A Review of the Need to License Respiratory Therapists in Virginia

Virginia Department of Health Professions

Virginia Board of Health Professions

September 25, 1995

EXECUTIVE SUMMARY

In response to a request from Senator Elliot Schewell, in response to the introduction of Senate Bill 100 in the 1995 General Assembly, and at the direction of the Secretary of Health and Human Resources, the Board of Health Professions and the Director of the Department of Health Professions prepared this report regarding the need to license respiratory therapists in Virginia. Current Virginia statute provides for voluntary certification of those who practice respiratory therapy and for the protection of certain titles used by those who are certified. The impetus for the present study centered around concern that current law allows anyone, even without certification, to provide respiratory therapy as long as not doing so using a protected title.

Proponents of licensure for respiratory care providers pointed out the highly technical nature of respiratory therapy procedures and equipment and the potential risk for serious harm to the patient. Opponents of licensure voiced concern over the potential increased costs to employers and consumers due to a reduction in the availability of respiratory care providers and over the potential loss of the ability to cross-train staff, which is believed to be particularly important in rural areas where staffing tends to be sparse.

As well as reviewing the relevant safety and cost issues, the Board also explored the competencies and standards of practice for respiratory therapists established within the Commonwealth and other jurisdictions in the United States. The Board applied its formal criteria and policies (see Appendices 1 and 2) to determine the feasibility of licensing this group and concluded the following:

1. **Given the danger involved in providing unqualified respiratory care, statutory title protection is insufficient to protect the public's health and safety. Licensure is warranted.**
2. **The definition of the practice of respiratory therapy found in Senate Bill 1000 is very broad and a more narrowly drawn defition should be used. A specific statutory definition needs to be established.**
3. **The economic impact of licensing respiratory therapists is minimal, when considering the threat to the public, an adequate supply of qualified individuals available, and that a structure is already in place to regulate respiratory therapists. No increase in fees should offset costs to the state.**

BACKGROUND

In Virginia, respiratory therapists are regulated by the Board of Medicine (§54.1-2900 et seq. of the Code of Virginia) as one of several allied health professions credentialed by this board within the Department of Health Professions. The current level of state regulation is limited to certification and title protection of individuals holding themselves out as a "respiratory therapist practitioner" or one of several related titles specified in law (see Appendix 3). Therefore, any person may render the services of a respiratory therapist

provided restricted titles are not assumed.

In the 1995 General Assembly Session, Senator Clarence A. Holland and others introduced Senate Bill 1000 (Appendix 4) to add to statute a definition of the practice of respiratory care and to provide for the licensure of respiratory therapists. Referred to the Senate Committee on Education and Health, no action was taken on the bill. However, the Senator Elliot Schewel, Chairman of the Committee, subsequently requested of the Board of Health Professions the need to change the regulation of respiratory therapists.

STUDY SCOPE AND METHODOLOGY

The primary focus of the study was to determine the safety issues relative to this profession by reviewing the general competencies and standards of practice for respiratory therapists established in the Commonwealth and other jurisdictions in the United States. Further, regulatory barriers to practice tend to restrict competition because only those who meet the regulatory requirements may legally practice. The supply of practitioners usually becomes curtailed as regulatory barriers increase, which generally results in a concomitant increase in the incomes of those regulated (Morrison & Carter, 1992). Given this general trend, the review also focused on obtaining statistics on the availability of current practitioners and the training institutions within the Commonwealth, on the settings for practice, and other information germane to determining the costs versus benefits of increasing the level of regulation to licensure.

Answers to the following questions served as the general outline for the study report:

- What is the degree of risk to the public that is attributable to the nature of the practice of respiratory therapy?
- What problems exist relative to current practice?
- Is the increased cost to the public due to increasing the level of regulation justified?
- Is licensure truly the least restrictive method of regulation consistent with the need for public protection?

Based on the answers to these questions taken from the available policy literature and a review of public comments, the Board used its Criteria for Evaluating the Need for Regulation (Appendix 1) and its policies for applying the criteria to determine the appropriate level of regulation (Appendix 2).

