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LICENSE RESPIRATORY THERAPISTS

House Bill 5598
Sponsor: Rep. Curtis Hertel
Committee: Public Health

Complete to 9-12-88

A SUMMARY OF HOUSE BILL 5598 AS INTRODUCED 5-4-88

The bill would amend the Public Health Code to require the licensing of respiratory therapists (also known as "respiratory care practitioners") in the same manner as physician's assistants currently are licensed.

Respiratory care practitioner task force. The bill would create a nine-member respiratory care practitioner task force which would promulgate rules establishing the requirements for licensure in respiratory therapy and criteria for evaluating respiratory care training programs. The task force would consist of two physicians (one allopathic, one osteopathic), one medical director of respiratory therapy services, one public member, and five respiratory care practitioners. Membership on the task force would be for a four-year term, and for two years after the effective date of the bill, the requirement that task force members have practiced for two years in their profession would be waived for respiratory therapists, if they had passed the appropriate national examination.

The rules establishing licensure and program requirements would have to take into account nationally recognized standards, and the Boards of Medicine and of Osteopathic Medicine and Surgery would be required to make written recommendations to the task force on the requirements for licensure and training programs. In establishing criteria for training programs, the task force also would be able to consult other licensing boards and the Department of Education. The task force would be able to revise the criteria for training programs whenever it decided that revision was appropriate.

At the task force's direction, the Boards of Medicine and of Osteopathic Medicine would grant licenses, license renewals, and temporary licenses (certificates of licensure would be issued by the Department of Public Health). The task force would be able to investigate applicants and training programs to determine their qualifications, as well as to investigate complaints against individual practitioners. The task force also would be responsible for determining a practitioner's continuing competence at least every six years and for deciding how to recognize the certification and experience of respiratory therapists from other states who applied for licensure in Michigan.

Qualifications and Licensing. The bill requires in general that "the standards and decisions regarding the qualifications of respiratory care practitioners" be such as to ensure that each practitioner have "the necessary knowledge and skill to perform in a safe and competent manner with due regard to the complexity and risks attendant to procedures and activities that may be ordered by a physician."

More specifically, in accordance with general health code requirements for health care professionals, applicants for respiratory care practitioner

licenses would be required to be at least 18 years old and "of good moral character." In addition, an applicant would be required either (a) to be a graduate of a program recognized by the task force or a legally recognized respiratory therapist in another state with qualifications substantially similar to those established by the task force or (b) to have passed an examination authorized by the task force which demonstrates that the applicant has the necessary education, training, or experience required by the bill.

An applicant would obtain an initial license by demonstrating on an examination (set by the task force) the degree of knowledge commonly and generally required of graduates of accredited respiratory therapy programs; the task force could not prevent an applicant from taking the exam because of a lack of specific previous education, training, or experience. The exam could be waived if an applicant had made an acceptable score on a national examination, were sponsored by a licensed physician, or were legally recognized as a respiratory care practitioner in another state with comparable requirements (including a state or national exam). To be eligible for a waiver, an applicant would have to apply within 90 days after the bill took effect.

If an applicant met the requirements for renewal of licensure as specified by the bill and promulgated rules, the task force would be required to direct the Board of Medicine to grant the applicant a renewal. The task force could require evidence of continuing competence when a practitioner applied for renewal, including retesting or continuing education. (Although the task force could require evidence of continuing competence at any time, based on public safety concerns, it would be required to do so at least every six years.)

Should the task force decide that an applicant for a license renewal were not qualified, it would have to write to the applicant explaining its reasons. Applicants who were denied would have the right to a hearing.

When examination was required for licensure, temporary licenses could be granted to applicants who had met all requirements for licensure except examination. A temporary license would be nonrenewable and would be valid until the results of a required exam were made available or for up to a year, whichever was sooner. Within 30 days of receiving an application for a temporary license (or after the Department of Public Health had completed an investigation), the task force would be required to decide whether or not to direct the Board of Medicine to grant a temporary license. If the board granted a temporary license, the Department of Public Health would be required to issue a certificate of temporary licensure within fifteen days.

