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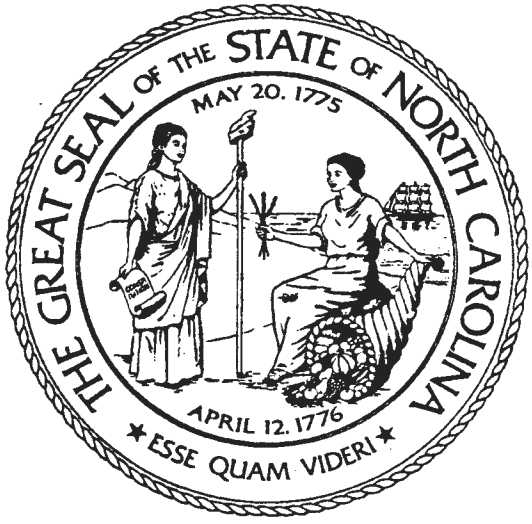
1993

LEGISLATIVE COMMITEE ON NEW LICENSING BOARDS

RESPIRATORY CARE THERAPY



ASSESSMENT REPORT
1993

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NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

STATE LEGISLATIVE BUILDING

RALEIGH, NC 27611

April 14, 1993

TO THE MEMBERS OF THE GENERAL ASSEMBLY:

The Legislative Committee on New Licensing Boards is pleased to present its assessment report on the licensing of respiratory care therapists. This report serves as both the preliminary and final assessment reports.

Representative Mary Jarrell, Chair
Legislative Committee on New Licensing Boards

KFN 7726.5 .R47l A25 1993

PREFACE

The Legislative Committee on New Licensing Boards was created by the General Assembly in 1984 to screen bills creating new licensing boards. In 1987, the Committee's jurisdiction was broadened to include reviews of bills that would give existing boards licensing authority over previously unregulated professions or occupations.

The purpose of the review is to determine whether there is a justifiable need for licensure. The criteria under which these bills are evaluated by the Committee are set out in the statutes and include factors such as whether the occupation requires special skills, whether the public on its own can evaluate the competence of the practitioner, and whether the occupation can be effectively regulated by other means.

The Committee's findings and recommendations are released through a preliminary assessment report and a final assessment report. Until the final assessment report is released by the Committee, the bill cannot be debated in any other committee or on the floor of either house. The preliminary report gives the sponsor an opportunity to review and comment on an unfavorable recommendation before the Committee makes a final recommendation. The sponsor has up to 7 days to review the report but can waive this review period. When the preliminary assessment report is favorable, the review period is routinely waived so that the final report can be issued immediately.

The Committee has no jurisdiction over proposals to create voluntary certification boards -- i.e., those boards that require certification as a prerequisite to using a certain title but do not otherwise prohibit practice of the profession. The reason these proposals are not reviewed is that they do not prevent persons from practicing a profession; they merely provide a mechanism whereby members of the profession who want to distinguish themselves as "certified" can do so voluntarily.

MEMBERSHIP (1993-94)

LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

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RESPIRATORY CARE THERAPISTS

Respiratory care therapists provide respiratory care services to patients under the direction of and in accordance with the instructions of a physician. The services include the delivery or drugs and oxygen, insertion and maintenance of artificial airways, institution and management of life support systems, arterial puncture, patient evaluation and education, and related respiratory care procedures and therapies.

There are approximately 2,200 persons practicing respiratory care therapy in North Carolina, 90% of which practice in hospitals and the remainder of which practice with home health care agencies. It is stated by the proponents of licensure that 25% of the hospital-based respiratory care therapists have no formal training in the profession and that the home health care-based respiratory therapists are not adequately supervised. It is also estimated that approximately 30% of all hospital admissions require respiratory care therapy.

Under the proposal to license respiratory care therapists, each applicant for a license must complete a JRCJRCE accredited or recognized program in respiratory care and pass an examination administered by or on behalf of the Board that will be created to govern the licensees. Persons who have already successfully completed the RRT (registered respiratory therapist) or CRCT (certified respiratory care technician) examinations can be grandfathered in. Persons currently practicing respiratory therapy but not meeting these requirements can get a provisional license to allow them to practice up to 2 more years, by which time they must pass the exam in order to continue practicing.

Two of the major concerns raised by the proponents about the lack of licensure standards are (1) patients receiving respiratory care therapy are often not at a sufficient level of consciousness to evaluate the competency of the respiratory care therapist, and (2) in the home health care setting, there is not adequate supervision of the respiratory care therapists who go into the homes. Approximately 35 states currently regulate respiratory care therapy through licensure or certification.

The Committee finds that the requirements of G.S. 120-149.1 have been met by the proposal to license respiratory care therapists and therefore recommends licensure of respiratory care therapists:

(1) The unregulated practice of respiratory care therapy can substantially harm or endanger the public health.

(2) Respiratory care therapy possesses qualities that distinguishes it from ordinary labor.

