APPLICATION FOR HEALTH PROFESSION REGULATION
PURSUANT TO A.R.S. §32-3105

TO: JOINT LEGISLATIVE OVERSIGHT COMMITTEE
CO-CHAIRMEN: SENATOR JAMES T. SOSSAMAN
REPRESENTATIVE BRENDA BURNS

Name of Occupational Group:

RESPIRATORY THERAPISTS

Organization Submitting Application:

ARIZONA SOCIETY FOR RESPIRATORY CARE

Date: August 30, 1989

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ATTACHMENT A

BACKGROUND

This application is being filed on behalf of the Arizona Society for Respiratory Care (AzSRC) which is the State affiliate of the American Association of Respiratory Care (AARC). The AzSRC has a current membership of approximately 500 respiratory care practitioners in Arizona and the AARC has over 27,000 members nationwide. Currently, approximately 1,400 persons are providing respiratory care services at some level within the State of Arizona. The primary purpose of the AzSRC is to provide for the professional development of respiratory care personnel and to assure the overall quality of service being provided to health care institutions and patients statewide.

Without state mandated regulation, a number of respiratory care providers in Arizona have not bothered to pass the credential level examination offered by the National Board for Respiratory Care nor participate in any type of continuing education. Respiratory care personnel in Arizona are not required to submit to any formal evaluation of their level of competency. The AzSRC believes that state licensing for respiratory care personnel is necessary to establish a verification process whereby all practitioners must demonstrate at least a minimal level of competence and education. Moreover, licensing will serve as a deterrent against the employment of unqualified and potentially unsafe persons as respiratory therapists.

Unlike some other licensed health care professionals, respiratory care practitioners deal with life and death procedures on a daily basis, whether it is monitoring and administering care to newborn premature infants, maintaining life support systems in the critical care unit or administering pulmonary care in the home. Life support equipment utilized in respiratory therapy is becoming increasingly sophisticated and complex with rapid advances in technology. Under a physician's direction, respiratory therapists administer a variety of drugs and therapy procedures which, if not administered correctly, could be life threatening. In today's world, the patient public has a right to expect a minimum level of medical training, competence and character from the people who occupy such critical positions in the health care field.

The AzSRC has been seeking licensing legislation in Arizona since 1982. In 1986, a Sunrise Report was submitted to the Joint Legislative Oversight Committee pursuant to A.R.S. §32-3104, but no further action was taken during that legislative session. Currently, twenty-five states have enacted legislation to regulate the practice of respiratory care.

It is submitted that the following discussion of the statutory criteria for licensure of health care practitioners should verify the need for such legislation in Arizona.

1. A DEFINITION OF THE PROBLEM AND WHY REGULATION IS NECESSARY INCLUDING:

(a) THE NATURE OF THE POTENTIAL HARM TO THE PUBLIC IF THE HEALTH PROFESSION IS NOT REGULATED AND THE EXTENT TO WHICH THERE IS A THREAT TO PUBLIC HEALTH AND SAFETY.

Respiratory therapists help to treat patients who have chronic or acute cardio-pulmonary ailments, i.e., any condition causing a disabling or life-threatening interruption of the normal respiratory functions. Very often the persons who must rely on treatment by respiratory therapists are confined to the intensive care unit of hospitals. Respiratory therapy is prescribed by physicians as a crucial part of the treatment of such serious diseases as pneumonia, lung cancer, cystic fibrosis and tuberculosis.

There is an obvious need for the formation of an appropriate licensing board to protect the public from unqualified or unstable individuals whose lack of expertise and/or training or current physical or mental status may threaten a patient's life or well-being. Currently, there is no effective means of preventing an unqualified practitioner from working in Arizona.

The nature of the potential harm to the people of Arizona can be better understood by focusing on the critical nature of respiratory care.

Respiratory Therapists often work with little or no direct supervision not only in hospitals but in nursing homes and home care, and in situations where a great degree of independent judgment is required. Such judgment calls and skills required cannot be carried out by uneducated and inexperienced on-the-job trainees.

Very often the practice of respiratory care includes the management of mechanical ventilators, which must be used in cases where patients have lost the ability to breathe on their own. Mechanical ventilation is artificial life support, without which <u>every</u> ventilator-dependent patient would die. This fact alone should make clear the need to establish the minimum competency of those who set up and manage ventilators. Any error -- even as simple as neglecting to set an alarm --can and has killed patients.

The demand for therapists in parts of Arizona is so great that some hospitals, especially those outside Phoenix and Tucson, are forced to hire noncredentialed therapists. Even some of the long-term care facilities in Phoenix hire noncredentialed respiratory therapists. Many uncredentialed new graduates are hired -- employment is easier to find outside the large hospitals -- and the credential is expected

to follow. Unfortunately, some of these graduates never become credentialed by the National Board of Respiratory Care -- i.e., they never establish even minimum competency in the field. Yet, in Arizona, they can continue to work. For that matter, anyone can walk in off the street, and if that hospital chooses to call him a respiratory therapist, he becomes one, despite having no training, no education, no skills.

In Phoenix, many nursing homes that accept ventilator-dependent patients have no respiratory therapy staff and may or may not offer in-service training to other personnel regarding ventilator management. Many of those institutions had no in-service training program.

Mechanical ventilation is just part of the role of the respiratory care practitioner. Although ventilator patients are the most critical, they account for only approximately 25 percent of the patient population requiring respiratory care. Many more patients are oxygen dependent: they do not need hospitalization but require home oxygen.

Home oxygen may be supplied several ways: optimally, by a home care company which employs respiratory therapists, or alternatively, by a medical gas supply company or an independent distributor of oxygen. Those patients who receive their oxygen from the home care company with respiratory therapists also receive education and training in

the proper use and precautions necessary while administering the gas. The patients who receive their gas from other sources may never be educated about its hazards or use. In fact, it is often the delivery truck driver who will set up the gas and apply it to the patient with no more instruction than how to turn the tank off and on. Oxygen is classified as a drug by the Federal Drug Administration, and is a flammable gas which can be hazardous if misused.

Many drugs are administered in respiratory care. Generally, they are classed as Beta stimulants. Beta stimulation affects the heart and central nervous system. Improper use or dosage of any of these medications can and has resulted in cardiac and/or respiratory arrest. It takes a trained and educated therapist to recognize a mistake in a medication order that was taken over the phone from a physician and incorrectly recorded in the patient chart.

For every procedure a respiratory therapist performs, there are associated hazards. Like physicians and critical care nurses who work side-by-side with respiratory therapists in the Intensive Care Unit, their mistakes can always be life threatening. But, in Arizona today the therapist who makes a mistake, be it deliberate or not, will not be held responsible. And that therapist, if asked to leave one hospital, can usually find a job in another, where the new employer knows nothing of his past record.

The job responsibility of a respiratory therapist is critical and the potential consequences of incompetence or inadequate training are lethal. The time has come for Arizona to require that all respiratory practitioners be qualified and competent and, above all, that they be held responsible for their actions.

(b) THE EXTENT TO WHICH CONSUMERS NEED AND WILL BENEFIT FROM A METHOD OF REGULATION IDENTIFYING COMPETENT PRACTITIONERS AND INDICATING TYPICAL EMPLOYERS, IF ANY, OF PRACTITIONERS IN THE HEALTH PROFESSION.

The majority of respiratory care practitioners currently working in the State of Arizona are employed by hospitals.

Virtually every other medical care practitioner with whom a patient would come in contact during his/her stay in a hospital is currently required to have a license to practice in Arizona. Yet to date in Arizona there has been no licensing program for respiratory care practitioners, who often help to treat patients with extremely serious injuries or diseases.

The licensing of respiratory care practitioners would benefit consumers both directly and indirectly. In those instances where a patient can select a respiratory therapist, the patient would have the ability to be able to identify competent practitioners in this area. In addition, the consumers would benefit indirectly from licensing in that the hospitals, physician's offices and home health agencies

who hire respiratory care practitioners would be able to have an objective, standard basis for evaluating job applicants in this area.

(c) THE EXTENT OF AUTONOMY A PRACTITIONER HAS, AS INDICATED BY THE FOLLOWING:

i) THE EXTENT TO WHICH THE HEALTH PROFESSION CALLS FOR INDEPENDENT JUDGMENT AND THE EXTENT OF SKILL OR EXPERIENCE REQUIRED IN MAKING THE INDEPENDENT JUDGMENT.

ii) THE EXTENT TO WHICH PRACTITIONERS ARE SUPERVISED.

Most of the routine functions performed by respiratory therapists (with the exception of those involving direct assistance to a physician, such as stress testing, bronchoscopy and portions of resuscitation efforts) are normally not monitored on the spot. For the most part, respiratory care practitioners function when no physician is present. Physician supervision normally consists of:

(1) Approval of standard written respiratory care procedures by the medical director of the respiratory therapy department;

(2) Transmittal of written or verbal orders;

(3) The physician's assessment of a patient's general progress; and

(4) Medical staff access to the results of periodic hospital-wide audits for the appropriateness of certain types of therapy for certain categories of patients.

Thus, in general, respiratory care practitioners provide diagnostic and therapeutic services on a physician's order. No matter what type of respiratory care is ordered, it must be kept in mind that no modern health care facility can function without the extensive use of verbal orders from physicians to nurses and other allied health care providers. Respiratory care practitioners also commonly accept verbal orders, especially in the emergency room but also in other acute and chronic care settings. Errors in communications are always possible. The inherent danger of communication errors between physicians and respiratory care practitioners will obviously be less, however, when the recipient of the order is trained to anticipate what treatment is normally required in a given situation and, therefore, able to recognize inappropriate orders or obvious errors in either written or oral communication.

Even though physicians are generally responsible for supervising the care provided by respiratory care practitioners, in many cases the instructions given by the physicians are fairly general and the details of carrying out the procedure are left to the respiratory therapist.

The most sophisticated mechanical ventilators available, regardless of how many alarms and monitors they incorporate, depend on the respiratory care practitioner to decide what conditions should and will activate an alarm. It

is unusual for the supervising physician to specify the instructions concerning the setting of alarms on mechanical ventilators. The failure to set alarms could result in undetected disconnection or gas leak, the most serious possible consequence of which would be the death of the patient.

Although respiratory care practitioners do not diagnose injuries or diseases, they are responsible for patient evaluation and the recognition of problems. They are also responsible for the unsupervised administration of both pharmacologic and mechanical therapeutic techniques, often to critically ill or injured patients. This means they must be able to recognize adverse patient reactions to therapy, complications relative to the course or kind of therapy, changes in the patient's cardiopulmonary status (from whatever cause) and technical irregularities or failures in the life support equipment attached to the patients in their care.

Some institutions have established mechanisms for direct referral of respiratory patients to the respiratory therapy department for recommendation of a treatment plan. Elsewhere, pre-arranged protocols have been established for the care of certain categories of patients, e.g. surgical, chronic lung disease, or ventilator cases. In such instances, the physician may depend on the respiratory care practitioner to implement the details of each step of the protocol, calling

on the physician only under unusual or specified circumstances. In such situations it is fair to say that the respiratory care practitioner, no less than the patient's nurse, has been deputized, at the very least, to recognize developments which require the physician's intervention or a change in the treatment plan.

Finally, in recent years the practice of respiratory therapy has spread out of the hospital setting into the patient's home. As such, the practitioner has taken on a role calling for more independent practice and with less supervision and is often the individual who is relied upon by the prescribing physician to assess the effectiveness of home therapy and/or the need for therapy modification. The unsupervised work by respiratory therapists in the home setting is especially common in Arizona, with its many elderly and retired persons.

2. THE EFFORTS MADE TO ADDRESS THE PROBLEM INCLUDING:

(a) VOLUNTARY EFFORTS, IF ANY, BY MEMBERS OF THE HEALTH PROFESSION TO EITHER:

i) ESTABLISH A CODE OF ETHICS.

ii) HELP RESOLVE DISPUTES BETWEEN HEALTH PRACTITIONERS AND CONSUMERS.

The National Board for Respiratory Care (NBRC) is a non-profit organization administering examinations for respiratory care practitioners. Two examination systems are

available for those meeting the established admission criteria: the basic entry-level Certification Examination for Respiratory Therapy Technicians (CRTT) and the advanced two-part Registry Examination for Respiratory Therapists (RRT). The purposes and objectives of the NBRC are to prepare and conduct examinations for certification and registration, to cooperate in supporting and accrediting schools for respiratory therapy, to pass on qualifications of candidates for certification and registration, and to prepare and maintain a Directory of Registered Respiratory Therapists and Certified Respiratory Therapy Technicians.

