserved acts are performed makes it clear that different levels of training are required for each. Situations involving “order-initiated” reserved acts and “autonomous” reserved acts fall within a profession's general entry-level scope of practice. Other reserved acts, while still within the RT scope, require advanced training. Some of these may be order-initiated or autonomous. These types of advanced practice situations would require some type of competency assessment and credentialing process by the regulatory body.

Ontario is the only other province to have implemented a regulatory model similar to that being developed in BC. When considering advanced practice within the RT scope of practice, the Council found it most useful to refer to the College of Respiratory Therapists of Ontario's (CRTO) *Professional Practice Guidelines*. In Ontario, RTs are granted reserved (controlled) acts subject to requirements set out in the CRTO's Standards of Practice. An order is required before RTs in Ontario can perform any of the controlled acts except suctioning. In addition, the *Professional Practice Guidelines* require individual RTs to demonstrate competency and to maintain certification to perform advanced procedures. The CRTO has specific requirements that must be met by its members to perform a number of advanced competencies. The requirements may be fulfilled by completion of an employer-provided, but CRTO-approved, post-graduate training course for the specific competency. This last requirement, approval by a regulatory body, is the key distinction necessary to provide a regulatory model that assures consistency and quality in training for advanced practice.

In several situations, the Council was presented with regulatory bodies who had handled advanced practice reserved acts differently. For example, the College of Physical Therapists of BC presented the Council with the well-established national curriculum for its post-graduate training program for the reserved act "*movement of the joints of the spine beyond the limits the body can voluntarily achieve but within the anatomical range of motion using a high velocity, low amplitude thrust.*" In that situation, the Council recommended granting this reserved act to qualified members of the College, who were in fact, already trained and had been providing the service for some time. A similar situation arose with dietitians, who presented the Council with evidence of a well-established training program for advanced dietitian practice in enteral and parenteral nutrition. The Council recommended granting the following reserved act to dietitians:

*Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.*

In the case of speech-language pathologists and audiologists, the proposed reserved act of "*putting instruments, pressurized air or water, cerumenolytic chemicals and earmold impression material into the external ear canal, up to the eardrum*", or "cerumen-management" was recommended provided the new college could establish an advanced credentialing program. There was evidence of significant public need for provision of these services and evidence that the service could be competently provided by audiologists who completed advanced training.

In the case of dental technicians, the College of Dental Technicians of BC proposed an expansion of scope to allow dental technicians to provide services directly to a patient, working in the patient's oral cavity, for which there was no training program in place, nor was there any regulatory mechanism proposed. The Council did not recommend granting this expanded scope. In the case of massage therapists, the College of Massage Therapists of BC proposed developing an advanced competency program for the proposed reserved act "*putting a finger beyond the labia majora or the anal verge: accessing the muscles of the pelvic floor.*" This proposed program was included in the College bylaws, which were not yet approved, nor was the program in existence. The Council did not recommend granting the reserved act. As the College acknowledged few massage therapists were actually utilizing this reserved act, the Council recommended it continue under the Council's delegation guidelines.

In all cases, except the dental technicians' situation, these reserved acts were within the scope of practice of the profession, but were advanced competencies requiring post-graduate training.

In general, the Council's position has been that in order to recommend that a reserved act be granted, the profession must demonstrate credentialing and competency monitoring for both basic and advanced practice.

In the Council's view, the development of a regulatory framework for the five different scenarios identified by BCNU can be accomplished by a new college of respiratory therapists. The applicant has clearly demonstrated that RTs are currently performing many reserved acts which carry a significant risk of harm, however at the present time, many are performed under a transfer of function or delegation. The Council is not prepared at this time to recommend granting RTs those reserved acts currently done under delegation. A new college of respiratory therapists will require significant amounts of time to develop its basic structure including registration of members and establishing credentialing processes, competency monitoring, standards of practice, as well as approval of training programs for advanced competencies. It is only once the college has established its basic regulatory framework that it can develop processes for credentialing advanced competencies. At that time, the Minister of Health Planning may then consider granting further independent reserved acts to advanced RT practitioners. Therefore, at this time a number of reserved acts will be recommended to continue under the Council's delegation guidelines.

### **3. Conclusions regarding specific reserved acts**

The Council believes it useful to proceed with each proposed reserved act as submitted by the applicant, based upon the Council's Reserved Acts List. The applicant indicates that the following items in italics fall within the Council's Reserved Acts List:

***Reserved act 1: Making a respiratory therapy diagnosis by determining the cause of subjective symptoms and objective signs relating to the cardiopulmonary system of the individual.***

The applicant submitted this proposed reserved act a few days prior to its scheduled public hearing and thus it did not form part of the consultation letter sent by the Council on September 20, 2000. The Council reviewed the CSRT 1997/98 *Occupational Profile* and the *Task Analysis Report: Respiratory Therapists (Task Analysis)* documents submitted by the applicant. The *Occupational Profile* includes competencies for basic RT practice. The Council reviewed the *Task Analysis* which was prepared for the Canadian Society for Respiratory Therapists in 1993. It contains an "Independence Scale" which is described as follows:

*The participants at the task analysis session were asked to estimate the degree of independence a Respiratory Therapist might require in carrying out their various tasks. The net results of this activity are a composite of the group. The level selected was the one representing the majority of the responses. Therefore, due to regional and policy differences, Respiratory Therapists may be performing the tasks at a higher or lower level than the one indicated.*

*The purpose of the scale is to provide a measure of the depth of knowledge and skills that an employer could expect of an experienced individual working at this job. The scale of independence is also a reflection of the degree of training required to accomplish the task.*

- 3 *Can perform this task without direction from physician.*
- 2 *Can perform this task with general direction from physician.*
- 1 *Can perform this task with specific direction from physician.*

The Council referred to the *Occupational Profile* and *Task Analysis* documents and noted a number of situations in which RTs must reach a diagnosis before proceeding with treatment:

#### *D) Patient Evaluation*

1. *Take patient history*
  - *Obtain the pertinent patient information*
  - *Review patient history*
  - *Verify the information collected*
  - *Analyze pertinent objective information from a patient's chart*
  - *Assess the clinical significance of the patient data as related to respiratory therapy*
2. *Conduct a complete physical assessment as related to respiratory therapy*
3. *Interpret laboratory and radiological data*
  - *gather appropriate data*
  - *make different assessment based upon the findings*
  - *laboratory data: PT, PTT, INR, cardiac enzymes, creatinine, ACTH, lactate, CBC, WBC, B.U.N., cholesterol levels, electrolyte levels*
4. *Develop treatment plan*

After carefully reviewing the *Occupational Profile* and *Task Analysis* document, the Council has determined that RTs are educated and trained in their basic training to perform this reserved act. On graduation a RT is required to be proficient at taking a patient history, conducting a complete physical assessment related to respiratory therapy, interpret laboratory and radiological data and develop a treatment plan.

The Council concludes that while RTs perform within their scope of practice with a variety of levels of independence an RT must arrive at a diagnosis before performing any treatment or intervention whether ordered to do so or as an independent reserved act. It would be unsafe to proceed otherwise.

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved act:**

- 1. Making a diagnosis of a cardio-respiratory disorder or condition as the cause of the signs or symptoms of an individual.**

**Reserved act 2(a): procedures on tissue below the dermis, below the surface of a mucous membrane**

- ***arterial punctures***
- ***capillary punctures***
- ***intravenous line insertion***
- ***arterial line insertion***
- ***central line insertion***

The Council heard extensive comment at the public hearing regarding a variety of procedures on tissue below the dermis. The submissions indicated that RTs perform many of these procedures either under supervision or delegation depending on facility protocols.

Capital Health Region (CHR) states that activities within this proposed reserved act, which includes arterial punctures and capillary punctures, are quite routine. RTs are also responsible for intravenous, arterial line and central line insertion.

HEABC understands that many RTs in pediatric settings also routinely perform capillary punctures to obtain blood samples. The Health Employers Association of BC (HEABC) agrees that this act be reserved for RTs, as many RTs routinely perform diagnostic tests, including arterial punctures.