I. What is the degree of risk to the public that is attributable to the nature of the practice of respiratory therapy?

For private certification at the national level, one must have completed high school

and successfully graduated from an American Medical Association approved program to legally use the title "Certified Respiratory Therapy Technician." Approved programs usually require one academic year, and candidates must pass a written examination given by the National Board of Respiratory Care.

In Virginia, to use the title, "Respiratory Therapist," one must have graduated from an American Medical Association approved program, usually two academic years long, have successfully completed 62 semester hours of approved college credit, and passed an entry-level examination (Virginia Health Council, 1994).

Training programs for respiratory therapists and technicians consist of academic classes, evaluation of clinical situations, case studies and on-the-job training (Douce & Cullen, 1993).

Under the direction of a physician, respiratory care therapists and respiratory care technicians treat patients with breathing difficulties due to various health problems including those involving cardiopulmonary complications. They treat conditions that include asthma, emphysema, bronchitis and pneumonia as well as emergency care for victims with heart or lung failure, chest injuries, stroke, shock, premature birth, or post-surgical complications (Virginia Health Council, 1994). Routinely, respiratory therapists manage patient ventilators, monitor patient airways, and ensure that oxygen is delivered in the correct amount and at the right time (Moore, 1994). They have been identified as among the most diverse of any allied health care professionals, with the largest skill inventory of any allied health profession. Respiratory therapists are the only allied professionals formally trained and tested in providing respiratory care (Dubbs, 1995). They are skilled in over 100 clinical interventions, some crucial in maintaining the lives of seriously ill patients. These procedures include: administering various types of gases, pulmonary function tests, ventilator operation and maintenance checks (Commonwealth of Virginia Department of Regulatory Boards and Commission of Health Regulatory Boards, 1983) and, recently, invasive direct patient assessments and evaluation of cardiac and pulmonary function through means such as arterial blood gas puncture and analysis and echocardiographic analysis (Travis, 1995).

Respiratory therapists use a wide range of mechanical devices daily which require extensive training and demonstrated proficiency. These devices include, but are not limited to, mist-inhalation equipment to deliver medications, iron lungs to maintain breathing in those who suffer chest paralysis, oxygen tents, intubators which also

administer medicinal gases and aerosol drugs, and catheters (Mahlmeister & Mahlmeister, 1991). Clinicians, educators, managers, and physicians have predicted that safe entry level practice will eventually require completion of two years of initial training. Advanced training will require more time (Douce & Cullen, 1993). Further, as with all health care providers, it is anticipated that technological advances in equipment will require constantly updated training (Dubbs, 1995).

Errors in the administration of oxygen or other gases, improper ventilation assistance, or blood gas analysis can lead to prolonged hospital stays, patient relapse, or death (Virginia Health Council, 1994).

II. What problems exist relative to current practice?

There are three areas of concern in the current practice of respiratory care in Virginia: (A) not all providers of respiratory care are certified by the Board of Medicine, (B) disciplinary statistics point to the potential for greater malpractice suits against allied health professionals, and (C) home health care settings pose a new potential risk for patient harm due to respiratory care.

Not all providers of respiratory care are certified by the Board of Medicine.

Of the approximately 3,000 (2,000 full-time) providers of respiratory care in Virginia currently, only 80 percent are certified. The remaining 20 percent of practitioners have not been required to demonstrate minimal competency to the Board of Medicine. These individuals may not have been required by their employers to have any educational requirements or specialized training beyond what the employer provides (Travis, 1995).

The Board of Medicine has no jurisdiction over those it does not regulate. Thus, if harm is caused through the negligence of the unregulated respiratory practitioner, the consumer's redress would lie within the civil courts, only. Nothing will prevent continued rendering of respiratory services to the consuming public.

Disciplinary statistics.

Malpractice cases against all types of health care providers have grown rapidly since 1981. A 1988 Harvard University study stated that 80,000 deaths occur annually due to health care provider negligence (Mahlmeister & Mahlmeister, 1991). Although there are no national statistics on malpractice suits or health regulatory board cases against respiratory care providers, respiratory care

providers are becoming more closely scrutinized to determine whether any act or omission may have contributed to a patient's adverse outcome.