The NBRC is endorsed by the American Association for Respiratory Therapy and functions merely as a voluntary peer review agency for the profession. There is no procedure available for filing complaints against practitioners who participate in the NBRC registration and certification process and obviously none for the many practitioners who do not take part in the NBRC program.

(b) RECOURSE TO AND THE EXTENT OF USE OF APPLICABLE LAW AND WHETHER IT COULD BE AMENDED TO CONTROL THE PROBLEM.

Existing laws covering unfair trade practices, consumer protection, deceptive advertising, etc. have little or no applicability to the practice of the respiratory care practitioner. This is primarily because most respiratory therapists are employed by hospitals or physician's offices and, therefore, do not advertise directly to the public.

Civil law protections are, of course, applicable in certain situations but do not provide any assurance of quality in the practice of a respiratory care practitioner or serve as a protection against mistreatment. Without standards set by a state regulatory act, there is truly little basis for effective malpractice litigation. Through the creation of a regulatory board, an accessible forum would be created in which a patient can raise charges of malpractice or unethical and unprofessional conduct, and have an opportunity to take his complaint through a well-defined process.

Certain sections of the Federal Medicare Act define the circumstances and situations under which respiratory therapy services are considered reasonable and necessary. Over the past several years, advances in treating patients with cardio-pulmonary problems have led to the establishment of respiratory therapy as a distinct professional entity. In response to this development, the Health Care Financing Administration issues guidelines for reviewing requests for

reimbursement for various respiratory services. However, none of these federal statutes or programs contains any standards for determining competence by respiratory care practitioners or any mechanisms by which incompetent practitioners can be kept from harming the public.

At the current time there is no regulating mechanism in Arizona regarding the practice of respiratory therapy which precludes any individual from being a part of the occupation. The only limitations are those established by institutions, such as hospitals, which hire respiratory therapists. These limitations are exercised primarily through personnel policies which state who may be precluded from employment. Such policies generally provide that any individual may be denied employment for conviction of an offense involving moral turpitude, misrepresentation, malpractice or drug or alcohol abuse.

Finally, although a hospital and/or an employing physician could be held liable in a civil lawsuit, such lawsuits are expensive and time consuming. Moreover, even if the plaintiff in such a lawsuit recovers damages for malpractice by a respiratory care practitioner, there is still no legal mechanism for preventing such a practitioner from continuing to negligently treat patients. In the long run such lawsuits could be minimized by imposing minimum, fair standards of competence and training.

3. THE ALTERNATIVES CONSIDERED INCLUDING:

(a) REGULATION OF BUSINESS EMPLOYERS OR PRACTITIONERS RATHER THAN EMPLOYEE PRACTITIONERS.

Respiratory therapists work in a number of different settings including hospitals, physicians' offices and for home care companies. It would be difficult if not impossible to derive fair and comprehensive regulations which would apply in all of these different types of settings.

More importantly, Arizona has already concluded that employer regulation is not adequate for doctors, nurses, x-ray technicians, anesthesiologists and physical and occupational therapists. Respiratory therapy is a critical component of health care and should not be treated any different.

(b) REGULATION OF THE PROGRAM OR SERVICE RATHER THAN THE INDIVIDUAL PRACTITIONERS.

Again, this is not the course of action which Arizona has chosen for virtually any other health profession. An attempt to regulate the program or service would actually be more cumbersome than regulating the individual. This is particularly true in the field of respiratory therapy, which is a rapidly advancing field in which the scope of practice is constantly changing.

(c) REGISTRATION OF ALL PRACTITIONERS.

This method would accomplish virtually nothing other than the creation of a alphabetical listing of the names and addresses of everyone claiming to be a respiratory therapist in Arizona. Any unqualified person could get himself/herself listed in such a registry, thus lending them an undeserved aura of competence based on their inclusion in such an "official" directory. It would not add any level of protection for patients or institutions utilizing such lists.

(d) CERTIFICATION OF ALL PRACTITIONERS.

This method is unsatisfactory for two reasons. First, it assumes that the "consumers" of respiratory care services -- namely, the patients -- would have the time and expertise to "shop around" and find a "certified" respiratory therapist. This is simply not the case, since most recipients of respiratory care services are patients in hospitals who really have no choice in the matter. Second, this approach, by definition, is voluntary and lacks any enforcement mechanism to prevent an unqualified or unprofessional individual from continuing to practice respiratory care or an employer from hiring such individuals.

A certification requirement would not protect the public from an individual who, even if certified, did not perform competently or had other problems, such as alcoholism or drug abuse, that interfered with his ability to deliver

professional care at the level necessary to assure the health of the patient.

(e) <u>OTHER ALTERNATIVES.</u>

The only other alternative is continuation of the present system, which does not satisfactorily protect the public.

(f) <u>WHY THE USE OF THE ALTERNATIVES SPECIFIED IN THIS PARAGRAPH WOULD NOT BE ADEQUATE TO PROTECT THE PUBLIC INTEREST.</u>

As explained above, the public interest can only be adequately protected by a regulatory method which has "teeth" i.e. which <u>prohibits</u> unqualified, incompetent or unprofessional persons from performing vital respiratory care services on persons in life-threatening situations.

(g) <u>WHY LICENSING WOULD SERVE TO PROTECT THE PUBLIC INTEREST.</u>

If a licensing system were established, it would establish minimum standards of education, training and competency which anyone practicing respiratory care would be required to meet. The public could thus be assured that they would not be treated by unqualified individuals in the vital area of respiratory services. Also, if a practitioner holding a license were guilty of negligence, malpractice, certain crimes or unethical acts, there would be a readily available system for bringing a proceeding to revoke or suspend that person's license.

4. <u>THE BENEFIT TO THE PUBLIC IF REGULATION IS GRANTED INCLUDING</u>:

(a) <u>THE EXTENT TO WHICH THE INCIDENTS OF SPECIFIC PROBLEMS PRESENT IN THE UNREGULATED HEALTH PROFESSION CAN REASONABLY BE EXPECTED TO BE REDUCED BY REGULATION</u>.

By allowing only those persons who possess adequate training and knowledge to practice respiratory care, licensing should significantly reduce the possibility that patients receive incompetent care. Moreover, respiratory care practitioners would have to maintain or improve their level of knowledge and skill with continuing education requirements.

As with any profession today, there are occasional problems with some practitioners regarding substance abuse and other personal problems that can threaten the delivery of adequate care to a patient. Right now, there is no way to police the profession to even be assured that an incompetent practitioner can not immediately resume employment in the State or elsewhere. A licensing and disciplinary system is the only effective way to deal with such problems.

(b) <u>WHETHER THE PUBLIC CAN IDENTIFY QUALIFIED PRACTITIONERS.</u>

Under the proposed system, there would be no need for the public to <u>identify</u> qualified practitioners, since <u>only</u> qualified persons would be allowed to practice. Because respiratory therapy involves complex medical and technical issues which the average person is not familiar with, it is unrealistic to expect the members of the public to be able to

distinguish between qualified and unqualified practitioners -- even assuming they had a choice in the matter, which most patients do not. The concept of a patient in an intensive care unit of a hospital rationally "choosing" a respiratory care practitioner is obviously ludicrous. The patient public would be able to better rely on the delivery of professional care if every practitioner must meet minimum qualifications.

(c) THE EXTENT TO WHICH THE PUBLIC CAN BE CONFIDENT THAT QUALIFIED PRACTITIONERS ARE COMPETENT INCLUDING:

i) WHETHER THE PROPOSED REGULATORY ENTITY WOULD BE A BOARD COMPOSED OF MEMBERS OF THE PROFESSION AND PUBLIC MEMBERS OR A STATE AGENCY, OR BOTH, AND, IF APPROPRIATE, THEIR RESPECTIVE RESPONSIBILITIES IN ADMINISTERING THE SYSTEM OF REGISTRATION, CERTIFICATION OR LICENSURE, INCLUDING THE COMPOSITION OF THE BOARD AND THE NUMBER OF PUBLIC MEMBERS, IF ANY, THE POWERS AND DUTIES OF THE BOARD OR STATE AGENCY REGARDING EXAMINATIONS AND FOR CAUSE REVOCATION, SUSPENSION AND NONRENEWAL OF REGISTRATIONS, CERTIFICATES OR LICENSES, THE ADOPTION OF RULES AND CANONS OF ETHICS, THE CONDUCT OF INSPECTIONS, THE RECEIPT OF COMPLAINTS AND DISCIPLINARY ACTION TAKEN AGAINST PRACTITIONERS AND HOW FEES WOULD BE LEVIED AND COLLECTED TO PAY FOR THE EXPENSES OF ADMINISTERING AND OPERATING THE REGULATORY SYSTEM.

A draft bill setting up a system for licensing respiratory care practitioners is attached to this application. The bill as drafted would create a "Board of Respiratory Care Examiners" consisting of five members, including one physician, three licensed respiratory practitioners and one member of the public. The Board would be responsible for establishing minimum standards for qualification, administering examinations and issuing licenses

to qualified applicants. The Board would also have a procedure for taking disciplinary action against anyone found to have violated any of a specified list of prohibited actions, including "unprofessional conduct."

The activities of the Board would be funded by the collection of various fees from applicants and practitioners, such as an initial application fee, an examination fee, etc. No public monies would be used with the possible exception of a small appropriation to fund start-up costs for the Board's operation, which could be repaid to the general fund.

ii) IF THERE IS A GRANDFATHER CLAUSE, WHETHER GRANDFATHERED PRACTITIONERS WILL BE REQUIRED TO MEET THE PREREQUISITE QUALIFICATIONS ESTABLISHED BY THE REGULATORY ENTITY AT A LATER DATE.

Pursuant to the draft bill, which is attached, any person who is actively engaged in the practice of respiratory care in Arizona on the date the bill becomes effective may continue to engage in the practice of respiratory care without being licensed until December 31, 1991 if he or she applies for a license on or before March 1, 1991. A practicing respiratory therapist would be exempted from the formal training education and requirements specified in the bill, but would still be required to pass an examination to demonstrate entry-level competence before that date.

iii) THE NATURE OF THE STANDARDS PROPOSED FOR REGISTRATION, CERTIFICATION OR LICENSURE AS COMPARED WITH THE STANDARDS OF OTHER JURISDICTIONS.

The standards for testing for licensure would be based on those established by the National Board for Respiratory Care, which are uniform throughout the country. These standards are intended to measure basic entry-level competence. The remainder of the licensing qualifications are comparable to what has been required by other states and by Arizona in the licensing of other health care professionals.

iv) WHETHER THE REGULATORY ENTITY WOULD BE AUTHORIZED TO ENTER INTO RECIPROCITY AGREEMENTS WITH OTHER JURISDICTIONS.

The bill provides that someone licensed and practicing as a respiratory care technologist in another state with comparable requirements for licensure could receive an Arizona license without taking the examination otherwise required of applicants.

v) THE NATURE AND DURATION OF ANY TRAINING INCLUDING WHETHER THE TRAINING INCLUDES A SUBSTANTIAL AMOUNT OF SUPERVISED FIELD EXPERIENCE, WHETHER TRAINING PROGRAMS EXIST IN THIS STATE, IF THERE WILL BE AN EXPERIENCE REQUIREMENT, WHETHER EXPERIENCE MUST BE ACQUIRED UNDER A REGISTERED, CERTIFIED OR LICENSED PRACTITIONER, WHETHER THERE ARE ALTERNATIVE ROUTES AND ENTRY OR METHODS OF MEETING THE PREREQUISITE QUALIFICATIONS, WHETHER ALL APPLICANTS WILL BE REQUIRED TO PASS THE EXAMINATION, AND IF AN EXAMINATION IS REQUIRED, BY WHOM IT WILL BE DEVELOPED AND HOW THE COSTS OF DEVELOPMENT WILL BE MET.

Qualifications set forth in the attached draft bill require graduation from a respiratory therapy training program and successful completion of an examination. There are currently seven such schools in Arizona which are accredited by the American Medical Association's Committee on Allied

Health Education which sets standards for supervised clinical training. However, there would be certain circumstances under which the examination would be waived, such as when the applicant is licensed in another state or is already registered or certified by the NBRC.

The Board is authorized to use a uniform examination system, such as the ones utilized by the NBRC. The costs of administering the examination will be raised solely through the collection of specified fees from applicants.

(d) ASSURANCE OF THE PUBLIC THAT PRACTITIONERS HAVE MAINTAINED THEIR COMPETENCE INCLUDING:

i) WHETHER THE REGISTRATION, CERTIFICATION OR LICENSURE WILL CARRY AN EXPIRATION DATE.