(3) Respiratory care therapy requires specialized skill or training.

(4) A substantial majority of the public does not have the knowledge or experience to evaluate whether a person practicing as a respiratory care therapist is competent.

(5) The public cannot be protected by means other than licensure.

(6) Licensure of respiratory care therapy would not appear to have a substantial adverse economic impact upon respiratory care therapy patients.

*This report serves as both the preliminary and final assessment report on the licensing of respiratory care therapists. The report is based on information provided in the response to the Committee's questionnaire, information provided by the North

Carolina Hospital Association and Neil MacIntyre, M.D., testimony received before the Committee at its April 14, 1993 meeting, and the proposed legislation before the Committee (House Bill 488).

The response to the questionnaire and the statements of the North Carolina Hospital Association and the Dr. Neil MacIntyre are provided in this report. Additional materials filed by the sponsor with the Committee are on file with the Committee Counsel and will be available from the Legislative Library at the end of the session.

The Committee is unable to print in the report all materials submitted to it. Materials referenced in the questionnaire response that are not published in this report are generally available from the Committee Counsel.

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31 March 1993

Mary Jarrell
N.C. House of Representatives
Room 2219
Legislative Building
Raleigh, N.C. 27611

Re: HB 488 - Respiratory Care Practice Act

Dear Representative Jarrell:

We represent the N.C. Society for Respiratory Care. Enclosed please find the completed questionnaire for the Respiratory Care Practice Act. It is my understanding that Committee on New Licensing Boards cannot begin consideration of the above referenced legislation until the questionnaire is completed. This submission is intended to complete this requirement. Also, we have sent this to Linwood Jones and the other members serving on this committee.

Please do not hesitate to call if you have any questions.

Sincerely yours,

JORDAN, PRICE, WALL, GRAY & JONES

Henry W. Jones, Jr.

Enclosures

cc: Rep. Howard Barnhill

Please supply information for the following questions to the Committee on New Licensing Boards. Please use the space provided. Supporting documents maybe attached.

I. A. In what ways has the marketplace failed to regulate adequately the profession?

Although there exists voluntary testing for respiratory care practitioners (RCP) through the National Board for Respiratory Care (NBRC) and 12 Respiratory Care programs in the North Carolina community college system, not all persons delivering respiratory care are properly trained. Of the 2000 RCP working in the hospital setting (1990 survey), approximately 400 show no formal training in this discipline. This use of untrained persons is even more prevalent in the growing home health care setting where numerous chronic respiratory patients require the services of RCP (about 200 RCP work in home care). In almost all cases, the patient does not have the needed expertise (or level of consciousness) to evaluate the competency of the RCP.

B. Have there been any complaints about the unregulated profession or occupation? Please give specific examples including complainant's names and addresses.

Two points about patient complaints must be made. Firstly, due to the highly technical nature of respiratory care and to the fact that much of respiratory care is delivered in the critical care areas of hospitals where patients have a decreased level of consciousness, patients are often not competent to judge the appropriateness of the care. Secondly, it has been estimated that over 95% of complaints which advance to the administrative level in hospitals are settled out of court and, therefore, are not a matter of public record, cannot be cited in this report, and "do not exist". However, most critical care physicians, nurses, and RCP can relate examples of untrained RCP posing a threat to patient care. The following are a representative group of persons receiving respiratory home care who have concerns about the absence of regulations requiring RCP to be trained. (There are currently about 2000 such North Carolinians at home.) They asked that their names be listed.

Jack Fraser-5205 Pineview Road, Lumberton, NC, 28358, has instituted a law suit alleging he received improper respiratory care in when an untrained person did not properly maintain his oxygen equipment and subsequently he did not receive oxygen for a prolonged period which in turn required of him a two-week stay in the hospital for treatment of his chronic lung disease.

Hubert Downing-Rt 2, Box 303, Elizabethtown, NC, 28337, is a patient requiring continuous mechanical ventilation (life support) because of Amyotrophic Lateral Sclerosis. He is at home and requires the services of a RCP. He has expressed extreme concern that RCP are not regulated in NC.

Martha W. Pitts-6005 Fairmarket Place, Charlotte, NC, 28215. Mrs. Pitts and her husband (deceased) both have chronic lung and heart disease and have been in the hospital on mechanical ventilation on several occasions. Mrs. Pitts figured out several years ago that not all RCP are credentialled and she refuses to let untrained RCP work with her.

-Richard Norman, 423 E. Davidson Avenue, Gastonia, NC 28052. Mr. Norman is on a mechanical ventilator and has a tracheostomy tube.

-Effie Johnson, 309 West 6th Avenue, Gastonia, NC. Mrs. Johnson is also on life support and has a tracheostomy tube.

The following also have tracheostomy tubes which are evaluated and changed by RCP as needed.