With respect to intravenous line insertion, CHR states this could have severe consequences and advises against granting this procedure as a reserved act for RTs.

The BC Medical Association (BCMA) states there is universal opposition within its members for RTs performing central line insertion. It states this procedure has great potential for complications and should be reserved for physicians specialized in these areas. BCMA further states that arterial line insertion should only be carried out under a transfer of function from the physician and only under circumstances where the RTs have demonstrated a particular level of competence.

The Registered Nurses Association of BC (RNABC) states it is unclear how this proposed reserved act fits within the scope of practice. It states that it would be helpful to clarify the specialized role of RTs working in positions such as anaesthetic technicians. RNABC states that none of the registered nurses consulted were aware of situations where RTs are independently responsible for the insertion of central lines. RNABC suggests that this proposed reserved act is more appropriately done as a delegated function for RTs.

The BC Nurses' Union (BCNU) states that insertion of arterial lines and central lines could be performed by RTs only as a delegated reserved act in accordance with the Council's delegation protocol.

The BC Thoracic Society (BCTS) representing respirologists states insertion of arterial lines and central lines is invasive and potentially too dangerous to be granted as a reserved act to RTs. BCTS suggests that RTs perform arterial line insertion as a delegated function from a physician.

Simon Fraser Health Region (SFHR) states that RT responsibility for capillary punctures, arterial line and central line insertions varies depending on the facility in which RTs practice. It also states that these procedures are usually a delegated medical function requiring initial training and supervision by a physician and annual skill testing. Further, SFHR states that most facilities have registered nurses specially trained to do IV insertions, which is a function not generally assigned to RTs.

The Council reviewed the CSRT *1997/98 Occupational Profile* which includes competencies for basic RT practice. A new graduate is expected to be proficient in performance of arterial and capillary puncture. The Council discussed these reserved acts with the applicant who stated that upon graduation RTs would be expected to be proficient in the performance of these procedures, however would follow written protocols to guide them in deciding when to initiate the performance of these two reserved acts. The Council reviewed several protocols for arterial puncture which require a physician's order.

The Council has heard that RTs in emergency and urgent situations may perform arterial puncture based on an order. The Council's research indicates that this varies from institution to institution based on hospital protocols that were submitted for review. For example, Ridge Meadows Hospital & Health Care Centre (Simon Fraser Health Region) permits RTs and certified critical care nurses to draw arterial blood gases at their own discretion in certain circumstances. However, the majority of protocols at other institutions require an order which could be either a direct order or a medical directive.

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved act only when the act is ordered by a health practitioner who is authorized by legislation to perform the**

**act:**

**2(a) Performing the physically invasive or physically manipulative act of procedures on tissue below the dermis: arterial puncture/capillary puncture.**

An RT upon graduation is not expected to be proficient in establishing vascular access such as intravenous, arterial or central lines. These are competencies that may be acquired in post-graduate experience. The *Task Analysis* document lists these as tasks which can be performed by an experienced RT with “*general direction from a physician.*”

With regard to intravenous, arterial and central line insertion, the Council heard that practice may vary from institution to institution. Additionally, the applicant provided the Council with a number of protocols in current use at various institutions. Given the range of institutional supervision and training as well as the differing experience and skill levels of RTs, the Council believes that intravenous, arterial and central line insertion is best governed by the delegation guidelines recommended in *Safe Choices*. It is not part of independent unsupervised practice of all RTs at a new graduate or core competency level. It is possible that a college of respiratory therapists may develop competency requirements for this and other advanced practices at some point in the future. If so the Minister of Health Planning may consider granting this reserved act to qualified members of a college of respiratory therapists.

**Reserved act 2(d): administering a substance other than a drug by injection or inhalation**

- ***oxygen***
- ***oxygen/air mixtures via positive pressure (i.e., Noninvasive positive pressure ventilation, invasive positive pressure ventilation)***
- ***oxygen under hyperbaric conditions***
- ***heliox***
- ***nitric oxide***
- ***nitrous oxide***
- ***anaesthetic agents***
- ***Pulmonary Function Testing gas mixtures***
- ***Inhalation medication administration***

At the public hearing, the applicant clarified that the only substances administered by injection are drugs listed under Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, and that they would only be administered on order. Administration of drugs by injection will be discussed at page 53.

HEABC agrees that these acts be granted as reserved acts to RTs, since they routinely

operate and monitor respiratory equipment to administer treatments such as oxygen, oxygen-air mixtures, humidified air and inhalation medications. Also, HEABC states that RTs working as anaesthetic assistants administer gaseous anaesthetic agents.

CHR states that the list of procedures – oxygen, ventolin assisting devices, heliox, nitric oxide, nitrous oxide and pulmonary function gas mixtures, and inhalation of medications by nebulizer and other devices – are all acceptable and are part of current practice. CHR is concerned with anaesthetic agents and states that this procedure is not performed by RTs without the supervision of an anaesthetist. CHR suggests that a qualification be made regarding this procedure.

BCMA states that administration of nitric oxide or anaesthetic agents should be administered by RTs only on the order of a physician. In particular, BCMA states that many physicians felt that the administration of anaesthetic substances should only be under the supervision of an anaesthetist.

RNABC comments that there is no distinction made between substances that require an order and those that RTs have the competency to self-initiate. RNABC also questions the inclusion of anaesthetic agents, as it is its understanding that this reserved act applies to substances other than Schedule I or II drugs listed in the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*. Further, RNABC states that administration of substances through inhalation is a common part of RTs' practice. But the role of the respiratory therapist in the administration of substances by injection is less clear. RNABC suggests it would be helpful for the applicant to specify the forms of injection and kinds of substances.

BCTS objects to the administration of nitrous oxide and anaesthetic agents. These are substances which should be administered on the order of a physician, or as a delegated function.

SFHR has no concern about granting to RTs the administration of nitrous oxide which it interprets to mean the administration of entonox for pain management. SFHR states that oxygen given under hyperbaric conditions requires additional training, is done under supervision of a physician, and is only available in certain facilities (Vancouver General Hospital, for example). Further, SFHR has a concern about the administration of anaesthetic agents as the agents and the circumstances under which they are to be administered are not clearly identified. It further explains that if nitrous oxide refers to entonox for pain management it is different from administering nitrous oxide to maintain anaesthesia during a surgical procedure. SFHR states that this may be related to the emerging role in some operating rooms where RTs are performing as anaesthetic assistants while being supervised by an anaesthetist. RTs assist the anaesthetist in the administration of anaesthetic agents. This is however not done independently. SFHR comments that if this role were to develop into an anaesthetic care provider as practiced in the United States, it would have to be regulated separately. Administration of anaesthetic

agents would not be an independent RT function and is a reserved act presently granted only to physicians.

The Council carefully considered the submissions and reviewed the *Task Analysis* document as well as the *Occupational Profile* for RTs. Both document entry level competency for provision of oxygen therapy using a variety of masks, cannulas, and catheters, utilizing both low and high flow devices. These documents also outline RTs education about the indications for use of oxygen therapy as well as its hazards.

It is clear that RTs are educated to be competent to manage oxygen delivery, however the *Task Analysis* and *Occupational Profile* documents did not indicate whether RTs are trained and educated to determine when to initiate oxygen therapy or medical gases in all circumstances. In conversations with the applicant the Council learned that RTs follow written protocols in administration of oxygen in various circumstances.

The Council reviewed several protocols and guidelines. The Council reviewed the SFHR Ridge Meadows Hospital Oxygen Saturation Protocol for RTs and registered nurses when dealing with adult patients which indicates reliance on independent decision-making by RTs and registered nurses within certain parameters set out in the protocol. The Council accepts that this is a nursing/RT protocol, not a medical directive.

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved act:**

**2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by inhalation to an adult patient: oxygen/air mixture by mask, cannula, or catheters.**

The applicant submitted in its response to this report that it is only in initiation of oxygen to infants and preterm neonates that a physician order is required. The Council reviewed the CHC policy and protocol for infants, preterm neonates and children under 12 years old receiving oxygen which requires a physician's order or medical directive.