The proposed bill includes a requirement that a license must be renewed every other year. Moreover, there will be continuing education requirements to be established by the board.

ii) WHETHER RENEWAL WILL BE BASED ONLY ON PAYMENT OF A FEE OR WHETHER RENEWAL WILL INVOLVE RE-EXAMINATION, PEER REVIEW OR OTHER ENFORCEMENT.

Normally, license renewal will involve only payment of a fee. Once a respiratory care practitioner is licensed, he will have an incentive to maintain a high quality of expertise and care by the potential sanction of having his license suspended or revoked if he does not. If problems have developed with a specific individual resulting in suspension or revocation of his license, the Board would have the

authority to require an examination before that person could have his license reinstated.

5. THE EXTENT TO WHICH REGULATION MIGHT HARM THE PUBLIC INCLUDING:

(a) THE EXTENT TO WHICH REGULATION WILL RESTRICT ENTRY INTO THE HEALTH PROFESSION INCLUDING:

i) WHETHER THE PROPOSED STANDARDS ARE MORE RESTRICTIVE THAN NECESSARY TO ENSURE SAFE AND EFFECTIVE PERFORMANCE.

ii) WHETHER THE PROPOSED LEGISLATION REQUIRES REGISTERED, CERTIFIED OR LICENSED PRACTITIONERS IN OTHER JURISDICTIONS WHO MIGRATE TO THIS STATE TO QUALIFY IN THE SAME MANNER AS STATE APPLICANTS FOR REGISTRATION, CERTIFICATION AND LICENSURE IF THE OTHER JURISDICTION HAS SUBSTANTIALLY EQUIVALENT REQUIREMENTS SO REGISTRATION, CERTIFICATION OR LICENSURE AS THOSE IN THIS STATE.

The standards proposed are to protect the public from incompetent care in an area of health care which is potentially life-threatening. Entry into the profession would not be unduly restricted by requiring the successful completion of education and certification testing in Arizona (as experience in other states has demonstrated). Practitioners who are licensed in other states would be allowed to obtain an Arizona license without taking an examination so long as that other state has licensure requirements equivalent to those in Arizona.

(b) WHETHER THERE ARE PROFESSIONS SIMILAR TO THAT OF THE APPLICANT GROUP WHICH SHOULD BE INCLUDED IN, OR PORTIONS OF THE APPLICANT GROUP WHICH SHOULD BE EXCLUDED FROM, THE PROPOSED LEGISLATION.

The proposal is designed to cover only those who are practicing respiratory care under the commonly accepted definition. Respiratory care should be carried out in all instances by someone who is qualified to do so, whether that person is a licensed respiratory care practitioner or a licensed doctor or nurse. The bill would specifically not limit or interfere with the scope of practice of other regulated health professionals or the practice of persons who perform specific diagnostic and testing techniques under medical direction.

6. THE MAINTENANCE OF STANDARDS INCLUDING:

(a) WHETHER EFFECTIVE QUALITY ASSURANCE STANDARDS EXIST IN THE HEALTH PROFESSION, SUCH AS LEGAL REQUIREMENTS ASSOCIATED WITH SPECIFIC PROGRAMS THAT DEFINE OR ENFORCE STANDARDS OR A CODE OF ETHICS.

The bill lists numerous grounds for disciplinary action against respiratory care practitioners, including the standard definition of unprofessional conduct recently approved by the legislature in S.B. 1174 last session involving licensure of Occupational Therapists.

(b) HOW THE PROPOSED LEGISLATION WILL ENSURE QUALITY INCLUDING:

i) THE EXTENT TO WHICH A CODE OF ETHICS, IF ANY, WILL BE ADOPTED.

ii) THE GROUND FOR SUSPENSION OR REVOCATION OF REGISTRATION, CERTIFICATION OR LICENSURE.

There are no plans for the adoption of a code of ethics and there is no need for one with the standards

required for professional competence in the draft legislation. The grounds for suspension or revocation of licenses are specifically listed in the bill. The public will be protected by the ability of the Board to take legal action against anyone found to have violated those standards or who is practicing without a license.

7. A DESCRIPTION OF THE GROUP PROPOSED FOR REGULATION, INCLUDING A LIST OF ASSOCIATIONS, ORGANIZATIONS AND OTHER GROUPS REPRESENTING THE PRACTITIONERS IN THIS STATE, AN ESTIMATE OF THE NUMBER OF PRACTITIONERS IN GROUP AND WHETHER THE GROUPS REPRESENT DIFFERENT LEVELS OF PRACTICE.

The group proposed for regulation is all those persons who are trained to actively participate in the health care practice consisting of the monitoring and treatment of cardio-pulmonary functions of patients pursuant to the orders of a licensed physician. The only association representing this group in Arizona is the Arizona Society for Respiratory Care. In order to belong to the AzSRC, an individual must also belong to the American Association for Respiratory Care.

There are approximately 1,400 practitioners in Arizona, of whom approximately 500 belong to the AzSRC.

8. THE EXPECTED COSTS OF REGULATION INCLUDING:

(a) THE IMPACT REGISTRATION, CERTIFICATION OR LICENSURE WILL HAVE ON THE COSTS OF THE SERVICES TO THE PUBLIC.

(b) THE COST TO THIS STATE AND TO THE GENERAL PUBLIC OF IMPLEMENTING THE PROPOSED LEGISLATION.

It is anticipated that licensure should have no impact on the costs of services to the public. With the number of school programs in Arizona, there should be an adequate number of persons seeking jobs as respiratory care practitioners; limiting employment to those who are sufficiently educated and qualified should not result in any shortage which might drive up costs. All other costs of regulation will be covered by the fees collected, with no or very limited cost to the state or general public. Indeed, the state general fund will receive ten percent of all fees collected.

REFERENCE TITLE: Respiratory Care; Regulation

State of Arizona
House of Representatives
Fortieth Legislature
First Regular Session
1989

DRAFT

H.B. ______________

Introduced by ____

AN ACT

RELATING TO PROFESSIONS AND OCCUPATIONS; PROVIDING FOR THE REGULATION OF THE PRACTICE OF RESPIRATORY CARE; PROVIDING FOR A BOARD OF RESPIRATORY CARE EXAMINERS; PRESCRIBING DEFINITIONS; PRESCRIBING MEMBERSHIP, APPOINTMENT, QUALIFICATIONS, MEETINGS, ORGANIZATION, COMPENSATION AND POWERS AND DUTIES OF THE BOARD; PROVIDING FOR A BOARD OF RESPIRATORY CARE EXAMINERS FUND; PRESCRIBING EXCEPTIONS TO LICENSURE; PRESCRIBING Application FOR LICENSURE; PRESCRIBING QUALIFICATIONS FOR LICENSURE; PROVIDING FOR LICENSURE WITHOUT EXAMINATION; PRESCRIBING RENEWAL OF LICENSURE; PRESCRIBING FEES; PRESCRIBING USE OF CERTAIN TITLES AND INITIALS; PRESCRIBING DENIAL OF LICENSES AND DISCIPLINARY ACTION; PROVIDING FOR INVESTIGATION OF COMPLAINTS; PROVIDING FOR REINSTATEMENT OF LICENSES AND MODIFICATION OF PROBATION; PRESCRIBING UNLAWFUL ACTS; PRESCRIBING DEFINITION AND CLASSIFICATION OF CERTAIN CRIMINAL OFFENSES; PRESCRIBING SUNSET TERMINATION OF THE BOARD AND RELATED STATUTES; PROVIDING FOR LICENSURE OF CERTAIN CURRENTLY PRACTICING RESPIRATORY CARE PRACTITIONERS; PRESCRIBING INITIAL TERMS OF MEMBERS; AMENDING TITLE 32 ARIZONA REVISED STATUTES, BY ADDING CHAPTER 35, ADDING SECTION 41-2368.05 ARIZONA REVISED STATUTES; AND MAKING AN APPROPRIATION.

1 Be it enactod by the Legislature of the State of Arizona:

2 Section 1. Legislative findings; intent

3 A. The legislature finds and declares that the practice
4 of respiratory care in this state affects the public health, safety
5 and welfare and should be subject to regulation and control in the
6 public interest to protect the public from the unauthorized and
7 unqualified practice of respiratory care and from unprofessional

1 conduct by persons licensed to practice respiratory care. The
2 legislature also recognizes that the practice of respiratory care
3 is a dynamic and changing art and science which is continually
4 evolving to include new developments and more sophisticated
5 techniques in patient care, thus creating a need for continuing
6 education and maintenance or minimum standards of competence for
7 those who practice in this area.

8 B. The intent of the legislature in this act is to
9 provide clear legal authority for functions and procedures which
10 have common acceptance and usage. In this act, the legislature
11 also intends to recognize the existence of overlapping functions
12 between physicians, registered nurses, physical and occupational
13 therapists, respiratory care practitioners and other licensed
14 health care personnel and to continue to allow appropriate sharing
15 of functions among the various health care professions.

16 Sec. 2. Title 32, Arizona Revised Statutes, is amended by
17 adding chapter 35 to read:

18 CHAPTER 35

19 RESPIRATORY CARE

20 ARTICLE 1. GENERAL PROVISIONS

21 32.3501. Definitions

22 IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

23 1. "BOARD" MEANS THE BOARD OF RESPIRATORY CARE
24 EXAMINERS.

25 2. "DIAGNOSTIC TESTING" INCLUDES BUT IS NOT LIMITED TO
26 OBTAINING PHYSIOLOGIC SAMPLES AND DETERMINING ACID-BASE STATUS AND

1 BLOOD GAS VALUES FROM BLOOD SAMPLES AND PULMONARY FUNCTION
2 MEASUREMENTS.
3 3. "LICENSED RESPIRATORY CARE PRACTITIONER" MEANS A
4 RESPIRATORY THERAPIST OR RESPIRATORY THERAPY TECHNICIAN LICENSED
5 PURSUANT TO THIS CHAPTER.
6 4. "MEDICAL DIRECTION" MEANS DIRECTION BY A PHYSICIAN
7 LICENSED PURSUANT TO CHAPTER 13 OR 17 OF THIS TITLE.
8 5. "PRACTICE OF RESPIRATORY CARE" SHALL INCLUDE DIRECT
9 AND INDIRECT RESPIRATORY CARE SERVICES, INCLUDING BUT NOT LIMITED
10 TO THE ADMINISTRATION OF PHARMACOLOGICAL, DIAGNOSTIC AND
11 THERAPEUTIC AGENTS RELATED TO RESPIRATORY CARE PROCEDURES NECESSARY
12 TO IMPLEMENT A TREATMENT, DISEASE PREVENTION, PULMONARY
13 REHABILITATIVE, OR DIAGNOSTIC REGIMEN PRESCRIBED BY A PHYSICIAN;
14 TRANSCRIPTION AND IMPLEMENTATION OF THE WRITTEN OR VERBAL ORDERS
15 OF A PHYSICIAN PERTAINING TO THE PRACTICE OF RESPIRATORY CARE;
16 OBSERVING AND MONITORING OF SIGNS AND SYMPTOMS, GENERAL BEHAVIOR,
17 GENERAL PHYSICAL RESPONSE TO RESPIRATORY CARE TREATMENT AND
18 DIAGNOSTIC TESTING, INCLUDING DETERMINATION OF WHETHER SUCH SIGNS,
19 SYMPTOMS, REACTIONS, BEHAVIOR OR GENERAL RESPONSE EXHIBIT ABNORMAL
20 CHARACTERISTICS; AND IMPLEMENTATION BASED ON OBSERVED
21 ABNORMALITIES, OF APPROPRIATE REPORTING, REFERRAL, RESPIRATORY CARE
22 PROTOCOLS OR CHANGES IN TREATMENT, PURSUANT TO A PRESCRIPTION BY
23 A PERSON AUTHORIZED TO PRACTICE MEDICINE PURSUANT TO ARTICLES 13
24 OR 17 OF THIS TITLE; OR THE INITIATION OF EMERGENCY PROCEDURES
25 UNDER THE REGULATIONS OF THE BOARD OR AS OTHERWISE PERMITTED IN
26 THIS ACT. THE PRACTICE OF RESPIRATORY CARE MAY BE PERFORMED IN ANY