Nationally, at least two cases against respiratory therapists are known:

- In July, 1993, a man was awarded $250,00 when a respiratory therapist applied the wrong application to his airway. The man suffered permanent speech loss.
- In 1990, a jury awarded $482,000 to the family of a woman whose respiratory therapist accidentally disconnected her from her life support. The result was serious brain damage which eventually led to death (Moore, 1994).

There is no evidence that any malpractice cases have been filed with the courts against respiratory care therapists in Virginia. The Board of Medicine has adjudicated eight cases recently, but none against certified respiratory therapists involved substandard care. Six of these cases were dismissed with no violation found. Of the remaining two cases, one therapist was placed on probation for impairment and later reinstated, and the other has had her certification mandatorily revoked due to a felony conviction.

Home health care potential risks.

A relatively new area of potential risk is respiratory care in the home health care setting. The practice of respiratory care in the home setting has increased dramatically over the last ten years due to technological advances in the field and the need for a cost effective higher quality of life solution for respiratory patients outside an institutional setting (Hospital 1991). As early a 1991, respiratory care was the third most widely practiced form of home health care, behind in-home nursing and pacemaker assistance (Hospital, 1991).

Although home care respiratory patients generally do not need as high a degree of direct monitoring as hospital patients, respiratory care still poses a substantial threat if performed inappropriately. As in the hospital, home respiratory care must be delivered under the orders of a physician. However, in a hospital setting a physician or other advanced health care provider is usually nearby to provide assistance and oversight to the respiratory care provider. When the patient is in his own home, the availability of such support is severely curtailed. In the typical home health setting, the respiratory care provider is largely left alone to gather information about the patient's condition and monitor the efficacy of respiratory therapy on site to report back to the physician (Bunch, 1995).

III. Is the increased cost to the public due to increasing the level of regulation justified?

Public comment was solicited at a hearing held on August 15, 1995 with written comment received until August 30th. The notice for comment requested information related the issue of increasing the level of state regulation from certification to licensure. The majority of the comments could be divided into that provided by two opposing camps, opponents and proponents of licensure (See Appendix 6 for detailed points). Opponents consisted of health care institution representatives, while the proponents consisted of certified respiratory care providers and members of the general public.

Opponents to licensure voiced concern over a potential increase in cost, first to hospitals and other employers, and, ultimately to the consumer. This was seen as due to a reduced supply of legally available providers and an increase in salaries expected to be demanded by those licensed. They also noted that an increase in regulatory fees and malpractice insurance premiums may also result. No data were used to support either contention. However, the commenters cited the often similar findings documented in much of health provider regulatory policy literature (see Morrison & Carter, 1992).

Another issue cited by opponents was that licensure of respiratory therapy providers would prohibit these individuals from extending their skill base to other areas of health care and that other health care providers (e.g., nurses) would be barred from extending their skills to respiratory therapy -- in effect, blocking cross-training of hospital staff. Their concern was that small, rural hospitals would be especially affected because staffing shortages necessitate cross-training in a variety of essential therapeutic procedures.

Proponents countered the idea that increased cost is inevitable by noting that an ample supply of certified providers exists in Virginia, that approximately 80 percent of hospitals and home health care companies already require certification, and that approximately 80 percent of all of the current practitioners are already certified. These commenters cited a 1994 report released by the Virginia Hospital Association which indicated a relatively minor shortage of respiratory therapists, 1.5% (approximately 50 practitioners), across the state. This report also indicated that the shortage could be alleviated by students who were in the eight training programs across the state at the time (Virginia Hospital Association, 1994). Another source cited by this group stated that pools of applicants to respiratory care programs had significantly increased recently (Meredith, 1994). The proponents further argued that the potential salary cost effect could be offset by the increased supply of practitioners.

Proponents also indicated that the use of appropriately educated and trained respiratory practitioners may actually provide for a reduction in cost. They reported that a North Dakota Blue Cross Blue Shield study (no date reported) indicated that when appropriately educated and trained respiratory therapy providers were used versus less adequately trained personnel, the difference in cost per patient averaged $7.04 versus $22.00. The difference was believed to be due to a reduction in the number of laboratory and other evaluative procedures being conducted. The trained respiratory therapy providers were believed to be knowledgeable enough to use their own discretion in evaluating the patients' conditions without recourse to all of the procedures felt needed by the relatively untrained providers.