With regard to other medical gases, the Council requested further information from the applicant with respect to existing protocols and guidelines which are in use at various institutions. Under all circumstances when administering medical gases, while RTs are trained in basic competencies, in practice they are following guidelines (for oxygen for example) or protocols (for example, for heliox, nitric and nitrous oxide) many of which require an order. In some instances (nitrous oxide, for example) there may be a transfer of function. In others (administration of anaesthesia, for example) the RT is operating in an

expanded scope and only under direct supervision of the anaesthesiologist. The Pulmonary Function Testing gas mixtures are administered on the order of a physician in an accredited laboratory setting.

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved act only when ordered by a health practitioner who is authorized by legislation to perform the act:**

**2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by inhalation: oxygen to preterm neonates, infants and children under 12 years of age; heliox, nitric oxide and other gases to all patients.**

#### **Proposed modification/expansion of reserved act 2(d)**

The applicant proposes that the following should be reserved for RTs:

- *management of patients' ventilatory status/needs using mechanical ventilation*
- *critical care ventilatory management, except in extraordinary and emergency situations,*
- *changes to mechanical ventilatory settings, and*
- *parameters and modes of ventilation*

The applicant submits the following:

1. *In their core training, all RRT's undertake vigorous studies in the health sciences: physics, chemistry, physiology, pneumatics, fluidics, mechanics and electronics and are therein prepared to apply these principles in the application of mechanical ventilation to human lungs.*
2. *RRT's are thoroughly trained to troubleshoot, repair and adjust mechanical, pneumatic and fluidic ventilators and their adjuncts.*
3. *RRT's provide serial monitoring and assessment of the ventilator to patient interface, and are readily able to detect trends and subtle changes in patient data using observation, assessment and the application of scientific formulae.*
4. *RRT's fully comprehend the hazards associated with changes to ventilatory parameters in that they:*

- a) *can enhance patient safety by setting alarms on ventilators AND their adjuncts/monitors appropriate to the patient's ventilatory needs.*
  - b) *are knowledgeable of the implications of parameter and mode changes to co-existing ventilatory parameters and pre-existing patient conditions.*
5. *There exists a wide variety of types and classifications of ventilators which, in turn, have numerous modalities incorporated within them. Some modalities are incompatible with other modalities, and the performance limitations of some ventilators differ from ventilator to ventilator.*
  6. *The BCSRT respectfully questions the ability of other health care providers with an already "broad scope of practice" to upgrade and maintain the required ventilator skill and knowledge base in a dynamic, ever changing capital equipment environment.*
  7. *The immediate availability of manual bag resuscitators and oxygen supplies in situations where mechanical ventilation is being used.*

The applicant submitted journal articles documenting the role of the RT in ventilator management. Several articles support the applicant's statement that RTs are experts in this area. *The Respiratory Therapists Role in Intensive Care Monitoring*<sup>1</sup> states:

*For the most part, respiratory therapists are the ones expected to be expert in the application of the devices they use. Technical aspects of equipment, such as mechanical ventilators and their support systems, are not generally part of medical or nursing training programs, making the respiratory therapists uniquely educated in this respect. Although other allied health groups receive technical training, it is often primarily for diagnostic rather than therapeutic purposes.*

...

*To help assure patient safety. ... Maintaining the correct interface between the patient and the life-support equipment is a high priority in the critical area. The respiratory therapist can play a significant role in this regard by assuring that alarm systems are working properly and are used appropriately.*

...

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<sup>1</sup> Charles B Spearman, BS, RRT. *Respiratory Care*, July `85, vol. 30, no. 7

*Therapists often must determine whether appropriate flows are set on devices used for ventilatory support. By observing airway pressure changes and patient effort during inspiration, the therapist can adjust flow to the appropriate level.*

...

*continuous monitoring of exhaled tidal and minute volumes often involves setting alarms for alerting personnel to changes in ventilation. Therapists must evaluate these alarm systems for proper function as well as appropriate settings. When alarms are set appropriately, the patient's safety is protected, while frequent, inconsequential alarms are avoided. Often these systems must be reevaluated on a frequent basis when the patient's ventilatory needs are fluctuating.*

However, the *Guidelines for Standards of care for patients with Acute Respiratory Failure on Mechanical Ventilatory Support*<sup>2</sup> indicates:

*Ventilator management must be directed or concurrently provided by a physician with appropriate qualifications ... This physician shall be responsible for directing airway management, ventilatory support, and removal from the ventilator.*

The Council received mechanical ventilation protocols from hospitals across BC. In all cases a physician's order is required to initiate, maintain, or wean a patient from mechanical ventilation. The RT is responsible for the competent performance of this reserved act once the order to initiate or wean from mechanical ventilation is made.

The Council has concluded that the use of mechanical ventilation constitutes a specific reserved act within the Council's general reserved act 2(d), "*performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by injection, inhalation, irrigation, or instillation through enteral or parenteral means.*" Mechanical ventilation carries a significant risk of harm and utilizes invasive means to administer oxygen/air mixtures under pressure. Based on the evidence presented the Council recommends expanding reserved act 2(d) as follows:

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved act only when ordered by a health practitioner who is authorized by legislation to perform the act:**

**2(d) Performing the physically invasive or physically manipulative act**

<sup>2</sup> Task Force on Guidelines; Society of Critical Care Medicine. *Critical Care Medicine*, 1991, The Williams & Wilkins Co.

<b>of administering a substance, other than a drug, by mechanical ventilation: oxygen/air mixture.</b>
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BCNU states that administering anaesthetic agents could be available to RTs only as a delegated reserved act in accordance with the Council's delegation protocol.

With regard to administration of anaesthetic agents, it is clear that those RTs who are currently performing this service are doing so under supervision of an anaesthesiologist. Therefore, this service is not one which should comprise a reserved act for the general RT as it is currently outside the RT scope of practice. It may however continue to be provided as it is currently, under supervision or delegation guidelines recommended in *Safe Choices*. Should the RT anaesthetic role develop to a level of independent practice, a college of respiratory therapists would need to develop certification criteria and demonstrate competency monitoring, for reserved acts performed by these advanced practitioners.

With regard to administration of oxygen under hyperbaric conditions, the *Occupational Profile* indicates a new graduate would be aware of this skill but "does not necessarily comprehend all aspects of it." Clearly, this is an advanced competency and should be performed by an RT only under supervision or the delegation guidelines recommended in *Safe Choices*.

**Reserved act 2(e)(ii) and 2(e)(iii): putting an instrument, hand or finger(s) beyond the point in the nasal passages where they normally narrow/beyond the pharynx**

- ***nasopharyngeal airway***
- ***suction catheter***
- ***esophageal airway***
- ***nasal endotracheal tube***
- ***bronchoscope***

HEABC agrees that this be granted as a reserved act to RTs since they routinely suction and insert esophageal and oropharyngeal airways. RTs also perform intubations (using a laryngoscope) in many settings. HEABC understands that the insertion of nasal endotracheal airways and nasal endotracheal intubation is currently done by RTs in a limited number of settings as a delegated function from a physician.

BCSCP states that clinical perfusionists also use instrumentation which enter into the areas beyond the nasal passages and beyond the pharynx during such "*transeophageal echocardiography monitoring and lung lavage therapy which involves instillation of fluids into the lungs and retrieving those fluids.*" BCSCP states that these procedures may involve the use of suction catheters, tubing and oral endotracheal tubes, along with

laryngoscopy and bronchoscopy. BCSCP requests that it be noted that clinical perfusionists are also involved in this proposed reserved act.

CHR states that this proposed reserved act includes the following: oropharyngeal and nasopharyngeal airway, suction catheter, esophageal airway, nasal and oral endotracheal tubes and laryngoscopes. It states that all these procedures are part of current practice of RTs. CHR is concerned with bronchoscopy as this is not part of training programs for RTs and has potential severe medical and legal consequences. Thus, CHR does not support the granting of this proposed procedure.

RNABC states that registered nurses also perform many of the activities listed under this reserved act. It states that it is unaware of situations where RTs independently perform insertion of bronchoscopes. RNABC suggests that it be a delegated function for RTs if it is rarely performed and since it is not included as part of educational programs for RTs.