1 CLINIC, HOSPITAL, SKILLED NURSING FACILITY, AND PRIVATE DWELLING;
2 OR OTHER PLACE DEEMED APPROPRIATE OR NECESSARY BY THE BOARD; IN
3 ACCORDANCE WITH THE PRESCRIPTION OR VERBAL ORDER OF A PHYSICIAN,
4 AND SHALL BE PERFORMED UNDER QUALIFIED MEDICAL DIRECTION.
5 RESPIRATORY CARE INCLUDES RESPIRATORY THERAPY AND INHALATION
6 THERAPY.
7 6. "RESPIRATORY THERAPIST" MEANS A PERSON WHO HAS
8 SUCCESSFULLY COMPLETED A TRAINING PROGRAM ACCREDITED BY THE
9 AMERICAN MEDICAL ASSOCIATION'S COMMITTEE ON ALLIED HEALTH EDUCATION
10 AND ACCREDITATION IN COLLABORATION WITH THE JOINT REVIEW COMMITTEE
11 FOR RESPIRATORY THERAPY EDUCATION AND IS ELIGIBLE TO TAKE THE
12 RESPIRATORY THERAPIST REGISTRY EXAMINATION ADMINISTERED BY OR WHO
13 IS REGISTERED BY THE NATIONAL BOARD FOR RESPIRATORY CARE, INC.
14 7. "RESPIRATORY THERAPY TECHNICIAN" MEANS A PERSON WHO
15 HAS SUCCESSFULLY COMPLETED A TRAINING PROGRAM ACCREDITED BY THE
16 AMERICAN MEDICAL ASSOCIATION'S COMMITTEE ON ALLIED HEALTH EDUCATION
17 AND ACCREDITATION IN COLLABORATION WITH THE JOINT REVIEW COMMITTEE
18 FOR RESPIRATORY THERAPY EDUCATION AND IS ELIGIBLE TO TAKE THE
19 RESPIRATORY THERAPY TECHNICIAN CERTIFICATION EXAMINATION
20 ADMINISTERED BY OR WHO IS CERTIFIED BY THE NATIONAL BOARD FOR
21 RESPIRATORY CARE, INC.
22 8. "RESPIRATORY THERAPY TRAINING PROGRAM" MEANS A
23 PROGRAM ACCREDITED BY THE AMERICAN MEDICAL ASSOCIATION'S COMMITTEE
24 ON ALLIED HEALTH EDUCATION AND ACCREDITATION IN COLLABORATION WITH
25 THE JOINT REVIEW COMMITTEE FOR RESPIRATORY THERAPY EDUCATION.

1 9. "THERAPEUTICS" INCLUDES, BUT IS NOT LIMITED TO, THE
2 APPLICATION AND MONITORING OF OXYGEN THERAPY, ADMINISTRATION OF
3 PHARMACOLOGICAL AGENTS TO THE CARDIOPULMONARY SYSTEMS, VENTILATION
4 THERAPY, ARTIFICIAL AIRWAY CARE, BRONCHIAL HYGIENE THERAPY,
5 CARDIOPULMONARY RESUSCITATION AND RESPIRATORY REHABILITATION
6 THERAPY AND ASSISTING PHYSICIANS LICENSED PURSUANT TO CHAPTER 13
7 OR 17 OF THIS TITLE WITH HEMODYNAMIC MONITORING.
8 10. "UNPROFESSIONAL CONDUCT" INCLUDES THE FOLLOWING
9 ACTS:
10 (a) COMMISSION OF A FELONY, WHETHER OR NOT
11 INVOLVING MORAL TURPITUDE, OR A MISDEMEANOR INVOLVING MORAL
12 TURPITUDE. IN EITHER CASE CONVICTION BY A COURT OF COMPETENT
13 JURISDICTION IS CONCLUSIVE EVIDENCE OF THE COMMISSION OF A
14 FELONY.
15 (b) HABITUAL INTEMPERANCE IN THE USE OF ALCOHOL.
16 (c) HABITUAL USE OF NARCOTIC OR HYPNOTIC DRUGS.
17 (d) GROSS INCOMPETENCE, REPEATED INCOMPETENCE OR
18 INCOMPETENCE RESULTING IN INJURY TO A PATIENT.
19 (e) HAVING PROFESSIONAL CONNECTION WITH OR LENDING
20 THE NAME OF THE LICENSEE TO AN ILLEGAL PRACTITIONER OF
21 RESPIRATORY THERAPY OR ANY OF THE OTHER HEALING ARTS.
22 (f) FAILING TO REFER A PATIENT WHOSE CONDITION IS
23 BEYOND THE TRAINING OR ABILITY OF THE RESPIRATORY THERAPIST
24 TO ANOTHER PROFESSIONAL QUALIFIED TO PROVIDE SUCH SERVICE.
25 (g) IMMORALITY OR MISCONDUCT THAT TENDS TO
26 DISCREDIT THE RESPIRATORY THERAPY PROFESSION.

1 (h) REFUSAL, REVOCATION OR SUSPENSION OF LICENSE
2 BY ANY OTHER STATE, TERRITORY, DISTRICT OR COUNTRY, UNLESS IT
3 CAN BE SHOWN THAT SUCH WAS NOT OCCASIONED BY REASONS WHICH
4 RELATE TO THE ABILITY SAFELY AND SKILLFULLY TO PRACTICE
5 RESPIRATORY THERAPY OR TO ANY ACT OF UNPROFESSIONAL CONDUCT
6 PRESCRIBED IN THIS PARAGRAPH.
7 (i) ANY CONDUCT OR PRACTICE CONTRARY TO RECOGNIZED
8 STANDARDS OF ETHICS OF THE RESPIRATORY THERAPY PROFESSION OR
9 ANY CONDUCT OR PRACTICE WHICH DOES OR MIGHT CONSTITUTE A
10 DANGER TO THE HEALTH, WELFARE OR SAFETY OF THE PATIENT OR THE
11 PUBLIC, OR ANY CONDUCT, PRACTICE OR CONDITION WHICH DOES OR
12 MIGHT IMPAIR THE ABILITY SAFELY AND SKILLFULLY TO PRACTICE
13 RESPIRATORY THERAPY.
14 (j) VIOLATING OR ATTEMPTING TO VIOLATE, DIRECTLY
15 OR INDIRECTLY, OR ASSISTING IN OR ABETTING THE VIOLATION OF
16 OR CONSPIRING TO VIOLATE ANY OF THE PROVISIONS OF THIS
17 CHAPTER.
18 32-3502. <u>Board of respiratory care examiners; membership,</u>
19 <u>appointment, qualifications</u>
20 A. A BOARD OF RESPIRATORY CARE EXAMINERS IS ESTABLISHED
21 CONSISTING OF FIVE MEMBERS APPOINTED BY THE GOVERNOR. EACH BOARD
22 MEMBER SHALL BE A RESIDENT OF THE STATE AT THE TIME OF APPOINTMENT.
23 THE GOVERNOR SHALL APPOINT:
24 1. THREE LICENSED RESPIRATORY CARE PRACTITIONERS, AT
25 LEAST ONE OF WHOM IS A TECHNICAL DIRECTOR OF A RESPIRATORY CARE
26 DEPARTMENT OR RESPIRATORY CARE CORPORATION OR AN OFFICER OR FACULTY

1 MEMBER OF ANY COLLEGE, SCHOOL OR INSTITUTION ENGAGED IN RESPIRATORY
2 THERAPY EDUCATION AND AT LEAST ONE OF WHOM IS INVOLVED IN DIRECT
3 PATIENT CARE.
4 2. A PHYSICIAN LICENSED PURSUANT TO CHAPTER 13 OR 17
5 OF THIS TITLE WHO IS KNOWLEDGEABLE IN RESPIRATORY CARE.
6 3. ONE PUBLIC MEMBER WHO IS NOT ENGAGED, DIRECTLY OR
7 INDIRECTLY, IN THE PROVISION OF HEALTH CARE SERVICES.
8 B. THE RESPIRATORY CARE PRACTITIONER MEMBERS SHALL:
9 1. HAVE AT LEAST FIVE YEARS EXPERIENCE IN RESPIRATORY
10 CARE OR RESPIRATORY THERAPY EDUCATION.
11 2. HAVE BEEN EMPLOYED ACTIVELY IN DIRECT PATIENT CARE,
12 RESPIRATORY THERAPY EDUCATION OR MANAGEMENT OR SUPERVISION OF
13 RESPIRATORY CARE FOR AT LEAST THREE YEARS IMMEDIATELY PRECEDING
14 APPOINTMENT.
15 3. SUBSEQUENT TO THE FIRST APPOINTMENTS TO THE BOARD,
16 BE LICENSED PURSUANT TO THIS CHAPTER.
17 C. THE GOVERNOR SHALL APPOINT THE LICENSED RESPIRATORY CARE
18 PRACTITIONERS FROM A LIST OF SEVEN QUALIFIED PERSONS SUBMITTED TO
19 THE GOVERNOR BY THE ARIZONA SOCIETY FOR RESPIRATORY CARE.
20 D. THE GOVERNOR SHALL APPOINT THE PHYSICIAN MEMBER FROM A
21 LIST OF THREE QUALIFIED PERSONS SUBMITTED TO THE GOVERNOR BY THE
22 ARIZONA THORACIC SOCIETY.
23 E. THE TERM OF OFFICE OF EACH MEMBER IS THREE YEARS, TO
24 BEGIN AND END ON JUNE 30. A MEMBER SHALL NOT SERVE FOR MORE THAN
25 TWO CONSECUTIVE TERMS.

1 F. THE GOVERNOR MAY REMOVE BOARD MEMBERS FOR NEGLECT OF
2 DUTY, MALFEASANCE OR MISFEASANCE.
3 32-3503. Meetings: organization; compensation
4 A. THE BOARD SHALL MEET IN JANUARY OF EACH YEAR TO ELECT A
5 CHAIRMAN AND OTHER OFFICERS. AT LEAST ONE ADDITIONAL MEETING SHALL
6 BE HELD BEFORE THE END OF EACH CALENDAR YEAR. OTHER MEETINGS MAY
7 BE CONVENED AT THE CALL OF THE CHAIRMAN OR THE WRITTEN REQUEST OF
8 ANY TWO BOARD MEMBERS. A MAJORITY OF THE MEMBERS OF THE BOARD
9 SHALL CONSTITUTE A QUORUM. ALL MEETINGS OF THE BOARD SHALL BE OPEN
10 TO THE PUBLIC, EXCEPT THAT THE BOARD MAY HOLD CLOSED SESSIONS TO
11 APPROVE EXAMINATIONS OR, UPON THE REQUEST OF AN APPLICANT WHO FAILS
12 AN EXAMINATION, TO PREPARE A RESPONSE INDICATING ANY REASON FOR HIS
13 FAILURE.
14 B. MEMBERS OF THE BOARD ARE ELIGIBLE TO RECEIVE COMPENSATION
15 AS DETERMINED PURSUANT TO SECTION 38-611 AND ARE ENTITLED TO
16 REIMBURSEMENT FOR ALL EXPENSES NECESSARILY AND PROPERLY INCURRED
17 IN CARRYING OUT DUTIES AS A MEMBER OF THE BOARD.
18 32-3504. Powers and duties
19 A. THE BOARD SHALL:
20 1. ENFORCE AND ADMINISTER THE PROVISIONS OF THIS
21 CHAPTER.
22 2. ADOPT RULES NECESSARY TO ADMINISTER OF THIS CHAPTER.
23 3. EXAMINE APPLICANTS FOR LICENSURE PURSUANT TO THIS
24 CHAPTER AT TIMES AND PLACES IT DESIGNATES.

1 4. INVESTIGATE EACH APPLICANT FOR LICENSURE, BEFORE A
2 LICENSE IS ISSUED, IN ORDER TO DETERMINE IF THE APPLICANT IS
3 QUALIFIED PURSUANT TO THIS CHAPTER.
4 5. KEEP A RECORD OF ALL ITS ACTS AND PROCEEDINGS
5 PURSUANT TO THIS CHAPTER, INCLUDING THE ISSUANCE, REFUSAL, RENEWAL,
6 SUSPENSION OR REVOCATION OF LICENSES.
7 6. MAINTAIN A REGISTER OF ALL PERSONS LICENSED PURSUANT
8 TO THIS CHAPTER. THE REGISTER SHALL CONTAIN THE NAME OF EVERY
9 LIVING RESPIRATORY CARE PRACTITIONER LICENSED PURSUANT TO THIS
10 CHAPTER, HIS LAST KNOWN PLACE OF RESIDENCE AND THE DATE AND NUMBER
11 OF HIS LICENSE.
12 7. COMPILE, ONCE EVERY TWO YEARS, A LIST OF LICENSED
13 RESPIRATORY CARE PRACTITIONERS WHO ARE AUTHORIZED TO PRACTICE IN
14 THIS STATE. ANY INTERESTED PERSON MAY OBTAIN A COPY OF THE LIST
15 ON APPLICATION TO THE BOARD AND PAYMENT OF THE PRESCRIBED FEE.
16 B. THE BOARD, OR ANY LICENSED RESPIRATORY CARE PRACTITIONER
17 APPOINTED BY THE BOARD, MAY INSPECT, OR REQUIRE REPORTS FROM, A
18 HOSPITAL OR ANY MEDICAL FACILITY OR CORPORATION PROVIDING
19 RESPIRATORY CARE TREATMENT OR SERVICES, WITH RESPECT TO THE
20 RESPIRATORY CARE, TREATMENT OR SERVICES PROVIDED THEREIN, AND MAY
21 INSPECT PATIENT RECORDS WITH RESPECT TO SUCH CARE, TREATMENT OR
22 SERVICES.
23 C. THE BOARD MAY EMPLOY AN EXECUTIVE OFFICER AND OTHER
24 TEMPORARY AND PERMANENT PERSONNEL IT DEEMS NECESSARY. THE
25 EXECUTIVE OFFICER AND OTHER PERSONNEL ARE ELIGIBLE TO RECEIVE
26 COMPENSATION PURSUANT TO SECTION 38-611.