Finally, proponents also commented that the risk to public safety outweighs monetary concerns. Due to concerns over public safety, respiratory therapists are statutorily regulated in some form by 38 states including the District of Columbia and Puerto Rico. Of these, 30 states, D.C. and Puerto Rico require licensure (See Appendix 5). State certification is required in six others (Eicher & Munser, 1995). These commenters contended that the public may have a false sense of security in that they may not realize that approximately 20 percent of hospitals and other institutional employers do not require certified respiratory personnel. Further, they voiced concern that the current title protection in Virginia does not adequately protect the public because they argue that some employers deliberately use alternative, but potentially misleading, titling for their non-certified respiratory staff.

IV. Is the scope of practice of this profession distinguishable from other licensed, certified, or registered occupations?

The practice of respiratory therapy has become clearly recognizable as a distinct health care field. Respiratory therapists treat patients with breathing difficulties due to chronic and acute conditions, some involving the heart as well as the lungs. Treatments include temporary or long term therapy for lung disorders such as asthma, emphysema, bronchitis, or pneumonia and emergency care for victims of heart failure, chest injuries, stroke, shock, premature birth, or postsurgical complications.

Respiratory therapy providers share some duties with other health care practitioners such as physicians, nurses, and pharmacists, for example:

- chest or breathing therapy related to pulmonary care;
- arterial blood sampling and blood gas analysis; and

- the administration of drugs and medications.

However, many duties are specifically performed by respiratory care providers, including:

- ventilation support systems management;
- administration of drugs and aerosols to the cardio-pulmonary system;
- oxygen therapy interpretation and blood gas evaluations;
- cardio-pulmonary testing, treatment and monitoring; and
- direct patient assessment and evaluation of pulmonary function.

Further, there are organizations in nearly all states that recognize this profession. Nationally, there is the National Association for the Medical Direction of Respiratory Care. The American Medical Association Committee on Allied Health Education and Accreditation, the American Society of Anesthesiologists, the American College of Chest Physicians, and the American Thoracic Society all recognize respiratory therapy providers (Commonwealth of Virginia Department of Regulatory Boards and Commission of Health Regulatory Boards, 1983).

V. Is licensure truly the least restrictive method of regulation consistent with the need for public protection?

Based on the answers to the above questions and reference to Appendix 3, it was clear to the Board that licensure provides the least restrictive regulation required for public protection. First, due to the highly invasive nature of respiratory therapy, injury and even death can result from incompetent practice with even the most routine interventions (e.g., administration of medicinal gases). Second, a high degree of specialized training and clinical skill is essential also due to the technical complexity of respiratory therapy and the serious consequences of inept practice. Third, although respiratory therapists work at the direction of physicians, they practice without direct supervision and usually exercise a great degree of independent judgment. This can be particularly hazardous in home health care settings where the therapist is rarely certified and is customarily the only health care provider on site. Fourth, the cost of licensure is not expected to be burdensome. And finally, given the specialized nature of the profession the scope of practice could be defined in legally enforceable terms.

EVALUATION

Criterion One: Risk for Harm to the Consumer

The unregulated practice of the health occupation will harm the public health, safety or

welfare. The harm is recognizable and not remote or dependent on tenuous argument.

Respiratory care practitioners must be competent in the administration of care to prevent patient harm. There is a high amount of risk in the field due to the nature of the care provided. Respiratory care practitioners routinely use complex mechanical devices and invasive procedures (i.e., blood gas punctures) which require extensive training and demonstrated proficiency. (Mahlmeister 1991). Malpractice case evidence demonstrates the potential risk to the public. There have been two cases within the United States.

Criterion Two: Specialized Skills and Training

The practice of the health occupation requires specialized education and training, and the public needs to have benefits of assurance of initial and continuing occupational competence.