With respect to using bronchoscopes, BCNU states these could be available to RTs only as a delegated reserved act in accordance with the Council's delegation protocol. BCMA states that bronchoscopy has great potential for complications and should be reserved for physicians specialized in these areas.

SFHR states that the insertion of nasal endotracheal tube is usually facility specific and would require a transfer of medical function. It further states regarding bronchoscopy, RTs assist physicians in this procedure but do not perform it independently as it is a reserved medical function.

HEABC understands that currently RTs may assist with bronchoscopy but do not perform it independently.

The Council reviewed the *Task Analysis* and *Occupational Profile* documents. It is clear that suctioning is within the competence of RTs, as part of their basic education and training. This includes suctioning beyond the point in the nasal passages where they normally narrow, beyond the pharynx and into an artificial opening (tracheostomy). None of the respondents indicated that RTs require supervision or direction to perform suctioning

Therefore, the Council makes the following recommendation:

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved acts:**

**2(e) Performing the physically invasive or physically manipulative act of putting an instrument**

**(ii) beyond the point in the nasal passages where they normally narrow,**  
**(iii) beyond the pharynx, and**  
**(vii) into an artificial opening into the body, for purposes of suctioning.**

The Council reviewed the *Task Analysis* and *Occupational Profile* documents with regard to the insertion of nasopharyngeal airways and nasal endotracheal tubes. Submissions indicate that in some institutions this is a transfer of medical function. The *Task Analysis* document indicates they may be performed with general direction from a physician. The *Occupational Profile* document indicates at page 79 that RTs are trained to “perform intubation” but not to independently “apply a range of accessories to intubation.” The University College of the Cariboo curriculum indicates that students receive supervision by a physician in the performance of two intubations before graduation; however, the curriculum states that “this is a skill that will depend on the clinical environment.” In summary, the Council did not receive sufficient evidence that intubation is within the competency of all RTs at a new graduate level.

SFHR states that when doing an oral endotracheal intubation RTs expose the vocal cords by using a laryngoscope which is different than doing laryngoscopy for diagnostic or therapeutic reasons. The use of a laryngoscope was not mentioned in the *Task Analysis* or *Occupational Profile* documents as part of basic RT training.

These appear to be more advanced competencies and therefore can be performed under supervision, or delegation guidelines recommended in *Safe Choices*. The Council reviewed the endotracheal intubation procedure at RMH for adult endotracheal intubation which requires completion of an inhouse certificate program and annual re-certification. Under these circumstances RTs are allowed to perform endotracheal intubation without a direct order. Should a College of respiratory therapists establish a program for credentialing these advanced competencies, the Minister of Health Planning could consider recommending granting those reserved acts to RTs.

Several other respondents (BCMA, BCTS and SFHR) object to granting the reserved act of bronchoscopy to RTs. It is clear that RTs’ role in bronchoscopy is to assist the physician. The independent use of bronchoscopes is not part of RT practice. At the public hearing the applicant clarified that RTs assist physicians but do not perform this independently.

**Reserved act 2(e)(vii): putting an instrument, hand or finger(s) into an artificial opening into the body**  
• ***tracheostomy devices***

HEABC agrees that this be granted to RTs as HEABC understands that RTs routinely

suction patients who have tracheostomies and they are often responsible for changing tracheostomy cannulas.

With respect to insertion of tracheostomy devices, BCMA states that this is problematic as there may be circumstances where a tracheostomy device is being replaced that could be done by a respiratory therapist, but only under special circumstances.

The Council reviewed the *Task Analysis* and *Occupational Profile* documents. It is clear that RTs are educated and trained to maintain tracheostomies; however, they do not insert tracheostomy devices in the first instance.

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved act:**

**2(e)(vii) Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s) into an artificial opening into the body for purposes of changing tracheostomy cannulas.**

**Reserved act 5(a): Administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act***

Like the proposed reserved act of respiratory therapy diagnosis, the applicant submitted this reserved act just prior to the public hearing and it was therefore not included in the Council's consultation letter. However, the applicant clarified that references to medication administration were part of its original proposal included in the consultation letter. Further, at the public hearing the applicant clarified that this would only be performed on the order of a physician. The Council reviewed the *Task Analysis* and *Occupational Profile* documents. These indicate that RTs study pharmacology and medication administration by inhalation, aerosol and instillation. New graduates are expected to be proficient in these routes of administration. While they study other routes of medication administration such as subcutaneous, intramuscular and intravenous they are not taught proficiency in these other administration techniques.

After reviewing the *Occupational Profile* and *Task Analysis* documents as well as various protocols and guidelines the Council concludes that any route of administration, other than by inhalation or instillation, must be performed by RTs only under supervision or delegation guidelines in *Safe Choices*.

**The Health Professions Council recommends that members of a college of respiratory therapists be granted the following reserved act only when ordered by a health practitioner who is authorized by legislation to perform the act:**

**5(a) Administering by inhalation or instillation a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, or as prescribed by regulation.**

**Reserved act 7(a): Allergy challenge testing in which a positive result of the test is a significant allergic response; or allergy desensitizing treatment in which there is a risk of significant allergic response**

- ***Bronchoprovocative testing***
- ***Skin scratch allergy testing***

RNABC states that bronchoprovocative testing is well within the scope of practice of RTs. It states that the roles of RTs in skin scratch testing is less clear. RNABC assumes that like registered nurses, RTs do not initiate allergy challenge testing without a patient-specific order, and it requests that this limitation be clarified or specified. Further, RNABC states that it is critical that any respiratory therapist administering allergy challenge testing is able to recognize and treat anaphylaxis.

BCSCP states that the proposed reserved act of allergy challenge testing is an appropriate proposal as a delegated act to RTs.

BCMA states its members oppose the granting of the application or interpretation of allergy testing, either bronchoprovocative or skin testing to RTs, citing patient safety. BCMA states that some physicians feel that the bronchoprovocative testing should only occur in an accredited laboratory and that skin testing, which often includes injections, may precipitate anaphylactic reactions, and should only be carried out by a qualified physician.

BCTS sees no rationale for skin scratch allergy testing to be performed by RTs unless under the supervision of or as a delegated function from a physician.

HEABC states that in some settings RTs perform bronchoprovocative testing and skin scratch allergy testing under the direction of a physician. Thus, HEABC understands that RTs do not perform this procedure independently.

SFHR states that this proposed reserved act is done by physicians and is not seen as the independent practice of RTs.

CHR states that these procedures are done under the supervision of a physician. CHR proposes some qualifications. Modern skin testing for allergy often requires more than just scratches but includes injections which CHR believes should not be included. Further, CHR states that a medical back-up system is always needed to deal with anaphylactic reactions, and it is inappropriate that RTs, should they develop a separate professional facility, be doing this type of work as they have not had the rest of the necessary medical training.

CHR requests more qualifications with respect to bronchoprovocative testing and the elimination of skin testing.

The *Task Analysis and Occupational Profile* documents indicate that RTs can perform this skill with general direction from a physician. The Council carefully considered the submission of the applicant and others, the responses indicating a variety of levels of supervision available, and considered the significant risk of harm involved in allergy challenge testing, including scratch tests and bronchoprovocative testing. In the Council's view, the applicant has submitted documentation to indicate that bronchoprovocative testing for allergies presents a significant risk of harm and clearly falls within reserved act 7(a). However, it is the Council's view that RTs who perform this procedure (or scratch testing) currently do so as a form of advanced RT practice and under the supervision or delegation of a physician. Those who currently perform these allergy challenge procedures may continue to do so under supervision or delegation guidelines recommended in the *Safe Choices*.