1 D. THE BOARD MAY CONDUCT EXAMINATIONS UNDER A UNIFORM
2 EXAMINATION SYSTEM AND MAY MAKE SUCH ARRANGEMENTS WITH THE NATIONAL
3 BOARD OF RESPIRATORY CARE OR OTHER ORGANIZATIONS REGARDING
4 EXAMINATION MATERIALS AS IT DETERMINES NECESSARY AND DESIRABLE.
5 E. THE BOARD AND ITS MEMBERS, TEMPORARY AND PERMANENT
6 PERSONNEL AND EXAMINERS OF THE BOARD SHALL BE PERSONALLY IMMUNE
7 FROM SUIT WITH RESPECT TO ALL ACTS DONE AND ACTIONS TAKEN IN GOOD
8 FAITH AND IN FURTHERANCE OF THE PURPOSES OF THIS CHAPTER.
9 F. THE BOARD SHALL ESTABLISH MINIMUM ANNUAL CONTINUING
10 EDUCATION REQUIREMENTS WITHIN TWO YEARS OF THE EFFECTIVE DATE OF
11 THIS ACT.
12 32-3505. Board of respiratory care examiners fund
13 A. THE BOARD OF RESPIRATORY CARE EXAMINERS FUND IS
14 ESTABLISHED. ALL MONIES FROM WHATEVER SOURCE WHICH COME INTO THE
15 POSSESSION OF THE BOARD SHALL BE TRANSMITTED TO THE STATE TREASURER
16 WHO SHALL DEPOSIT TEN PER CENT OF SUCH MONIES IN THE STATE GENERAL
17 FUND AND TRANSFER THE REMAINING NINETY PER CENT TO THE BOARD OF
18 RESPIRATORY CARE EXAMINERS FUND. MONIES IN THE FUND MAY BE USED
19 BY THE BOARD FOR PAYMENTS OF ALL NECESSARY BOARD EXPENSES.
20 B. MONIES DEPOSITED IN THE BOARD OF RESPIRATORY CARE
21 EXAMINERS FUND ARE SUBJECT TO SECTION 35-143.01.
22 ARTICLE 2. LICENSURE
23 32-3521 Exceptions
24 A. AN APPLICANT WHO HAS FILED AN APPLICATION FOR LICENSURE
25 MAY RENDER RESPIRATORY CARE SERVICES UNDER THE DIRECT AND IMMEDIATE
26 SUPERVISION OF A LICENSED RESPIRATORY CARE PRACTITIONER WITHOUT

1 BEING LICENSED PURSUANT TO THIS CHAPTER BETWEEN DATE OF RECEIPT OF
2 NOTICE THAT HIS APPLICATION IS ON FILE AND THE DATE OF RECEIPT OF
3 HIS LICENSE. THIS PERIOD SHALL NOT EXCEED ONE YEAR. DURING THIS
4 PERIOD THE APPLICANT SHALL BE GRANTED A TEMPORARY LICENSE. AFTER
5 THAT TIME PERIOD, THE BOARD SHALL REVIEW THE APPLICANT'S EXCEPTED
6 STATUS AND MAY RENEW THE TEMPORARY LICENSE FOR AN ADDITIONAL ONE
7 HUNDRED TWENTY DAYS.

8 B. THIS CHAPTER DOES NOT PROHIBIT:

9 1. THE PERFORMANCE OF RESPIRATORY CARE SERVICES WHICH
10 ARE AN INTEGRAL PART OF A PROGRAM OF STUDY BY STUDENTS ENROLLED IN
11 RESPIRATORY THERAPY TRAINING PROGRAMS IF THE SERVICES ARE RENDERED
12 UNDER THE SUPERVISION OF A LICENSED RESPIRATORY CARE PRACTITIONER
13 OR A PHYSICIAN LICENSED PURSUANT TO CHAPTER 13 OR 17 OR THIS TITLE.
14 A STUDENT ENROLLED IN A RESPIRATORY THERAPY TRAINING PROGRAM SHALL
15 BE IDENTIFIED AS A RESPIRATORY CARE PRACTITIONER STUDENT OR BY THE
16 INITIAL "R.C.P.S."

17 2. SELF CARE BY A PATIENT OR THE GRATUITOUS CARE BY A
18 FRIEND OR RELATIVE WHO DOES NOT REPRESENT OR HOLD HIMSELF OUT TO
19 BE A LICENSED RESPIRATORY CARE PRACTITIONER.

20 3. THE PERFORMANCE OF RESPIRATORY CARE SERVICES IN CASE
21 OF AN EMERGENCY, INCLUDING AN EPIDEMIC OR PUBLIC DISASTER.

22 C. THIS CHAPTER IS NOT INTENDED TO LIMIT, PRECLUDE OR
23 OTHERWISE INTERFERE WITH THE PRACTICES OF OTHER REGULATED
24 PROFESSIONALS IN CARRYING OUT AUTHORIZED AND CUSTOMARY DUTIES AND
25 FUNCTIONS OR THE PRACTICE OF PERSONS WHO ARE EMPLOYED TO PERFORM
26 SPECIFIC DIAGNOSTIC AND TESTING TECHNIQUES UNDER MEDICAL DIRECTION.

1 32-3522. Application for licensure

2 A. ALL APPLICATIONS FOR LICENSES TO PRACTICE RESPIRATORY
3 CARE SHALL BE FILED WITH THE BOARD.

4 B. EACH APPLICATION SHALL:

5 1. BE ACCOMPANIED BY THE PRESCRIBED APPLICATION FEE.

6 2. BE SIGNED BY THE APPLICANT.

7 3. CONTAIN A STATEMENT UNDER OATH OF THE FACTS
8 ENTITLING THE APPLICANT TO TAKE AN EXAMINATION OR TO RECEIVE A
9 LICENSE WITHOUT EXAMINATION.

10 4. CONTAIN INFORMATION THE BOARD DEEMS NECESSARY TO
11 DETERMINE THE QUALIFICATIONS OF THE APPLICANT.

12 C. IF AN APPLICANT'S APPLICATION IS BASED ON A DIPLOMA FROM
13 A FOREIGN RESPIRATORY THERAPY SCHOOL OR A CERTIFICATE OF LICENSE
14 ISSUED BY ANOTHER STATE, HE SHALL FURNISH DOCUMENTARY EVIDENCE, TO
15 THE SATISFACTION OF THE BOARD, THAT HE HAS COMPLETED COURSES OF
16 STUDY WHICH ARE AT LEAST EQUIVALENT TO THE MINIMUM STANDARDS
17 ESTABLISHED BY THE BOARD IN ITS RULES.

18 32-3523 Qualifications

19 AN APPLICANT FOR A LICENSE SHALL:

20 1. BE A HIGH SCHOOL GRADUATE OR THE EQUIVALENT AS
21 PRESCRIBED BY THE BOARD IN ITS RULES.

22 2. BE A GRADUATE OF A RESPIRATORY THERAPY TRAINING
23 PROGRAM.

24 3. HAVE PASSED A WRITTEN EXAMINATION APPROVED BY THE
25 BOARD.

1 4. NOT HAVE COMMITTED ACTS OR CRIMES WHICH CONSTITUTE
2 GROUNDS FOR DENIAL OF A LICENSE OR DISCIPLINARY ACTION PURSUANT TO
3 SECTION 32-3552.
4 32-3524 Licensure without examination
5 THE BOARD MAY ISSUE A LICENSE TO AN APPLICANT WITHOUT
6 EXAMINATION IF THE APPLICANT:
7 1. FILES AN APPLICATION PURSUANT TO SECTION 32-3522.
8 2. SATISFIES THE REQUIREMENTS PRESCRIBED IN SECTION 32-3528
9 PARAGRAPHS 1, 4, AND 5.
10 3. AT THE TIME OF HIS APPLICATION IS EITHER:
11 (a) LICENSED AS A LICENSED RESPIRATORY CARE PRACTITIONER
12 IN ANOTHER STATE IN WHICH, IN THE OPINION OF THE BOARD, THE
13 LICENSURE REQUIREMENTS ARE AT LEAST EQUIVALENT TO THOSE IN
14 THIS STATE, AND HAS PASSED, TO THE SATISFACTION OF THE BOARD,
15 AN EXAMINATION IN THE STATE WHERE HE IS LICENSED THAT IS, IN
16 THE OPINION OF THE BOARD, EQUIVALENT TO THE EXAMINATION GIVEN
17 UNDER ITS DIRECTION. OR
18 (b) REGISTERED AS A RESPIRATORY THERAPIST OR CERTIFIED
19 AS A RESPIRATORY THERAPY TECHNICIAN BY THE NATIONAL BOARD FOR
20 RESPIRATORY CARE, INC.
21 32-3524. Renewal of license
22 A LICENSE ISSUED UNDER THIS CHAPTER IS SUBJECT TO RENEWAL
23 EVERY OTHER YEAR ON OR BEFORE THE BIRTHDAY OF THE LICENSEE AND
24 EXPIRES UNLESS RENEWED. THE BOARD MAY REINSTATE A LICENSE
25 CANCELLED FOR FAILURE TO RENEW ON COMPLIANCE WITH BOARD
26 REQUIREMENTS FOR RENEWAL OF LICENSES.

1 32-3526. Fees

2 THE BOARD SHALL BY RULE ESTABLISH AND COLLECT FEES INCLUDED
3 BUT NOT LIMITED TO FEES FOR THE FOLLOWING:
4 1. APPLICATION FOR A LICENSE,
5 2. AN APPLICATION BASED ON A DIPLOMA FROM A FOREIGN
6 RESPIRATORY THERAPY SCHOOL,
7 3. AN INITIAL LICENSE,
8 4. A RENEWAL OF A LICENSE,
9 5. A DUPLICATE LICENSE,
10 6. AN EXAMINATION FEE.