The practice of respiratory care has become a highly specialized profession. Currently, entry level training programs are approximately one year in length post high school. As technological advances continue, program length it is expected that program length may need to increase (Douce & Cullen, 1993).

The education of certified respiratory care providers requires education in physics, biology, pharmacology, anatomy and other lab sciences. They are trained to evaluate and monitor patients in the absence of a physician. They are trained to use complex, high-technology medical equipment, such as mechanical ventilators and iron lungs. No other allied health care provider group is formally trained to use this technology (Dubbs, 1995). These attributes distinguish respiratory care from other health care professions. It would be difficult to perform the tasks of an respiratory care provider without extensive training.

Criterion Three: Autonomous Practice

The functions and responsibilities of the practitioner require independent judgement and the members of the occupational group practice autonomously.

Respiratory therapists operate under the direction of a physician. However, most procedures are done in the physical absence of a physician. Respiratory care providers are in constant demand throughout health care facilities in patient rooms, in neonatal units, in intensive care units, and in cardiac care units, as well as in the home health setting (Virginia Health Council, 1994). Most institutions have a respiratory therapist on duty 24 hours a day. Under these circumstances, it would be impossible for a therapist to be under constant direct supervision. Therapists often must be able to use their own skill and judgement

autonomously to assess patients and perform procedures. These are usually situations in which no physician is present and the patient relies on only the therapist's on site skill and judgement.

Criterion Four: Scope of Practice

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation or therapeutic modalities.

The scope of practice of respiratory therapy providers may be readily distinguished from other regulated occupations, based on their unique training in respiratory care, on their use of specialized equipment, on their unique duties, as well as based on nationwide recognition of respiratory therapy providers as a separate allied health care profession.
The profession is highly distinguishable from those of other therapists as recognized by the majority of states today.

Criterion Five: Economic Impact

The economic costs to the public of regulating the occupational group are justified.

As described by those opposing licensure, the potential sources for an increased cost to the public due to licensure relate to the fees paid by the regulated group and to an increase in salary due to a reduced supply.

Current fees for certified respiratory therapists/technicians in Virginia are $100 for initial certification and $65 once every two years for renewal. Although the Board of Medicine is currently reducing fees for many of the professions it regulates, the fees for this group have remained at the current levels for some time. If you increase the number by 20 %, the fee should decrease.

The future supply of licensed respiratory care providers may be somewhat estimated based on those already certified (approximately 80% of those practicing currently) and the availability of new graduates. Currently, a minor (1.5%) shortage exists in certified and non-certified providers.

Proponents of licensure have pointed out that costs may actually decrease due to improved efficiency through elimination of unnecessary laboratory tests. Further, they contend that cost savings could be achieved because licensure would ensure that only individuals meeting the standards set by the Board of Medicine would be allowed to actually practice and that this should reduce malpractice cases for institutions as well as lead

to improved quality.

Criterion Six: Alternatives to Regulation

There are no alternatives to State regulation of the occupation which adequately protect the public.

One out of five respiratory therapy practitioners is not state certified. In home health settings there is little, if any, direct oversight by a physician or other health care licensee. Title protection of respiratory therapists, alone, cannot effectively protect the home health care patient. An alternative to licensure of respiratory therapists could be to regulate the procedures actually conducted in home health care settings.

Further, the statutory language regarding respiratory therapists does not define the duties of this group. If the procedures used by respiratory care providers is to be overseen by the state, clearer language defining what a respiratory therapist is needs to be adopted.

Licensure is the most restrictive form of professional and occupational regulation. However, under this form of regulation not only would language defining the duties of a respiratory therapy provider be developed, it would be illegal to practice respiratory therapy without meeting the state's practice requirements. Licensure is mandatory in 32 of the 38 states with some form of respiratory therapist regulation.

CONCLUSIONS

The chief conclusion from Board's evaluation is that licensure of respiratory therapists is warranted. All seven of the Board's evaluative criteria are met.

(1) The risk for harm to the consumer is real. Little direct supervision is evidenced in any practice setting, and it is conspicuously absent in home health settings. Errors made by respiratory therapists can result in long term injury and even be fatal.