Under the Public Health Code (MCL 333.16201), health professionals can have their licenses revoked if they fail to renew within 60 days of their license expiration date. The bill would allow reinstatement of a license revoked because of failure to renew, if the individual in question showed that he or she met the necessary requirements for licensure. The task force could establish equivalent requirements and recommend the issuance of temporary licenses in such cases.

Disciplinary actions. The Public Health Code specifies how alleged violations are to be reported and handled (MCL 333.16231), as well as listing grounds for investigating licensed health professionals (MCL 333.16221). (Grounds for investigation include violations of general duty, "personal disqualifications"--such as imcompetence, substance abuse, mental or physical

incompetence, and certain criminal convictions--fraud or deceit, unethical business practices, and unprofessional conduct.) In accordance with these sections, the task force would be able to instigate investigations of complaints about individual licensees, and could direct the Board of Medicine to take disciplinary actions when appropriate. Disciplinary actions could include license actions (license denial, suspension, limitation, or revocation), reprimands, and probation.

The task force, upon probable cause, could compel a licensee to submit to an examination by a physician designated by the task force, if the task force decided that such an exam was necessary to determine the licensee's fitness to practice. Under the bill, anyone who was licensed and who practiced in the state would be considered to have consented to such an exam when ordered by the task force and to have waived the right to physician-patient confidentiality in the case of such an exam. Failure to submit to such an exam would constitute admission to the allegations, and no further testimony or evidence would be required.

Before the task force ordered an exam, the respiratory care therapist in question would be given an opportunity for a hearing. The task force could delegate responsibility for a contested case hearing to a hearing examiner, whose decision would be final unless the task force authorized a review. A practitioner judged unfit to practice under this procedure would be able, at "reasonable intervals,"to attempt to show that he or she was once again competent to practice.

License reinstatement. An individual whose license had been revoked could not apply for reinstatement for at least three years after his or her license had been revoked. Someone whose license had been denied, suspended, or limited could not apply for reinstatement until the task force specified. The task force could direct the Board of Medicine to reinstate or restore an applicant's license (with limitations, if necessary), if the task force decided that the applicant were "of good moral character, such that the individual is able to serve the public as a respiratory care practitioner in a fair, honest, and open manner and should be permitted in the public interest to resume practice." The task force could require the applicant to undergo corrective measures, including additional training or special supervision, as a condition of reinstatement or restoration.

Restrictions on practice. Practice as a respiratory care practitioner would be prohibited except as allowed under the bill. Licensed practitioners would be required to display their current certificate of licensure permanently in their place of practice, to wear proper identification when working, and, if feasible, carry a pocket card (issued by the Department of Public Health) with essential license information. Except in emergency situations, licensees would be able to provide services only under the supervision of a qualified physician and only in a setting where the standards of respiratory care were established and regularly reviewed by a medical director who was a qualified physician. Under the supervision of a qualified physician, a licensee could make calls or go on rounds in private homes, public institutions, emergency vehicles, ambulatory care clinics, hospitals, intermediate or extended care facilities, health maintenance organizations, nursing homes, or other health care facilities, to the extent allowed by those facilities. The bill would prohibit licensed respiratory care therapists from doing or saying that they were qualified to provide any service that they knew (or should have known) to be outside their competence or that was legally prohibited.

Other provisions. The bill would make practice as a respiratory care practitioner a health profession subfield of the practice of medicine and of osteopathic medicine and surgery, and would add a respiratory care practitioner to each of the Boards of Medicine and of Osteopathic Medicine and Surgery. The bill contains provisions regarding privileged communications and limits liability in emergency situations. It defines "practice as a respiratory care practitioner," restricts the use of "respiratory care practitioner" (and related titles) to licensees, exempts students in training to become respiratory care practitioners from the bill's provisions, and requires the Department of Public Health to keep a list of qualified respiratory care therapy training programs.

MCL 333.16131 et al.