11 32-3551. Use of title; initials

12 A. A PERSON WHO IS LICENSED PURSUANT TO THIS CHAPTER MAY:
13 1. USE THE TITLE LICENSED "RESPIRATORY CARE
14 PRACTITIONER" OR THE INITIALS "R.C.P." OR ANY OTHER WORDS, INITIALS
15 OR SYMBOLS WHICH INDICATE THAT HE IS A LICENSED RESPIRATORY CARE
16 PRACTITIONER.
17 2. USE AN INITIAL OR OTHER SUFFIX WHICH INDICATES
18 POSSESSION OF A SPECIFIC ACADEMIC DEGREE EARNED AT AN INSTITUTION
19 ACCREDITED BY AN ACCREDITING AGENCY RECOGNIZED BY THE NATIONAL
20 COMMISSION ON ACCREDITING WHICH THE BOARD DETERMINES IS AT LEAST
21 EQUIVALENT TO ITS MINIMUM STANDARDS.
22 3. USE AN INITIAL OR INITIALS WHICH INDICATE POSSESSION
23 OF A SPECIFIC CREDENTIAL ISSUED BY THE NATIONAL BOARD FOR
24 RESPIRATORY CARE, INC.
25 B. A PERSON WHO IS LICENSED PURSUANT TO THIS CHAPTER SHALL
26 NOT USE THE PREFIX "DR.," THE WORD "DOCTOR" OR ANY OTHER PREFIX,

1 SUFFIX OR INITIALS WHICH INDICATE OR IMPLY THAT HE IS LICENSED
2 PURSUANT TO ANY OTHER CHAPTER OF THIS TITLE IF HE IS NOT; HOWEVER,
3 THIS SHALL NOT PROHIBIT A PERSON WHO HOLDS A DOCTOR OF PHILOSOPHY
4 DEGREE FROM USING AN APPROPRIATE PREFIX, SUFFIX OR INITIALS SO LONG
5 AS HE DOES NOT DO SO WITH THE INTENT OF CONVEYING THE IMPRESSION
6 THAT HE IS LICENSED PURSUANT TO ANY OTHER CHAPTER OF THIS TITLE.
7 33-3552 <u>Grounds for denial of licenses or disciplinary action,</u>
8 <u>appeal</u>
9 A. THE BOARD MAY DENY AN APPLICATION FOR A LICENSE OR TAKE
10 DISCIPLINARY ACTION PURSUANT TO SECTION 32-3553 FOR ANY OF THE
11 FOLLOWING CAUSES:
12 1. FRAUD IN PROCURING A LICENSE PURSUANT TO THIS
13 CHAPTER.
14 2. KNOWINGLY EMPLOYING UNLICENSED PERSONS WHO REPRESENT
15 THEMSELVES AS LICENSED RESPIRATORY CARE PRACTITIONERS.
16 3. UNPROFESSIONAL CONDUCT AS DEFINED IN THIS ACT.
17 B. DECISIONS OF THE BOARD ARE SUBJECT TO JUDICIAL REVIEW
18 PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.
19 32-3553 <u>Disciplinary action; duty to report; immunity;</u>
20 <u>proceedings; board action</u>
21 A. THE BOARD ON ITS OWN MOTION MAY INVESTIGATE ANY EVIDENCE
22 WHICH APPEARS TO SHOW THE EXISTENCE OF ANY OF THE CAUSES FOR
23 DISCIPLINARY ACTION PRESCRIBED IN SECTION 32-3552 OR THAT A
24 LICENSED RESPIRATORY CARE PRACTITIONER IS OR MAY BE PROFESSIONALLY
25 INCOMPETENT OR IS OR MAY BE MENTALLY OR PHYSICALLY UNABLE TO ENGAGE
26 SAFELY IN THE PRACTICE OF RESPIRATORY CARE. ANY LICENSED

1 RESPIRATORY CARE PRACTITIONER, THE ARIZONA SOCIETY FOR RESPIRATORY
2 CARE OR ANY HEALTH CARE INSTITUTION AS DEFINED IN SECTION 36-401
3 SHALL, AND ANY OTHER PERSON MAY, REPORT TO THE BOARD ANY
4 INFORMATION THE LICENSED RESPIRATORY PRACTITIONER HEALTH CARE
5 INSTITUTION, SOCIETY OR INDIVIDUAL MAY HAVE, WHICH APPEARS TO SHOW
6 THE EXISTENCE OF ANY OF THE CAUSES FOR DISCIPLINARY ACTION
7 PRESCRIBED IN SECTION 32-3552 OR THAT A LICENSED RESPIRATORY CARE
8 PRACTITIONER IS OR MAY BE PROFESSIONALLY INCOMPETENT OR IS OR MAY
9 BE MENTALLY OR PHYSICALLY UNABLE TO ENGAGE SAFELY IN THE PRACTICE
10 OF RESPIRATORY CARE.
11 B. ANY LICENSED RESPIRATORY CARE PRACTITIONER, HEALTH CARE
12 INSTITUTION OR OTHER PERSON WHO REPORTS OR PROVIDES INFORMATION TO
13 THE BOARD IN GOOD FAITH SHALL NOT BE SUBJECT TO AN ACTION FOR CIVIL
14 DAMAGES AS A RESULT OF REPORTING THE INFORMATION, AND THE NAME OF
15 THE REPORTER IF REQUESTED SHALL NOT BE DISCLOSED UNLESS THE
16 INFORMATION IS ESSENTIAL TO PROCEEDINGS CONDUCTED PURSUANT TO THIS
17 SECTION. IT IS AN ACT OF UNPROFESSIONAL CONDUCT FOR ANY LICENSED
18 RESPIRATORY CARE PRACTITIONER TO FAIL TO REPORT AS REQUIRED BY THIS
19 SECTION. ANY HEALTH CARE INSTITUTION WHICH FAILS TO REPORT AS
20 REQUIRED BY THIS SECTION SHALL BE REPORTED BY THE BOARD TO THE
21 INSTITUTION'S LICENSING AGENCY.
22 C. THE BOARD SHALL NOTIFY THE LICENSED RESPIRATORY CARE
23 PRACTITIONER ABOUT WHOM INFORMATION HAS BEEN RECEIVED AS TO THE
24 CONTENT OF THE INFORMATION WITHIN SIXTY DAYS OF RECEIPT OF THE
25 INFORMATION.

1 D. A HEALTH CARE INSTITUTION SHALL INFORM THE BOARD WHEN THE
2 PRIVILEGES OF A LICENSED RESPIRATORY CARE PRACTITIONER TO PRACTICE
3 IN THE HEALTH CARE INSTITUTION ARE REVOKED, SUSPENDED OR LIMITED
4 DUE TO ANY CAUSE LISTED IN SECTION 32-3552, ALONG WITH A GENERAL
5 STATEMENT OF THE REASONS WHICH LED THE HEALTH CARE INSTITUTION TO
6 TAKE THE ACTION. THE BOARD SHALL INFORM ALL OTHER HEALTH CARE
7 INSTITUTIONS IN THIS STATE OF THE REVOCATION, SUSPENSION OR
8 LIMITATION, AND THE GENERAL REASON FOR THIS ACTION, WITHOUT
9 DIVULGING THE NAME OF THE REPORTING HEALTH CARE INSTITUTION.
10 E. IF THE BOARD FINDS, BASED ON THE INFORMATION IT RECEIVED
11 PURSUANT TO THIS SECTION, THAT THE PUBLIC HEALTH, SAFETY OR WELFARE
12 IMPERATIVELY REQUIRES EMERGENCY ACTION, AND INCORPORATES A FINDING
13 TO THAT EFFECT IN ITS ORDER, THE BOARD MAY ORDER A SUMMARY
14 SUSPENSION OF A LICENSE PENDING PROCEEDINGS FOR REVOCATION OR OTHER
15 ACTION. IF AN ORDER OF SUMMARY SUSPENSION IS ISSUED, THE LICENSEE
16 SHALL ALSO BE SERVED WITH A WRITTEN NOTICE OF COMPLAINT AND FORMAL
17 HEARING, SETTING FORTH THE CHARGES MADE AGAINST HIM, AND IS
18 ENTITLED TO A FORMAL HEARING BEFORE THE BOARD ON THE CHARGES WITHIN
19 SIXTY DAYS.
20 F. IF, AFTER COMPLETING ITS INVESTIGATION, THE BOARD FINDS
21 THAT THE INFORMATION PROVIDED PURSUANT TO THIS SECTION IS NOT OF
22 SUFFICIENT SERIOUSNESS TO MERIT DIRECT ACTION AGAINST THE LICENSE
23 OF THE LICENSED RESPIRATORY CARE PRACTITIONER, IT MAY TAKE EITHER
24 OF THE FOLLOWING ACTIONS:
25 1. DISMISS IF, IN THE OPINION OF THE BOARD, THE
26 INFORMATION IS WITHOUT MERIT.

1 2. FILE A LETTER OF CONCERN IF, IN THE OPINION OF THE
2 BOARD, WHILE THERE IS INSUFFICIENT EVIDENCE TO SUPPORT DIRECT
3 ACTION AGAINST THE LICENSE OF THE LICENSED RESPIRATORY CARE
4 PRACTITIONER, THERE IS SUFFICIENT EVIDENCE FOR THE BOARD TO NOTIFY
5 THE LICENSED RESPIRATORY CARE PRACTITIONER THAT THE CONTINUATION
6 OF THE ACTIVITIES WHICH LED TO THE INFORMATION BEING SUBMITTED TO
7 THE BOARD MAY RESULT IN ACTION AGAINST THE LICENSED RESPIRATORY
8 CARE PRACTITIONER'S LICENSE.
9 G. IF, IN THE OPINION OF THE BOARD, AND AFTER COMPLETING THE
10 INVESTIGATION, IT APPEARS SUCH INFORMATION IS OR MAY BE TRUE, THE
11 BOARD MAY REQUEST AN INTERVIEW WITH THE LICENSED RESPIRATORY CARE
12 PRACTITIONER CONCERNED. IF THE LICENSED RESPIRATORY CARE
13 PRACTITIONER REFUSES THE INVITATION FOR AN INFORMAL INTERVIEW OR
14 IF HE ACCEPTS THE INVITATION AND IF THE RESULTS OF THE INTERVIEW
15 INDICATE SUSPENSION OR REVOCATION OF HIS LICENSE MIGHT BE IN ORDER,
16 A FORMAL COMPLAINT SHALL BE ISSUED AND A FORMAL HEARING SHALL BE
17 HELD. IF, AFTER COMPLETING THE INVESTIGATION, AT THE INFORMAL
18 INTERVIEW, THE BOARD FINDS THE INFORMATION PROVIDED PURSUANT TO
19 THIS SECTION IS NOT OF SUFFICIENT SERIOUSNESS TO MERIT SUSPENSION
20 OR REVOCATION OF LICENSE, IT MAY TAKE THE FOLLOWING ACTIONS:
21 1. DISMISS IF, IN THE OPINION OF THE BOARD, THE
22 INFORMATION IS WITHOUT MERIT.
23 2. FILE A LETTER OF CONCERN IF, IN THE OPINION OF THE
24 BOARD, WHILE THERE IS INSUFFICIENT EVIDENCE TO SUPPORT DIRECT
25 ACTION AGAINST THE LICENSE OF THE LICENSED RESPIRATORY CARE
26 PRACTITIONER, THERE IS SUFFICIENT EVIDENCE FOR THE BOARD TO NOTIFY

1 THE LICENSED RESPIRATORY CARE PRACTITIONER THAT CONTINUATION OF THE
2 ACTIVITIES WHICH LED TO THE INFORMATION BEING SUBMITTED TO THE
3 BOARD MAY RESULT IN ACTION AGAINST THE LICENSED RESPIRATORY CARE
4 PRACTITIONER'S LICENSE.
5 3. ISSUE A DECREE OF CENSURE WHICH CONSTITUTES AN
6 OFFICIAL ACTION AGAINST THE RESPIRATORY CARE PRACTITIONER'S
7 LICENSE.
8 4. FIX A PERIOD AND TERMS OF PROBATION BEST ADAPTED TO
9 PROTECT THE PUBLIC HEALTH AND SAFETY AND REHABILITATE OR EDUCATE
10 THE LICENSED RESPIRATORY CARE PRACTITIONER CONCERNED. FAILURE TO
11 COMPLY WITH ANY SUCH PROBATION IS CAUSE FOR FILING A SUMMONS,
12 COMPLAINT AND NOTICE OF HEARING PURSUANT TO THIS SECTION BASED ON
13 THE INFORMATION CONSIDERED BY THE BOARD AT THE INFORMAL INTERVIEW
14 AND ANY OTHER ACTS OR CONDUCT ALLEGED TO BE IN VIOLATION OF THIS
15 CHAPTER OR RULES ADOPTED PURSUANT TO THIS CHAPTER.
16 H. IF THE BOARD FINDS THAT THE INFORMATION PROVIDED PURSUANT
17 TO THIS SECTION WARRANTS SUSPENSION OR REVOCATION OF A LICENSE
18 ISSUED UNDER THIS CHAPTER, FORMAL PROCEEDINGS FOR THE REVOCATION
19 OR SUSPENSION OF THE LICENSE SHALL BE IMMEDIATELY INITIATED AS
20 PROVIDED IN TITLE 41, CHAPTER 6, ARTICLE 1.
21 32-3554. Reinstatement of license; modification of probation
22 A. IF A LICENSED RESPIRATORY CARE PRACTITIONER HAS HIS
23 LICENSE REVOKED OR PROBATION IMPOSED HE MAY APPLY TO THE BOARD FOR
24 REINSTATEMENT OF HIS LICENSE OR MODIFICATION OF THE CONDITIONS OF
25 HIS PROBATION ONE YEAR AFTER THE DATE OF REVOCATION OR IMPOSITION
26 OF PROBATION.