### **Reserved act 7(b): Cardiac stress testing conducted for medical diagnosis and treatment planning**

At the time of the public hearing in May 2001, the Council had reviewed the application for designation of the BC Society of Cardiology Technologists (BCSCT) but had not issued its final report. The representative of the BCSCT who spoke at the RT hearing questioned the ability of RTs to perform cardiac stress testing. The Council in its October 2001 report to the Minister of Health Planning recommended that *cardiac stress testing conducted for medical diagnosis and treatment planning* be a reserved act granted to members of a college of cardiology technologists. Representatives of the applicant asserted that RTs are performing cardiac stress testing in some institutions. The Council requested further documentation of RT education and training for cardiac stress testing. The Council reviewed the information submitted which included the University College of the Cariboo (UCC) Curriculum and the *Occupational Profile* document. In its review the Council learned that RTs are provided with a general overview of the basic principles of cardiac diagnostic procedures, equipment used, the difference between cardiopulmonary exercise testing and cardiovascular stress testing and the types of monitoring required for each. The *Occupational Profile* document indicates, however, that RTs are not trained to an "A" level, i.e., to be "proficient" in cardiac stress testing but rather are trained to a "B" level of "clinical exposure":

The Council concludes that cardiac stress testing when conducted for medical diagnosis and treatment planning purposes is not within the competence of new graduate RTs. Cardiac stress testing performed for medical diagnosis and treatment planning purposes can continue to be performed by RTs under supervision or delegation from a member of a health profession who has been granted this reserved act following the delegation guidelines recommended in *Safe Choices*.

## **E. RESERVED TITLES**

Currently, in British Columbia under the *Society Act*, the applicant has the exclusive right to use the following titles:

- Registered Respiratory Therapist
- Registered Respiratory Technologist
- R.R.T.

The applicant proposes the following reserved title:

- “Registered Respiratory Therapist”, “R.R.T.”

The respondents generally agree with the proposed reserved title.

The BC Society of Clinical Perfusionists (BCSCP) states that the proposed reserved title “Registered Respiratory Therapist” adequately delineates the role of the respiratory therapist and distinguishes the profession from others performing similar services. The BC Thoracic Society (BCTS) states it has not received any negative feedback regarding the proposed reserved title “Registered Respiratory Therapist”. The BC Lung Association (BCLA) agrees with the proposed reserved title “Registered Respiratory Therapist” and states it would adequately describe the appropriately accredited respiratory therapy practitioner and the services provided, and it distinguishes the practitioner from others performing services outside the jurisdiction of the college.

The Health Employers Association of BC (HEABC) states that the title “Registered Respiratory Therapist” is acceptable. Simon Fraser Health Region (SFHR) agrees with the title “Registered Respiratory Therapist”. Yukon Health and Social Services (YHSS) states the title “Registered Respiratory Therapist” seems to adequately distinguish RTs from others.

The Registered Nurses Association of BC (RNABC) has no concern about the proposed reserved title, but comments that the title “Registered” would be inconsistent with previous recommendations by the Council.

The Council agrees with RNABC’s comment. It has been the Council's practice to avoid use of the term "registered" where possible, as the system which is envisaged by the *Terms of Reference* is not a "registration" system, per se.

**The Health Professions Council recommends the reserved title “Respiratory Therapist” be granted to members of a college of respiratory therapists.**

**F. NAME OF THE COLLEGE**

The applicant proposes the college name “British Columbia College of Respiratory Therapists”. In accordance with its previous practice regarding the title of colleges, the Council recommends the use of the practitioners' title rather than the title of the profession and does not recommend including “British Columbia” within the title.

**The Health Professions Council recommends that the college to be established for respiratory therapy be named the "College of Respiratory Therapists".**

## G. OTHER ISSUES

### 1. Society Act

The Council recommends that any other titles reserved under the *Society Act* which conflict with the above recommendation regarding reserved titles for RTs should be reviewed by the appropriate ministers as they may be misleading to the public.

It is the Council's view that the current situation where other titles with respect to health professions can be reserved under section 9(1) of the *Society Act* is not in the public interest as the Council noted in its *Report on the Designation of Occupational Therapy*, July 1996, and in its *Report on the Designation of Dietetics*, October 1999. Unlike the Council's review of an application for designation under the *HPA*, the Registrar under the *Society Act* does not conduct a detailed public interest analysis of the society, its membership or the services it provides with a view to regulation of the members of the applicant society. The Council believes that the title protection system under the *Society Act* could be confusing or misleading to members of the public.

Exclusive use of title conferred under the *Society Act* may be interpreted by the public to mean that a member of a registered society or association is subject to regulation which does not, in fact, exist. Further, there is no restriction on a health care worker using a title which includes the words *registered, licensed or certified* even though he or she has not been granted a title under either the *Society Act* or the *HPA*. This situation can be misleading to the public. In the Council's view, such unregulated use of these terms is not in the public interest as it may imply government sanction.

In its 1991 Report: *Closer to Home*, the Royal Commission on Health Care and Costs recommended that:

7. a. *the Society Act be amended so that the Health Professions Council must approve an occupational title or abbreviation before the Registrar grants protection of it;*

*b. all health profession titles previously granted protection under the Society Act that have not been approved by the Health Professions Council be revoked two years after the passing of the revised Health Professions Act; and*

*c. the Health Professions Act be amended to prohibit the use of words like "registered", "licensed" or "certified" by any health care worker unless that use has been approved by the Health Professions Council.*

The Council adopts and supports these conclusions and recommends their implementation.

**SUMMARY OF RESPONSES TO  
RESPIRATORY THERAPISTS APPLICATION FOR DESIGNATION**

1. **BC Association of Optometrists (BCAO)**  
**1 page letter from Cheryl Williams, Executive Vice President, September 28,2000**

BCAO states it has no specific knowledge about the applicant.

2. **BC Psychological Association (BCPA)**  
**1 page e-mail letter from Dr. Jean Stewart, Chair, Health Professions Council Task Force, October 13, 2000**

BCPA does not wish to respond regarding this application for designation.

3. **Association of Dental Surgeons of BC (ADSBC)**  
**1 page letter from Jocelyn Johnston, Executive Director, October 25, 2000**

ADSBC makes no comment about this application.

4. **Dispensing Opticians Association of BC (DABC)**  
**1 page letter from Ilona Rule, Executive Director, November 29, 2000**

DOABC states it does not feel it has the expertise or knowledge required to comment on this application.

5. **Licensed Practical Nurses Association of BC (LPNABC)**  
**1 page letter from Sheila Wilkinson, President, November 22, 2000**

**Scope of practice**

LPNABC states the proposed scope of practice adequately describes the practice of respiratory therapy. Currently, it does not foresee any limitations to be imposed on the service provided by respiratory therapy.

**Reserved acts**

LPNABC states the proposed reserved acts are appropriate. It states that there appears to be an occasional overlap on the proposed reserved acts which are insufficient to deny them to respiratory therapists (RTs).

6. **BC Medical Association (BCMA)**  
**2 page letter from Dr. Dan McCarthy, Director of Professional Relations, December 7, 2000**

BCMA states it does not oppose designation of RTs as a self-regulating profession.

**Scope of practice**

BCMA states there were no responses from members of its profession disagreeing with the

proposed scope of practice statement.

### **Reserved acts**

BCMA states there is universal opposition within its membership to the request for central line insertion based on the very real potential for hazardous outcome to the patient.

BCMA further states that arterial line insertion should only be carried out under a transfer of function from the physician and only under circumstances where the RTs have demonstrated a particular level of competence.

BCMA makes further detailed comments, as follows.

#### **Section 1b: Administering a substance by injection or inhalation**

The BCMA supports the position of its physicians which is that the administration of nitric oxide or anaesthetic agents should only be carried out on the order of a physician or under the supervision of an anaesthetist.

#### **Section 1c: Putting an instrument, hand or finger(s)**

BCMA states that there was universal opposition to the granting of bronchoscopy. It refers to submissions from Dr. Stephen Lam and others outlining the hazards. The BCMA supports their position.

#### **Section 2: Allergy challenge testing**

BCMA states its members oppose granting application or interpretation of allergy testing, either bronchoprovocative or skin testing to RTs, citing patient safety. BCMA states that some physicians feel that the bronchoprovocative testing should only occur in an accredited laboratory and that skin testing, which often includes injections, may precipitate anaphylactic reactions and should only be carried out by a qualified physician.