(2) Respiratory therapists' highly specialized education and training is fundamental to public safety. Respiratory therapists must know how to adequately interpret and complete physicians' orders for respiratory analysis and care. They must know how to use safely use extremely complex and highly technical equipment. Further, as technology advances at an ever more rapid pace, their knowledge of respiratory analyses and interventions must keep pace.

(3) Respiratory therapists' independent judgment and autonomous practice are routinely called for. Because respiratory care, in one form or another, is in constant demand, most hospitals have respiratory therapists available on a 24-hour basis. The direct, on-site supervision of the physician giving orders may not be possible. In home health

settings, this is especially true. Should changes in the patient's status emerge quickly, the patient's wellbeing may rest entirely upon the respiratory therapist's knowledge and skill.

(4) The scope of practice of respiratory therapists, in practice, is clearly distinguishable. This view is shared by a majority of states.

Crafting of appropriate statutory language is beyond the scope of the current study. However, the Board deems that the definition in Senate Bill 1000(95) fails to provide a sufficiently clear definition. Consumers, health care providers, administrators, and the therapists, themselves should be consulted for guidance in the formulation of the language for the practice act.

(5) The economic impact of licensing respiratory therapists should be minimal. An adequate supply of practitioners is and should remain available. Further, because a regulatory structure is already in place under the Board of Medicine to certify respiratory therapists, only a small increase in fees to those regulated should be anticipated.

(6 & 7) The current statutory certification of respiratory therapists does not adequately protect the public against those who are insufficiently trained and call themselves "respiratory aides" or some other unrestricted title. The consequences of incompetent practice are severe, the supervision of respiratory therapists is slight, their training is clearly distinct from other allied health groups, and the cost associated with greater regulation is justified. The least restrictive form of regulation consistent with responsible public protection is licensure.

DIRECTOR'S ADDITIONAL COMMENTS

Consistent with the Governor's policies and initiatives, I have reviewed the study and the Board's conclusions and have determined the following.

The Board has fulfilled its role in evaluating the need to regulate respiratory therapists. Although licensure is typically viewed as a more restrictive form of regulation, in this instance, it is a more effective form because of the danger involved in continuing to allow unqualified individuals to practice relatively unsupervised.

Any licensure legislation that is enacted should include a definition of practice that is narrowly drawn in order to minimize any negative impact that may result. In addition, legislation should not affect the practice of any other currently licensed profession such as nurses who perform respiratory care services and the current exemption found in §54.1-2901.19 of the Code should be maintained.

Licensure of this group should also prove cost-effective. There is a sufficient supply of qualified therapists in Virginia. The cost to health care organizations and the public should be minor. The cost to the state could easily be offset by a minimal increase in the fees charged by the Board of Medicine which already regulates this group. There should be no effect on state employment.

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APPENDIX 1

VIRGINIA BOARD OF HEALTH PROFESSIONS
CRITERIA FOR EVALUATING THE NEED FOR REGULATION

Adopted October, 1991

Criterion One: Risk for Harm to the Consumer
The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

Criterion Two: Specialized Skills and Training
The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice
The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice
The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact
The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation
When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

APPENDIX 2

APPLICATION OF THE CRITERIA

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently, depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration and specifies the criteria applicable to each level.

LICENSURE

Licensure confers a monopoly upon a specific profession whose practice is well defined.

RISK: High potential, attributable to the nature of the practice.

SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.

AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.

SCOPE OF PRACTICE: Definable in enforceable legal terms.

COST: High

APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

STATUTORY CERTIFICATION

Certification is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.

SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.

AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.

SCOPE OF PRACTICE: Definable, but not stipulated in law.

COST: Variable, depending upon level of restriction of supply of practitioners.

APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

REGISTRATION

Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.

RISK: Low potential, but consumers need to know that redress is possible.

SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.

AUTONOMY: Variable.

APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.

APPENDIX 3

§ 54.1-2955. Restriction of titles.