1 B. THE BOARD MAY ACCEPT OR REJECT AN APPLICATION FOR
2 REINSTATEMENT OR MODIFICATION OF PROBATION AND MAY REQUIRE AN
3 EXAMINATION FOR REINSTATEMENT OR MODIFICATION.
4 32-3555. Hearings and investigations; subpoenas
5 A. THE BOARD MAY ISSUE SUBPOENAS TO COMPEL ATTENDANCE OF
6 WITNESSES AND PRODUCTION OF DOCUMENTS AND ADMINISTER OATHS, TAKE
7 TESTIMONY, HEAR OFFERS OF PROOF AND RECEIVE EXHIBITS IN EVIDENCE
8 IN CONNECTION WITH A BOARD INVESTIGATION OR HEARING. IF A BOARD
9 SUBPOENA IS DISOBEYED, THE BOARD MAY INVOKE THE AID OF ANY COURT
10 IN THIS STATE IN REQUIRING THE ATTENDANCE AND TESTIMONY OF
11 WITNESSES AND THE PRODUCTION OF DOCUMENTARY EVIDENCE.
12 B. ANY PERSON APPEARING BEFORE THE BOARD MAY BE REPRESENTED
13 BY COUNSEL.
14 32-3556. Unlawful acts
15 IT IS UNLAWFUL FOR ANY PERSON TO:
16 1. ENGAGE IN THE PRACTICE OF RESPIRATORY CARE UNLESS
17 HE IS LICENSED OR EXCEPTED FROM LICENSURE PURSUANT TO THIS CHAPTER.
18 2. REPRESENT HIMSELF TO BE A LICENSED RESPIRATORY CARE
19 PRACTITIONER OR AN INHALATION THERAPIST OR USE THE LETTERS "R.C.P."
20 OR "I.T." UNLESS HE IS LICENSED PURSUANT TO THIS CHAPTER.
21 32-3557. Injunctive Relief
22 IN ADDITION TO ALL OTHER REMEDIES, WHEN IT APPEARS TO THE
23 BOARD, EITHER UPON COMPLAINT OR OTHERWISE, THAT ANY PERSON HAS
24 VIOLATED ANY PROVISION OF THIS CHAPTER OR ANY RULE OR REGULATION
25 OF THE BOARD, THE BOARD MAY THROUGH THE ATTORNEY GENERAL OR THE
26 COUNTY ATTORNEY OF THE COUNTY IN WHICH THE VIOLATION IS ALLEGED TO

1 HAVE OCCURRED APPLY TO THE SUPERIOR COURT OF THAT COUNTY FOR AN
2 INJUNCTION RESTRAINING SUCH PERSON FROM ENGAGING IN SUCH VIOLATION.
3 A TEMPORARY RESTRAINING ORDER, A PRELIMINARY INJUNCTION OR A
4 PERMANENT INJUNCTION SHALL BE GRANTED WITHOUT BOND. ANY PROCESS
5 IN SUCH ACTION MAY BE SERVED UPON THE DEFENDANT IN ANY COUNTY OF
6 THIS STATE WHERE HE IS FOUND.
7 32-3558. Violations; classification
8 A PERSON WHO VIOLATES ANY PROVISION OF THIS CHAPTER IS GUILTY
9 OF A CLASS 1 MISDEMEANOR.
10 33-3559. Severability
11 SHOULD ANY PORTION OF THIS ACT BE DECLARED UNLAWFUL OR VOID,
12 THE REMAINDER OF THIS ACT SHALL REMAIN IN EFFECT.
13 Section 3. Section 41-2368.05, Schedule for Termination; July
14 1999
15 Section 41-2368.05 is added to read:
16 The following agencies shall terminate on
17 July 1, 1999:
18 1. THE BOARD OF RESPIRATORY CARE EXAMINERS.
19 Section 4. Current respiratory care practitioners; licensure
20 Any person who is actively engaged in the practice of
21 respiratory care, as defined in section 32-3501, Arizona Revised
22 Statutes, in this state on the effective date of this act may
23 continue to engage in the practice of respiratory care without
24 being licensed until December 31, 1991, if he applies for licensure
25 on or before March 1, 1991, and any such person shall be exempt

1 from the formal training requirements prescribed in
2 section 32-3523, paragraph 2, Arizona Revised Statutes.
3 Section 5. Initial terms of board members
4 A. Notwithstanding section 32-3502, Arizona revised
5 statutes, the initial term of members are:
6 1. one term ending on June 30, 1991.
7 2. two terms ending on June 30, 1992.
8 3. two terms ending on June 30, 1993.
9 B. The governor shall make all subsequent appointments as
10 prescribed by statute.
11 Section 6. Appropriation; purpose; exemption from lapsing;
12 repayment
13 A. The sum of twenty-five thousand dollars is appropriated
14 in fiscal year 1991-1992 from the state general fund to the board
15 of respiratory care examiners for start-up costs associated with
16 the provisions of this act. This appropriation is exempt from the
17 provisions of section 35-190, Arizona Revised Statutes, relating
18 to lapsing of appropriations.
19 B. Notwithstanding the provisions of section 32-3505,
20 Arizona Revised Statutes, as added by this act, the state treasurer
21 shall deposit ten percent of the monies collected pursuant to this
22 act in the state general fund in accordance with the requirements
23 of section 32-3505, Arizona Revised Statutes, as added by this act,
24 an additional ten percent of the monies collected pursuant to this
25 act in the state general fund to repay the state general fund for
26 the appropriation made in subsection A of this section, and

1 transfer the remaining eighty percent to the board of respiratory
2 care examiners fund until such time that all monies appropriated
3 pursuant to subsection A of this section have been repaid to the
4 state general fund. If the monies have not been repaid in full by
5 June 30, 1992, the state treasurer shall transfer from the board
6 of respiratory care examiners fund to the state general fund such
7 monies as necessary to repay in full the amount appropriated in
8 subsection A of this section.
9

ARIZONA STATE LEGISLATURE

Thirty-ninth Legislature - First Regular Session
Joint Interim Committee Meeting

MINUTES OF JOINT LEGISLATIVE OVERSIGHT COMMITTEE

DATE: September 20, 1989 **TIME:** 9:30 a.m. **ROOM:** House HR 3

Chairman Sossaman called the meeting to order at 9:40 a.m. and roll call was taken.

Members Present

Senator Mawhinney	Representative Hink
Senator Osborn	Representative McLendon
Senator Rios	Representative Wessel
Senator Sossaman	Representative B. Burns

Members Absent

Senator Stump	Representative McCune

Speakers Present

Douglas R. Norton, Auditor General
Norman Moore, House Staff

Norman Moore, House Staff, addressed the committee regarding the assignment of the Respiratory Therapist applicant group to the appropriate Committees of Reference for the Sunrise Process. (Attachment A)

Representative Burns moved, seconded by Representative Hink, that the application be assigned to the House Tourism, Professions & Occupations Committee and the Senate Health, Welfare, Aging & Environment Committee. The motion carried.

Mr. Moore answered questions by committee members. He briefly updated the committee on the audits of agencies in the 1990 Sunset schedule. (Attachment B)

Douglas Norton, Auditor General, addressed the committee and reported that the Department of Corrections is scheduled for five different areas of auditing. He requested direction from the Legislature if there was a need for a report on any issue for the next legislative session.

Senator Osborn requested that Mr. Norton expedite the audit for the DOC's Parole Eligibility and Alternative Programs, but at the same time, he requested that they continue the process for the Board of Paroles and Pardons.

Senator Sossaman noted that another meeting date would have to be set for the near future. Without objection, the meeting adjourned at 9:55 a.m.

Dorothy Rademaker, Secretary

dmr

9/21/89

MINUTES OF

HOUSE TOURISM, PROFESSIONS AND OCCUPATIONS COMMITTEE
AND
SENATE HEALTH, WELFARE, AGING AND ENVIRONMENT COMMITTEE

COMMITTEE OF REFERENCE
RESPIRATORY THERAPISTS

DATE: Thursday, November 2, 1989

TIME: 9:30 a.m.

PLACE: House Hearing Room 2

SUBJECT: Sunrise Hearing of Application of Respiratory Therapists for Regulation

Co-chairman Wrzesinski called the meeting to order at 9:42 a.m. and roll call was taken:

MEMBERS PRESENT:

Representative Wrzesinski, Co-chairman
Representative Jackson
Representative Nagel
Senator Hays, Co-chairman
Senator Gutierrez

MEMBERS ABSENT:

Representative R. Burns
Representative Ortega
Senator Brewer
Senator Patterson
Senator Stephens

Representative Wrzesinski asked if anyone was present who would be speaking against regulation of respiratory therapists and no one responded.

DALE PONTIUS, Attorney representing the Arizona Society for Respiratory Care, introduced **DR. BARRY FISHER, a Pediatric Pulmonologist with Phoenix Children's Hospital**, who explained the need for qualified respiratory therapists.

Dr. Fisher stated the trend in medicine today is toward greater home care with less supervision, therefore the necessity for respiratory therapists who are answerable to a minimum standard is crucial. He said in his practice, he now has twelve infants and children on home ventilators requiring home respiratory therapist visits at least twice a week. He explained respiratory therapists are not only required to manage equipment and perform treatments, but are also required to make assessments and to know the effects of drugs being administered to patients.

Dr. Fisher stated at Children's Hospital they only hire respiratory therapists who have certification credentials because it is essential for a minimum standard of care for infants. He concluded he thought it appropriate that respiratory therapists be licensed, as other medical professions, and pointed out that patients do not have a choice when it comes to needing a respiratory therapist; a doctor simply selects one for them.

Senator Hays questioned how much abuse now exists in this field within the State. Dr. Fisher responded less than one-half of the respiratory therapists now practicing are credentialed. He said he personally feels anyone practicing must be credentialed.

In response to Senator Hays, Dr. Fisher explained a respiratory therapist takes a first phase exam for certification, then registration, but there is no provision for licensure in statute.

Representative Wrzesinski stated there was a difference between assessment of a medical condition and establishing a diagnosis and functioning from that point on and asked if the goal of the respiratory therapists is to regularly make assessments or just in cases of emergency. Dr. Fisher replied a respiratory therapist can regularly assess if a patient is having an adverse effect to medication or if equipment is faulty, etc. and they should be qualified to do so.

Representative Wrzesinski inquired if they ever envision a time when a respiratory therapist would be able to open an office, perhaps for the treatment of asthma. Dr. Fisher said he did not and if they do work in an office, it must be under the supervision of a physician.

Representative Wrzesinski asked if a high school diploma is sufficient basic education for entrance into a respiratory therapist school when they face so many grave medical conditions on a regular basis. Dr. Fisher responded that a person who completes an approved school, passes a certifying exam and works under the supervision of a physician should be qualified to handle medical conditions required of this field.

Dr. Fisher explained that a respiratory therapist performs a variety of tasks including inhalation therapy, chest physiotherapy and ventilation support and if they do not perform effectively, they are causing damage to the public. He also stated that by not having a licensure law you cannot require continuing education for these therapists.

Representative Jackson inquired why it has taken Arizona so long to require licensure. Dr. Fisher stated they would like the same answer and the medical field agrees they should be licensed.

Representative Wrzesinski asked Dr. Fisher if he thought it satisfactory that respiratory therapists set their own standards or should another group be involved such as the Pulmonary Therapist Association. Dr. Fisher stated an

examination approved by the Respiratory Therapist Board would be the minimum standard he would be comfortable with and if the proposed legislation were passed he would be satisfied.

Dale Pontius explained the purpose of this meeting was to provide the Committee with as much education and insight to the scope of practice of a respiratory therapist and proceeded to show the members two videotapes relating to the scope and practice of respiratory therapy.

LEANNA REECE, President, Arizona Society for Respiratory Care, explained she represented the Arizona branch of the National Association which represents 1,400 Arizona respiratory therapists. She added that nationally, twenty-five states and Puerto Rico have recognized the need for minimum requirements for certification. She explained that current Arizona practice allows for voluntary certification, meaning if a therapist cannot pass the certification exam, they are still able to work and if they are negligent, employers cannot pass that information on. She stated therapists from other states who cannot pass their exams come to Arizona to work and concluded the respiratory therapists profession is at risk by being represented by unqualified individuals.

In response to Representative Wrzesinski, Ms. Reece state the requirement for completion of a one-year program was merely to set minimum standards, even though there are two-year and four-year programs available.

Again in response to Representative Wrzesinski, Ms. Reece stated that when an individual becomes eligible to take the exam, they are issued a temporary license which allows them to work for one year and take the exam during that period three times if needed. If they do not pass the exam in that period, further education would be required.

In response to Representative Nagel, Ms. Reece explained those respiratory therapists who are grandfathered in with this proposed legislation would be allowed to take a review course before taking the examination. She stated this legislation has the support of the respiratory therapists profession.

Ms. Reece explained the first obstacle they had to overcome was the issue of paying dues and the licensure fee, but as time passed, they felt they could pretty well offset that expense. Mr. Pontius responded they did not have an exact figure, but thought the licensure fee would be less than $50.00 per year.