## **7. BC Society of Clinical Perfusion (BCSCP) 3 page letter from Filippo Berna, President, December 11, 2000**

### **Scope of practice**

BCSCP states that the proposed scope of practice appropriately reflects the areas of current clinical practice of RTs.

### **Reserved acts**

BCSCP makes the following comments specific to each proposed reserved acts:

#### **Section 1a: Procedures on tissue below the dermis**

BCSCP wishes to put on record that clinical perfusionists also perform the proposed reserved acts and requests that these proposed reserved acts not be considered as mutually exclusive to be reserved only to RTs.

#### **Section 1b: Administering a substance by injection or inhalation**

BCSCP states that clinical perfusionists administer a number of these gaseous agents, including oxygen/air oxygen mixtures, carbon dioxide, nitrogen, nitric oxide, helium and anaesthetic inhalational gases such as forane, desflurane and halothane. BCSCP states that in sum, the daily

responsibilities of the clinical perfusionist involve the same proposed reserved acts.

Section 1c: Putting an instrument, hand or finger(s) beyond the point in the nasal passages where they normally narrow, and beyond the pharynx

BCSCP states that clinical perfusionists also use instrumentation which enter into the areas beyond the nasal passages and beyond the pharynx during such “*transeophageal echocardiography monitoring and lung lavage therapy which involves instillation of fluids into the lungs and retrieving those fluids.*” BCSCP states that these procedures may involve the use of suction catheters, tubing and oral endotracheal tubes, along with laryngoscopy and bronchoscopy. BCSCP requests that it be noted that clinical perfusionists are also involved in this proposed reserved act.

BCSCP states it has no comment on the proposed reserved act involving tracheostomy devices. Further, BCSCP states that the proposed reserved act of allergy challenge testing is an appropriate proposal as a delegated act to RTs.

### **Reserved title**

BCSCP states that the proposed reserved title “Registered Respiratory Therapist” adequately delineates the role of the respiratory therapist and distinguishes the profession from others performing similar services.

## **8. BC Nurses’ Union (BCNU) 4 page submission from Patricia Shuttleworth, December 20, 2000**

BCNU states it would be in the public interest for RTs to become a regulated health profession, subject to proper selection and framing of the proposed reserved acts. It also suggests that RTs align themselves with other non-laboratory technology professions to create a larger, single multi-profession college. This would reduce the costs of creating a college.

### **Scope of practice**

BCNU has no concerns about the proposed scope of practice.

### **Reserved acts**

BCNU has two concerns for the proposed reserved acts: first, RTs do not perform certain proposed reserved acts, and second, the way the proposed reserved acts have been framed.

#### **1. Performing certain proposed reserved acts**

BCNU states RTs do not insert arterial lines or central lines, and they do not administer anaesthetic agents or use bronchoscopes.

#### **2. Framing the proposed reserved acts**

BCNU questions whether RTs are capable of independently initiating the proposed reserved acts, and whether they should be required to hold a special license or follow a prescribed protocol when performing these reserved acts. BCNU makes reference to its submission to the Council regarding the scope of practice review of registered nursing where it outlined five different situations that would arise in relation to reserved acts. BCNU believes most of the applicant’s proposed reserved acts fall into the category of “order-initiated” reserved acts. It doubts that RTs have sufficient competencies to self-initiate most, if not all, proposed reserved acts.

With respect to the four proposed reserved acts of insertion of arterial lines or central lines, administering anaesthetic agents, and using bronchoscopes, BCNU states these could be available to RTs only as a delegated reserved act in consonance with the Council's delegation protocol. In sum, BCNU proposes that the Council apply the regulatory framework it has proposed as part of the registered nurses scope of practice review.

**9. Registered Nurses Association of BC (RNABC)  
5 page letter from M. Laurel Brunke, Executive Director, January 22, 2001**

**Scope of practice**

RNABC states it would be useful to include a definition of "*technical therapeutics*". It further states that the use of the term "cardio-respiratory" may be confusing, since the focus of the respiratory therapist is the respiratory system and the equipment related to it.

**Reserved acts**

RNABC has no opinion on the reserved acts that should be reserved for RTs but states that clarifying some of the proposed reserved acts would be helpful. RNABC notes and approves the Council's approach of not listing the various activities that can be carried out within a particular reserved act. RNABC states that if the Council intends to specifically list activities for RTs within a particular reserved act, it would like clarification that these activities are not prohibited to registered nurses. Further, RNABC states that there needs to be more clarification on which reserved acts are to be self-initiated by RTs and which should be delegated to them.

1. Performing the physically invasive or physically manipulative act of procedures on tissues below the dermis

RNABC states it is unclear how this proposed reserved act fits within the proposed scope of practice. It states that it would be helpful to clarify the specialized role of RTs working in positions such as anaesthetic technicians. It further states that insertion and management of intravenous lines is commonly done by registered nurses. RNABC states that none of the registered nurses consulted were aware of situations where RTs are independently responsible for the insertion of central lines. RNABC suggests that this proposed reserved act is more appropriately done as a delegated function for RTs.

2. Performing the physically invasive or physically manipulative act of administering a substance by injection or inhalation

RNABC comments that there is no distinction made between substances that require an order and those that RTs have the competency to self-initiate. RNABC also questions the inclusion of anaesthetic agents, as it is its understanding that this reserved act applies to substances other than Schedule I or II drugs. Further, RNABC states that administration of substances through inhalation is a common part of RTs' practice. But the role of the respiratory therapist in the administration of substances by injection is less clear. RNABC suggests it would be helpful for the applicant to specify the forms of injection and kinds of substances.

3. Performing the physically invasive or physically manipulative act of putting an instrument hand or

finger(s)

RNABC states that registered nurses also perform many of the activities listed under this reserved act. It states that it is unaware of situations where RTs independently perform insertion of bronchoscopes. RNABC suggests that it be a delegated function for RTs if it is rarely performed and since it is not included as part of educational programs for RTs.

#### 4. Allergy challenge testing

RNABC states that bronchoprovocative testing is well within the scope of practice of RTs. It states that the roles of RTs in skin scratch testing is less clear. RNABC assumes that like registered nurses, RTs do not initiate allergy challenge testing without a patient-specific order, and it requests that this limitation be clarified or specified. Further, RNABC states that it is critical that any respiratory therapist administering allergy challenge testing is able to recognize and treat anaphylaxis.

#### **Reserved titles**

RNABC has no concern about the proposed reserved title, but comments that the title "Registered" would be inconsistent with previous recommendations by the Council.

#### **10. BC Medical Association (BCMA)**

**2 page letter from Dr. Dan MacCarthy, Director of Professional Relations, January 22, 2001, and Dr. Milt Baker, President, Section of Internal Medicine, January 15, 2001**

#### **Reserved acts**

BCMA comments that the proposed reserved acts do not specify under what conditions these acts are allowed to be done and under whose orders. It further states that it seems unreasonable to recommend granting the following procedures to RTs: central line insertion, bronchoscopy, insertion of tracheostomy devices, and allergy challenge testing. BCMA states that the first two procedures have great potential for complications and should be reserved for physicians specialized in these areas. With respect to the third procedure, BCMA states that this is problematic as there may be circumstances where a tracheostomy device is being replaced that could be done by a respiratory therapist, but only under special circumstances. Regarding allergy challenge testing, BCMA states this proposal is ambitious.

#### **11. College of Dental Hygienists of BC (CDHBC)**

**1 page letter from Nancy Harwood, Registrar, October 3, 2000**

CDHBC makes no comment on this application.

#### **12. Certified Dental Assistants of BC (CDABC)**

**1 page letter from Marlene Robinson, Executive Director, September 26, 2000**

CDABC makes no comment on this application.

#### **13. BC Thoracic Society (BCTS)**

**3 page letter from F.L.C. Ervin, President, November 7, 2000**

BCTS supports the applicant's request for designation and indicates there has been no negative feedback on the request.

### **Reserved acts**

BCTS states it has received negative feedback regarding the proposed reserved acts.