It shall be unlawful for any person not holding a current and valid certificate from the State Board of Medicine to claim to be a respiratory therapy practitioner or to assume the title "Respiratory Therapist," "Respiratory Therapist, Registered," "Certified Respiratory Therapist," "Respiratory Therapist Practitioner," "Respiratory Practitioner," or "Certified Respiratory Therapy Practitioner," or any similar term or to assume the designations "R.T.," "R.T.R.," "C.R.T.," "R.T.P.," "R.P." or "C.R.T.P." However, a person who has graduated from a duly accredited educational program in respiratory therapy shall be exempt from the preceding prohibition until he has taken and received the results of an examination required by the Board or until one year from the date of graduation, whichever occurs sooner. This section shall not be construed to prohibit any person from claiming to practice respiratory therapy using the title "Respiratory Therapy Assistant, R.T.A." or other titles licensed or certified by the Commonwealth.

§ 54.1-2956. Advisory Board on Respiratory Therapy; appointment; terms; duties; etc.

A. The Advisory Board on Respiratory Therapy shall assist the Board in carrying out the provisions of this chapter regarding the qualifications, examination, registration and regulation of certified respiratory therapy practitioners.

The Advisory Board shall consist of five members appointed by the Governor for four-year terms. Three members shall be at the time of appointment respiratory therapy practitioners who have practiced for not less than three years, one member shall be a physician licensed to practice medicine in the Commonwealth, and one member shall be appointed by the Governor from the Commonwealth at large.

Vacancies occurring other than by expiration of term shall be filled for the unexpired term. No person shall be eligible to serve on the Advisory Board for more than two consecutive terms.

B. The Advisory Board shall, under the authority of the Board, recommend to the Board for its enactment into regulation the criteria for certification as a respiratory therapy practitioner and the standards of professional conduct for holders of certificates.

The Advisory Board shall also assist in such other matters dealing with respiratory therapy as the Board may in its discretion direct.

APPENDIX 4

APPENDIX 5
Regulation of Respiratory Therapists in U.S. Jurisdictions as of July 1995.

Jurisdiction	Regulation Level
Alabama	None
Alaska	None
Arizona	Licensure
Arkansas	Licensure
California	Licensure
Colorado	None
Connecticut	Licensure
District of Columbia	Licensure
Florida	Licensure
Georgia	Licensure
Hawaii	None
Idaho	Licensure
Illinois	None
Indiana	Licensure
Iowa	Certification
Kansas	Certification
Kentucky	Licensure
Louisiana	Licensure
Maine	Licensure
Maryland	Certification
Massachusetts	Licensure
Michigan	None
Minnesota	Certification
Mississippi	Licensure
Missouri	Certification
Montana	Licensure
Nebraska	Licensure
Nevada	None
New Hampshire	Licensure
New Jersey	Licensure
New Mexico	Licensure
North Dakota	Licensure
Ohio	Licensure
Oklahoma	Licensure
Oregon	Licensure
Pennsylvania	Licensure
Puerto Rico	Licensure
Rhode Island	Licensure
South Carolina	Certification
South Dakota	Licensure
Tennessee	Licensure
Texas	Licensure
Utah	Licensure
Vermont	None
Virginia	Certification
Washington	Certification
West Virginia	Licensure
Wisconsin	Licensure
Wyoming	None

APPENDIX 6

BOARD OF HEALTH PROFESSIONS

STUDY OF THE NEED TO REGULATE RESPIRATORY THERAPISTS 1995-96

SUMMARY OF PUBLIC COMMENT

During the Public Comment Period which ended August 30, 1995, the Board received forty-six (46) written comments on the need to license respiratory therapists in the Commonwealth. Thirty-nine (39) comments favored legislation requiring licensure; and seven (7) comments opposed. At a Public Hearing on August 15, 1995, the Board heard comments from six persons supporting the need from licensure.

Comments which were favorable to licensure were received from directors of hospital respiratory care or cardiopulmonary services, practicing respiratory therapists, physicians, and several concerned citizens who cited the following:

1) Respiratory therapy is a distinct health profession requiring specific education and training, performance of specialized, complex and highly technical tasks, and assurance of continuing competency in a rapidly evolving medical field.