Representative Wrzesinski stated most health professionals set levels for the fees under which their Board can function and suggested they put a range in the proposed legislation that reflects the fee's cap.

Representative Wrzesinski asked if the respiratory therapists would be opposed to reporting inappropriate behavior of other respiratory therapists. Mr. Pontius responded the reporting requirement is presently included in the proposed legislation.

ED THOMAS, Respiratory Therapist Manager, Arizona Society for Respiratory Care, reviewed the areas of responsibility of respiratory therapists and stressed they were not interested in being independent and wanted to work under the direction of a physician.

Mr. Thomas stated among his concerns were that many other states require some type of licensure and those not meeting those qualifications come to Arizona to practice. He explained during the winter months Arizona has a higher need for respiratory therapists because of winter visitors and they have to rely on services who hire therapists at their own standards without the benefit of licensure requirements.

Mr. Thomas explained that if he hadn't taken the opportunity himself to further his education he would be behind the times in the respiratory therapist profession by about 20 years. He cited an incident where a respiratory therapist was fired from one hospital for stealing and using drugs, yet he went to work for another hospital a week later.

Representative Wrzesinski suggested the regulations include that hospitals in the State only hire certified respiratory therapists and asked Mr. Thomas what his feeling would be to include a recertification requirement after 5 or 7 years. Mr. Thomas stated a continuing education requirement would be acceptable.

BARBARA S. BRUNNER, representing herself, stated she spends a lot of time with respiratory therapists and requires inhalation treatment, antibiotics and chest physiotherapy because of her cystic fibrosis. She stated the competence of a respiratory therapist influences the quality of her life and was surprised to find out Arizona did not have a minimum standard for these professionals.

Mr. Pontius summarized that the testimony heard today indicates a need for a verification process to insure protection of the public. He stated he had not seen any evidence that licensure would result in increased health care costs and said the Board would be self-sufficient.

Senator Hays moved that legislative staff draft appropriate legislation covering the items discussed at today's meeting regarding licensing.

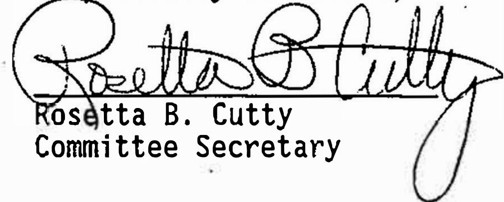
Representative Wrzesinski called for a five minute recess at 11:00 a.m. to gather a quorum to vote on the motion.

The meeting reconvened at 11:07 a.m. at which time Senator Hays withdrew his motion because a quorum was not present.

Senator Hays requested legislative staff draft appropriate legislation regarding the areas discussed at today's meeting.

Senator Gutierrez moved to adjourn the meeting at 11:09 a.m. Representative Jackson seconded the motion.

Respectfully submitted,



Rosetta B. Cutty
Committee Secretary

MINUTES OF THE MEETING OF THE

HOUSE TOURISM, PROFESSIONS, AND OCCUPATIONS COMMITTEE
AND
SENATE HEALTH, WELFARE, AGING AND ENVIRONMENT COMMITTEE

COMMITTEE OF REFERENCE FOR RESPIRATORY THERAPISTS
ON
SUNRISE HEARING OF APPLICATION OF RESPIRATORY THERAPISTS FOR REGULATION

Tuesday, December 12, 1989 9:00 a.m. H.H.R. 2

PRESENT

Representative R. Burns
Representative Jackson
Representative Ortega

Senator Brewer
Senator Gutierrez
Senator Patterson
Senator Stephens
Senator Hays, Co-Chairman

ABSENT

Representative Nagel
Representative Wrzesinski, Co-Chairman

OTHERS PRESENT

See attached attendance sheet

The meeting was called to order at 9:10 a.m. by Co-Chairman Hays and roll was taken by Senator Brewer. Senator Hays noted the meeting would be recorded on tape until a secretary could be obtained to take minutes.

Senator Hays stated the purpose of the meeting was to consider and review the proposed legislation on licensing respiratory therapists.

Dale Pontius, attorney, representing Arizona Society for Respiratory Care explained the proposed bill, which is a licensing proposal for respiratory practitioners. The bill would:

* establish a 5-member State Board for Respiratory Care, appointed by the Governor

* allow the State Board to license all respiratory practitioners in the State and everyone who was to practice after a 'grandfathering' period

* establish licensing requirements, such as:

  * having a high school education

  * graduating from an accredited respiratory therapy training program

  * passing a written examination -- basically the National accredited examination approved by the Board

  * determining whether a license applicant had committed any acts or crimes which would provide grounds for denial or renewal of license -- basically the unprofessional conduct statute is the same as in all the State statutes

* establish a scope of practice to follow the national guidelines which are fairly extensive

Mr. Pontius pointed out the practitioners would be acting under direct supervision and would not be acting on their own.

Senator Brewer asked if the bill was licensing two types of individuals, i.e., therapists and technicians. Mr. Pontius said that was correct. There are presently two types of practitioners: respiratory therapists and respiratory therapy technicians. When asked the difference of the two care providers by Senator Brewer, Mr. Pontius referred the question to Mr. Thomas.

Ed Thomas, Director of Respiratory Care Services, Thunderbird Samaritan Hospital explained the difference was primarily one of education. The technician level has a minimum of one year's education whereas the therapist has a minimum of two years of education. As far as their functions, Mr. Thomas said many technician-level individuals can do what many therapist-level individuals can do. The bill addresses primarily the educational level of the technician, i.e., trying to set a minimal education level in the State.

Senator Brewer inquired why there should be two different kinds of licenses when the individuals do practically the same things. Mr. Thomas explained only one license was being requested, and that would be for respiratory care practitioners, which would include both technicians and therapists. The terms 'technician' and 'therapist' are used because, at present, these are the more commonly used terms within the health care industry.

Senator Brewer questioned the use of the term 'practitioner' as it is a term usually used for physicians or possibly a nurse practitioner. Mr. Thomas said this term was adopted initially from legislation used in other states, and was not intended in any way to imply 'physician'. He stated

the bill specifically states a therapist must work under the direction of a physician.

Senator Brewer inquired if there would be reciprocity. Mr. Thomas said that had been included in the proposed bill on page 7, lines 40-46.

With regard to Senator Brewer's question on malpractice insurance for practitioners now and after becoming licensed, Mr. Thomas said at present this insurance was optional. Mr. Thomas said he had not personally looked into the cost of obtaining such malpractice insurance, but had been informed it was available through the national professional organization under a reasonable group rate.

Charline Franz, Vice President, Government Relation, Arizona Hospital Association spoke of the Association's concerns regarding the proposed bill. She stated the Association's general position was to oppose further licensing without showing the licensure will enhance the public's safety or improve health care services. The questions presented by the Association had not been answered as of this date, although Mr. Thomas was to speak to her group later this week.

Some questions posed to the respiratory therapists, but not yet answered, were:

* can they demonstrate the level of care will improve through licensure

* can they insure this new regulation will not drive up the cost of care to patients in hospitals or under home health care

* can they assure this will not result in shortages, particularly in the rural areas

* will agency be self-supporting in perpetuity, or will it have to come back to the State's general fund for its funding

Ms. Franz said if the Association receives satisfactory answers to its questions, it is possible it would change its stand on this legislation.

Senator Hays said he would be interested in the answers Ms. Franz might receive regarding the costs. Ms. Franz said she would provide the Chair with whatever information was gathered.

Senator Gutierrez commented about the 'benchmark' of cost containment being addressed by Ms. Franz in regard to using that as a 'benchmark' for the hospitals for the legislation they request. Ms. Franz responded that the hospitals' dilemma was how to pay for health care services when there were so many individuals unable to pay for their own services, which in turn raised the hospitals' health care costs tremendously.

In answer to questions from Mr. Ortega, Ms. Franz said she did believe that presently therapists are registered OJT (on the job training), but she did not have any percentage figures, although she understood that most of the respiratory therapists working in the hospitals in the State have had some kind of training. As to respiratory therapists, especially in the rural areas, who might be put suddenly into an emergency room situation, Ms. Franz replied that hospitals would not realistically hire people who are not trained because of the hospitals' liability exposure. Ms. Franz said she understood in talking with the therapists, the concern was primarily with those working outside the hospitals. She commented that being regulated did not guarantee there would be no mistakes made.

Senator Hays expressed concern over the impact of licensure on health care and its cost. He said personally he would not support anything that would increase the cost of health care.

Mr. Pontius responded that the cost impact is being looked at. He read a letter from Blue Cross in North Dakota (copy on file with original minutes) which stated examples of how the cost of using licensed respiratory therapists was less than using a lesser-trained individual for the same work. Mr. Pontius pointed out that an inexperienced person takes longer to do a job and does it less efficiently than the trained person.

In answer to Senator Brewer's question on malpractice insurance, Mr. Pontius said such insurance was available through the American Association and ran approximately $60/year under its group rate.

Senator Brewer stated she did not believe in licensing a lot of people, and did not feel she had received any compelling information to change her mind regarding the licensing of respiratory therapists. Mr. Pontius pointed out technology changed so fast, that to be effective and reliable, there should be some guideline requiring therapists to stay current with their profession. The respiratory practitioners would be required, under the licensing, to pass a nationally recognized examination established by the State Board.

Mr. Ortega inquired about who would be responsible for the cost involved in inspecting or requiring reports from a hospital or medical facility regarding a patient's treatment by a practitioner whose treatment had been questioned. Mr. Pontius said any such expenses incurred would be the responsibility of the State Board, and would be paid from the money it received from issuing licenses. The State Board would be a 90/10 agency and would be self-funded.

Mr. Ortega asked what assurance he had that the licensure of respiratory therapists would not negatively affect the rural communities, and what would be done to encourage such therapists to work in the rural areas. Mr. Pontius responded he could not answer that today, however, if the present therapists were well-trained already there should be no problem in them becoming licensed and staying where they are. If the rural

therapists today were not that well trained, then there might be a problem of them not passing the examination for their licenses.

Leanna Reece, President, Arizona Society for Respiratory Care had noted she would address the Committee, if needed. When called upon by Senator Hays, Ms. Reece said there was nothing further she needed to add.

Senator Stephens moved the Committee of Reference on Respiratory Therapists send this concept of the rough draft legislation on to the full Legislature for a full hearing. The motion was seconded by Senator Gutierrez.

Senator Stephens commented this did not guarantee the Committee's support of the bill, but by sending this bill out of Committee it would give the Legislature the opportunity to consider the licensing.

The motion passed on a roll call vote of 6 ayes, 2 noes and 2 not voting, as follows:

Ayes: Representatives Jackson and Ortega
Senators Hays, Gutierrez, Patterson and Stephens

Noes: Representative R. Burns
Senator Brewer

Not voting: Representatives Nagel and Wrzesinski

Senator Stephens explained his vote by saying he shared the concern about the costs, but thought the legislation would have a minor fiscal impact. He said he also felt a positive vote of this Committee would not ensure passage, but he believed the legislation deserved a hearing.

It was moved and seconded that the meeting adjourn at 10:05 a.m.

Respectfully submitted,

Sonja Wandro
Senate Committee Secretary

Attachment

MEETING OF COMMITTEE ON

RESPIRATORY THERAPISTS

Hearing Room No. 2

Date 12/12/89 9:00 Am

NAME	REPRESENTING	BILL NO.
Leanna Reece	Arizona Society for Resp. Care	
Phillip Strittmatter	Arizona State Professional Educators	
Ed Thomas	Az SRC	
Liz Greenwood	Az SRC	
Tony [illegible]	Az SRC	
Sam Lopez	~~[illegible]~~ Az SRC	
[illegible]	Az SRC	
[illegible] Marrietta		
[illegible]	Ariz Society for Respiratory Care	
William E. [illegible]	Az SRC / GSRMC	
Mark J Anderson	Az SRC / PCH	
Cherrie Mangano	Career One	
Joan Weaver	Career One	
Steve VanPatten	Career One	
Karen [illegible]	Az SRC	
Becky Shockley	Az SRC	
John Martin	Alhambra Dist	
Barry Matthews	PRCS	
Susan McGlaughlin	Career One	
[illegible]	Az. SRC	
John Stinner	AzSRC	
[illegible]	AzSRC	
[illegible]	Az SRC - MSMC	
Gail Clevenger	Az SRC	
Kimberly Brooks	AzSRC	
Maria La Marca	Az SRC [illegible]	
[illegible]	Az SRC	