1. Arterial line insertion and central line insertion

BCTS states these procedures are too invasive and potentially dangerous to be granted as reserved acts to RTs. BCTS suggests that RTs be granted arterial line insertion as a delegated function from a physician.

2. Administering substances by injection or inhalation

BCTS objects to the administration of nitrous oxide and anaesthetic agents. These are substances which should be administered under the order of a physician, or as a delegated function.

3. Instrumentation

BCTS strongly objects to bronchoscopy and attaches a letter from Dr. Stephen Lam, a bronchoscopist. Dr. Lam explains the objection by the BCTS.

4. Allergy challenge testing

BCTS sees no rationale for skin scratch allergy testing to be performed by RTs unless under the authority or as a delegated function from a physician.

### **Reserved titles**

BCTS states it has not received any negative feedback regarding the proposed reserved title "Registered Respiratory Therapist".

**14. BC Lung Association (BCLA)**

**2-page submission from Graham Riches, Professor and Director, September 13, 2000**

While BCLA supports the application by BCSRT it does not comment specifically on the proposed reserved acts. It attaches the Professional Practice Guideline by the College of Respiratory Therapists of Ontario, *Delegation of Controlled Acts*.

### **Reserved titles**

BCLA agrees with the proposed reserved title "Registered Respiratory Therapist" and states it would adequately describe the appropriately accredited respiratory therapy practitioner and the services provided, and it distinguishes the practitioner from others performing services outside the jurisdiction of the college.

**15. Health Employers Association of BC (HEABC)**

**5 page letter from Gary Moser, Chief Executive Officer, December 20, 2000**

### **Scope of practice**

HEABC states that its understanding of current respiratory therapy practice is to generally monitor, evaluate and treat patients with respiratory and cardiopulmonary disorders. In some facilities, RTs also provide respiratory/cardiopulmonary assistance or intervention to patients undergoing surgery that require anaesthetic, sometimes working in an anaesthetic assistant role. In this regard, HEABC

does not see the need to create a new and separate professional body for the role of anaesthetic assistant, as this can be regulated within the scope of existing and currently pending professional standing applications.

HEABC suggests the term “*application of technical therapeutics and cardio-respiratory equipment*” be reworded as “*performance of therapeutic interventions and the operation of cardio-respiratory equipment*”.

Finally, HEABC does not see the necessity to impose limitations within the proposed scope of practice statement given that the scope of practice does not in itself grant an exclusive scope of practice to a professional group.

### **Reserved acts**

HEABC makes the following specific comments on 1) the reserved acts that the applicant proposes be granted to RTs and 2) additional reserved acts that might be considered by the Council to be ones that are appropriately undertaken by RTs in certain circumstances.

#### **1. Procedures on tissue below the dermis**

HEABC agrees that this act be reserved for RTs, as many RTs routinely perform diagnostic tests, including arterial punctures. RTs are also responsible for intravenous, arterial line and central line insertion. HEABC understands that many RTs in pediatric settings also routinely perform capillary punctures to obtain blood samples.

#### **2. Administering a substance by injection or inhalation**

HEABC agrees that this be granted as a reserved act to RTs, since they routinely operate and monitor respiratory equipment to administer treatments such as oxygen, oxygen-air mixtures, humidified air and inhalation medications. Also, HEABC states that RTs working as anaesthetic assistants administer gaseous anaesthetic agents.

#### **3. Putting an instrument, hand, or finger(s)**

- beyond the point in the nasal passages where they normally narrow  
HEABC agrees that this be granted as a reserved act to RTs since they routinely suction and insert esophageal airways. HEABC understands that the insertion of nasal endotracheal airways and nasal endotracheal intubation is currently done by RTs in a limited number of settings as a delegated function from a physician.
- beyond the pharynx  
HEABC agrees that this reserved act should be granted to RTs as they routinely perform suctioning and the insertion of oropharyngeal airways. They also perform oral endotracheal intubations (using a laryngoscope) in many settings. HEABC understands that currently RTs may assist with bronchoscopy but do not perform it independently.
- into an artificial opening into the body  
HEABC agrees that this be granted to RTs as HEABC understands that RTs routinely suction patients who have tracheostomies and they are often responsible for changing tracheostomy cannulas.

#### 4. Allergy challenges testing

HEABC states that in some settings RTs perform bronchoprovocative testing and skin scratch allergy testing under the direction of a physician. Thus, HEABC understands that RTs do not perform this procedure independently.

#### 5. Other proposed reserved acts

HEABC understands that RTs routinely establish intravenous lines and currently administer some medications by intravenous, intramuscular, subcutaneous, endotracheal and topical routes. It states that given the Council's qualification of this reserved act with the phrase "*other than a drug*", it suggests that the following additional reserved acts would be appropriately granted to RTs:

- Performing the physically invasive or physically manipulative act of administering a substance other than a drug, by irrigation or instillation through enteral or parenteral means.
- Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

#### **Reserved titles**

HEABC states that the title "Registered Respiratory Therapist" is acceptable.

#### **16. BC Ambulance Service (BCAS)**

**1 page letter from Paul Gotto, Executive Director, September 28, 2000**

BCAS makes no comment on this application.

#### **17. Simon Fraser Health Region (SFHR)**

**3 page letter from Bonnie Lantz, Director, Patient Care Services, November 2, 2000**

In general, SFHR supports this application for designation.

#### **Scope of practice**

SFHR states it is in general agreement with the proposed scope of practice and comments that the focus is primarily the respiratory system with lesser involvement with the cardiac system.

#### **Reserved acts**

SFHR makes a definition of reserved acts as "*the delivery of a health care service which carries such a significant risk of harm that it should be reserved to a particular health profession or shared among qualified health professions*", and makes the following observations:

1. Performing the following physically invasive or physically manipulative acts:
  - (a) SFHR states that RT responsibility for capillary punctures, arterial line and central line insertions depend on the facility in which RTs practice. It also states that these procedures are usually a delegated medical function requiring initial training and supervision by a physician and annual skill testing. Further, SFHR states that most facilities have registered nurses specially trained to

do IV insertions, which is a function not generally assigned to RTs.

(b) Administering a substance by injection or inhalation

SFHR states that oxygen given under hyperbaric conditions requires additional training, is only available in special facilities (i.e., Vancouver General Hospital), and is done in conjunction with a physician.

SFHR has no concern about granting to RTs the administration of nitrous oxide which it interprets to mean the administration of entonox for pain management.

SFHR has a concern about the administration of anaesthetic agents as the agents and the circumstances under which they are to be administered are not clearly identified. It further explains that if nitrous oxide refers to entonox for pain management it is different than administering nitrous oxide to maintain anaesthesia during a surgical procedure. SFHR states that this may be related to the emerging role in some operating rooms where RTs are performing as anaesthetic assistants while being supervised by an anaesthetist. RTs assist the anaesthetist in the administration of anaesthetic techniques including the administration of anaesthetic agents. This is however not done independently. SFHR comments that if this role were to develop into an anaesthetic care provider as practiced in the US, it would have to be regulated separately. To administer anaesthetic agents, RTs would need to work under the supervision/orders of the anaesthetist/respirologist even when administering Isoflurane in status asthmaticus. This would not be an independent function and is a reserved medical act.

(c) Putting an instrument hand or finger(s)

i. beyond the point in the nasal passages where they normally narrow

SFHR states that the insertion of nasal endotracheal tube is usually facility specific and would require a transfer of medical function. It further states that for bronchoscopy, RTs assist physicians in this procedure but do not perform it independently as it is a reserved medical function.

ii. beyond the pharynx

SFHR states that RTs do not perform laryngoscopy or bronchoscopy independently but assist physicians. It further states that when doing an oral endotracheal intubation they expose the cords by using a laryngoscope which is different than doing laryngoscopy for diagnostic or therapeutic reasons.

2. Allergy challenge testing

SFHR states that this proposed reserved act is done by physicians and is not seen as the independent practice of RTs.

In sum, SFHR states that the acts proposed with the exceptions of the above are appropriate to be granted to RTs. The acts described above are better designated as delegated functions from a physician, and ongoing skill assessment is needed to determine and maintain competence in the skill.