2) There is a high risk of harm to patients from untrained or poorly trained personnel delivering care (comment from physician). Respiratory therapy involves such tasks as the administration of medicinal gases, invasive procedures, and delivery of mechanical life-support to critically ill patients. There is potential for great harm in almost every procedure and task performed. Licensure is necessary to protect the public health and safety.

3) Certification is not sufficient to ensure minimum competency and accountability. Certification only provides title protection and offers no assurance to the patient that respiratory therapy is being delivered by a trained, qualified therapist. Other health professions that directly affect patient care in critical situations are currently licensed.

4) Hospitals seeking to cut costs and "cross-train" personnel to do multiple tasks are allowing undertrained or "on-the-job" trained persons to do respiratory therapy. Certification does not prevent a person with no specific training from performing respiratory therapy. In a 1994 ruling by the Office of the Attorney General, anyone may practice respiratory therapy if he does not use a protected title of RRT, CRTT, or RCP. Employers use persons to do respiratory therapy under titles such as "critical care technologist."

5) Licensure may actually decrease costs when respiratory therapy is always delivered more efficiently and effectively. Appropriate, skilled care may produce quicker healing and patient discharge. Studies from other states indicated a decrease in cost when credentialed respiratory therapists were used, because of a reduction in the number and length of procedures. The

availability of licensed therapists to provide safe, quality respiratory care at home may also improve management of health costs and patient outcomes. (Case cited from subacute care facility where a newly employed RRT was able to wean a patient from long-term use of a tracheostomy tube, resulting in improved quality of life and lower cost of care.)

6) The majority of states (comments offered a range from 38 to 42) now require licensure of respiratory therapists, including neighboring states of Maryland, Tennessee, Kentucky, and West Virginia. Virginia may attract unqualified, undereducated persons who are unable to meet the standards for licensure in nearby states. Comments reported incidents of persons who had been disciplined for incompetence, prescription fraud, or substance abuse or who were unqualified for licensure in other states coming to Virginia to work.

7) While respiratory therapists work under orders from a physician, they practice without direct supervision, often exercise independent judgement, and provide consultation on a diagnosis and course of treatment. Respiratory therapists in skilled care and subacute care settings have less supervision than in acute care settings. (A physician commented that orders are usually given with the expectation that a qualified respiratory therapist will use his knowledge and experience to judge appropriate flows, exhalation, radius, etc.)

8) Respiratory therapy in home care is particularly vulnerable to incompetent practice. Services are often provided by private contractors who hire persons with no formal training to deliver unnecessary or inappropriate treatment. (Report from a rural county in Virginia of a Durable Medical Equipment company staffing home respiratory equipment with persons who have no medical training)

9) Opponents of licensure cite a potential shortage of qualified therapists; proponents cite the inability of some certified RRT's to find full-time employment and the existence of eight respiratory care educational programs in the Commonwealth.

10) Licensure is necessary to provide accountability and to protect the public from malpractice, fraud, or negligence by removing those persons from possible employment at other sites.

Comments which opposed licensure were received from the Virginia Hospital Association and hospital administrators who stated the following:

1) Licensure would increase costs and thus reduce patient access to care.

2) Licensure would be an overly restrictive barrier to entry into the field and would decrease the availability of practitioners and result in shortages.

3) Cross-training of respiratory therapists by hospitals seeking to cut costs and increase flexibility in health care (fewer professionals performing multiple tasks) would be limited by requirements of licensure.

4) Current standards for certification are sufficient to protect the public and to ensure that

practitioners are qualified. Certification provides adequate safeguards; licensure provides no additional benefits to the public. (The Virginia Hospital Association's "Workforce Survey 1994" indicates that about 75% of the respiratory therapists are certified.)

5) There are no public health, safety, or welfare issues leading to the need for licensure of respiratory therapists. The competency of respiratory therapists is monitored by the hospitals, which are required to supervise their practices. Most Virginia hospitals are accredited to Medicare standards which require that "qualified" individuals provide care and treatment. Each department within the hospital is charged with determining who is qualified and competent.

6) If licensed, respiratory therapists might seek independent practice rather than acting under the orders of a licensed physician.

The Virginia Hospital Association is opposed to licensure of any additional categories of health care practitioners.

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