**Reserved titles**

SFHR agrees with the title “Registered Respiratory Therapist”.

**18. Capital Health Region (CHR)**

**3 page letter from Dr. Bruce Sanders, Program Director, Lung Health, November 6, 2000**

CHR encourages this application for designation.

**Reserved acts**

CHR states its impression of the proposed list of reserved acts was that the applicant presented a broad and ambitious range, without regard for the practical considerations that affect day-to-day patient care and which could have serious consequences

1. Procedures on tissue below the dermis

CHR states that this proposed reserved act, which includes arterial punctures and capillary punctures, are quite routine. With respect to intravenous line insertion, CHR states this could have severe consequences and advises against granting this as a reserved act. CHR however states that its program presently allows training in all these areas.

2. Administering a substance

CHR states that the list of procedures – oxygen, ventolin assisting devices, heliox, nitric oxide, nitrous oxide and pulmonary function gas mixtures, and inhalation of medications by nebulizer and other devices – are all acceptable and are part of current practice. CHR is concerned with anaesthetic agents and states that this procedure is not performed by RTs without the supervision of an anaesthetist.

3. Putting an instrument, hand or finger(s) beyond the point in the nasal passages where they normally narrow

CHR states that this proposed reserved act includes the following: nasopharyngeal airway, suction catheter, esophageal airway, nasal endotracheal tube. It states that all these procedures are part of current practice of RTs. CHR is concerned with bronchoscopy as this is not part of training programs for RTs does not support the granting of this proposed procedure.

4. Putting an instrument, hand or finger(s) beyond the pharynx

CHR states this includes suction catheter, oropharyngeal airway, oropharyngeal airway, laryngoscope and oral endotracheal tube, which are all acceptable procedures. Again, CHR reiterates its opposition to granting bronchoscopy to RTs.

5. Putting an instrument, hand or finger(s) into an artificial opening into the body

CHR states that inserting tracheostomy devices is part of RT practice.

6. Allergy challenge testing – including bronchoprovocative testing and skin scratch allergy testing

CHR states that these procedures are done under the supervision of a physician. CHR proposes some qualifications. Modern skin testing for allergy often requires more than just scratches but includes injections which CHR believes should not be included. Further, CHR states that a medical back-up system is always needed to deal with anaphylactic reactions, and it is inappropriate that RTs, be doing this type of work as they have not had the rest of the necessary medical training.

**19. Saskatchewan Association of Respiratory Therapists (SART)  
1 page submission from Brent Kitchen, President, November 3, 2000**

SART states it has had a long, productive relationship with the applicant, and it supports this application for designation. It further states that the educational standards which are a requirement of licensure under the proposed BC College of Respiratory Therapy are those currently recognized by the applicant, the Canadian Society of Respiratory Therapists, SART, and nearly every provincial jurisdiction within Canada.

**20. Alberta Health and Wellness (AHW)  
1 page letter from Dona Carlson, Health Workforce Consultant, October 10, 2000**

AHW states that RTs in Alberta have been a self-governing profession since 1986, under the *Health Disciplines Act*, and will be regulated under the *Health Professions Act* like other health professions in Alberta. The Alberta College and Association of Respiratory Therapy is developing its policy proposals to be submitted to AHW. One of the issues to be considered will be the authorization for RTs to perform restricted activities.

**21. Yukon Health and Social Services (YHSS)  
1 page letter from Bruce McLennan, Deputy Minister's Office, October 10, 2000**

YHSS states that RTs in the Yukon are not regulated nor is YHSS planning to do so in the near future.

**Scope of practice**

YHSS states that the proposed scope of practice is not clearly worded. It suggests to clarify the intent, by saying "... *restoration, palliation or prevention of cardio-respiratory disorders.*"

**Reserved titles**

YHSS states the title "Registered Respiratory Therapist" seems to adequately distinguish RTs from others.

**22. New Brunswick Health and Wellness (NBHW)  
1 page letter from Marilyn Evans-Born, Senior Advisor, November 14, 2000**

NBHW states that given the fact that there is no respiratory therapy legislation in New Brunswick, it is inappropriate to comment on this application.

**HEALTH PROFESSIONS COUNCIL**

**Dianne Tingey, Chair  
Jim Chisholm, Member  
Brenda McBain, Member**

**HEARING WITH RESPECT TO THE  
DESIGNATION OF RESPIRATORY THERAPISTS'  
PURSUANT TO THE  
HEALTH PROFESSIONS ACT**

9:00 a.m., May 17, 2001  
The Empire Landmark Conference Centre  
Conference Room 526

**AGENDA**

- 9:00           Opening remarks by the Chair
- 9:15           Rich Payne,  
Registrar, Cardiology Technologists Association of British Columbia
- 9:45           Gary A. Moser,  
President, Health Employers Association of British Columbia
- 10:15           15 minute break**
- 10:30          Frank Ervin, M.D.  
President, British Columbia Thoracic Society
- 11:00          Filippo Berna  
President, British Columbia Society of Clinical Perfusion
- Applicant**
- 11:30          Patty Wickson  
President, British Columbia Society of Respiratory Therapists and  
John Andruschak  
Chair, The College Task Force Committee

**RESERVED ACTS LIST**

1. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.
2. Performing the following physically invasive or physically manipulative acts:
  - (a) procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;
  - (b) setting or casting a fracture of a bone or reducing a dislocation of a joint;
  - (c) movement of the joints of the spine beyond the limits the body can voluntarily achieve but within the anatomical range of motion using a high velocity, low amplitude thrust;
  - (d) administering a substance, other than a drug,
    - i. by injection,
    - ii. by inhalation,
    - iii. by mechanical ventilation,
    - iv. by irrigation, or
    - v. by instillation through enteral or parenteral means; and
  - (e) putting an instrument, hand or finger(s),
    - i. into the external ear canal, including applying pressurized air or water,
    - ii. beyond the point in the nasal passages, where they normally narrow,
    - iii. beyond the pharynx,
    - iv. beyond the opening of the urethra,

- v. beyond the labia majora,
- vi. beyond the anal verge, or
- vii. into an artificial opening into the body.

- 3. Managing labour or delivery of a baby.
- 4. Applying or ordering the application of a hazardous form of energy including ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray, or as prescribed by regulation.
- 5. (a) Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, or as prescribed by regulation.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug;

"compounding": mixing ingredients, at least one of which is a drug;  
and

"dispensing": preparing or filling a prescription for drugs.

- (b) Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for enteral or parenteral nutrition;

"compounding": mixing ingredients, for enteral or parenteral nutrition;  
and

"dispensing": filling a prescription for enteral or parenteral nutrition.

- 6. Prescribing appliances or devices for vision, hearing or dental conditions;

dispensing such prescribed appliances or devices for dental conditions; fitting such appliances or devices for dental conditions, or fitting contact lenses.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": ordering the fabrication or alteration of appliances or devices for vision, hearing, or dental conditions; and

"dispensing": filling a prescription by fabricating or altering a dental appliance or device.

7. (a) Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction;
- (b) Cardiac stress testing conducted for medical diagnosis and treatment planning.

**Glossary of Abbreviations/Acronyms**

In order of appearance:

1. BC Society of Respiratory Therapists .....BCSRT and/or applicant
2. Respiratory therapists .....RTs
3. Canadian Society of Respiratory Therapists ..... CSRT
4. *Safe Choices: A New Model for  
Regulating Health Professions in British Columbia*..... *Safe Choices*
5. Health Employers Association of BC ..... HEABC
6. Canadian Medical Association..... CMA
7. Licensed Practical Nurses Association of BC ..... LPNABC
8. BC Society of Clinical Perfusionists ..... BCSCP
9. Registered Nurses Association of BC.....RNABC
10. *Shared Scope of Practice Model Working Paper*..... *Working Paper*
11. BC Nurses' Union ..... BCNU
12. BC Medical Association ..... BCMA
13. Simon Fraser Health Region.....SFHR
14. College of Respiratory Therapists of Ontario..... CRTO
15. BC Thoracic Society .....BCTS