-Carl Bell, 222 Brookwood Road, Belmont, NC
-Martha Costner, 408 East 6th Avenue, #A, Gastonia, NC
-Tommy Ballard, 607 South York Street, Gastonia, NC

II. A. In what ways has the public health, safety, or welfare sustained harm or is in imminent danger of harm because of the lack of state regulation?

In most cases where a patient is injured a result of improper or inadequate respiratory care and/or monitoring , the doctor or health facility is named as the liable party, although a trained RCP could have recognized and corrected the problem before serious injury resulted. A particular area of concern for the public safety and health is the respiratory care provided by home health care companies. These cases involve individuals with chronic conditions (emphysema, cystic fibrosis, asthma, etc.) who, pursuant to their doctor's prescribed treatment, contract with a home health care company for regular treatments and monitoring in their homes. Unlike the clinical situation in a doctor's office or hospital, there is no supervision of these RCP and presently no standard by which to determine that they are properly trained to independently evaluate a patient's condition and administer and modify therapy. What makes the disclosure of improper respiratory care so very difficult, especially in the home care setting, is the fact that the resulting damage (eg., oxygen toxicity or depression of respiration, pneumothorax, cardiac arrythmias, infection, hypoxic brain damage, reduced life expectancy) or expense is often not immediately apparent and very difficult to exclusively relate to the malpractice. State regulation is essential to ensure the competency of RCP and the safety of patients with acute or chronic respiratory problems.

B. Please give specific examples including names and addresses.

-Jack Fraser-5205 Pineview Road, Lumberton, NC, 28358

-Betty Saiki (see attached, Betty Saiki vs Henry Mayo, Newhall Memorial Hospital)

-Marvin Lemm (see attached, Marvin Lemm vs St. Lukes Hospital)

- See package from Rosiene H. Weaver and other attached litigation.

III. A. Is there potential for substantial harm or danger by the profession or occupation to the public health safety or welfare? How can this potential for substantial harm or danger be recognized?

The potential for substantial harm or danger to the public by the delivery of respiratory care by untrained persons is evident by the very nature of respiratory care itself: delivery of drugs and oxygen, insertion and maintenance of artificial airways, institution and management of life support systems, invasive procedures (arterial puncture), patient evaluation and education.

Currently, almost 30% of all hospital admissions require some form of respiratory care. As the general population is moving in the direction of a higher concentration of the elderly, the numbers of those needing extended respiratory care will also rise. There are approximately 2000 persons receiving respiratory care at home in NC and this figure is expected to increase by at least 10% each year as the population ages and as more care which was once delivered in the hospital setting moves into the home.

B. Has this potential harm or danger to the public been recognized by other states or the federal government through the licensing or certification process? Please list the other states and give the relevant statutory citations.

As of January, 1993, thirty-five (70%) of the United States regulate the practice of respiratory, including the states bordering NC. See attached. Canada, the District of Columbia, and Puerto Rico also regulate RCP. Six state legislatures will hear licensure proposals this year.

The Veterans Administration recognizes the necessity of using trained persons to deliver respiratory care and only utilizes credentialled RCP.

State Licensure Update

Seventy percent (70%) of the United States or thirty-five (35) states currently regulate the practice of respiratory care through formal licensure, certification, registration, or title protection. All states use the NBRC's Entry Level Respiratory Care Examination and/or recognize the NBRC's CRTT or RRT credentials as the basis for awarding licensure. The chart below lists the name, address, and telephone number of the agency responsible for regulating respiratory care in the respective states.

Arizona	Arizona State Board of Respiratory Care Examiners	1645 West Jefferson, Room 420, Phoenix, AZ 85007	(602) 542-5995
Arkansas	Respiratory Care Examining Committee, Arkansas State Medical Board	12304 Shawnee Forrest, Little Rock, AR 72212	(501) 324-9410
California	Respiratory Care Examining Committee	1426 Howe Avenue, Suite 48, Sacramento, CA 95825	(916) 924-2314
Connecticut	Department of Health Services, RCP Certification	150 Washington, Hartford, CT 06106	(203) 566-1039
Florida	Department of Professional Regulation, Adv. Council on Respiratory Care	1940 N. Monroe Street, Tallahassee, FL 32301	(904) 487-3372
Georgia	Composite State Board of Medical Examiners, Respiratory Therapy Committee	166 Pryor St. SW, Atlanta, GA 30303	(404) 656-3913
Idaho	Idaho State Board of Medicine	280 N. 8th, #202, State House Mail, Boise, ID 83720	(208) 334-2822
Indiana	Health Professions Bureau	402 W. Washington Street, Indianapolis, IN 46204	(317) 232-2960
Iowa	Board Administrator, Respiratory Care Adv. Council	Lucas State Office Bldg., Des Moines, IA 50319	(515) 281-4422
Kansas	Kansas State Board of Healing Arts	235 S. Topeka Blvd., Topeka, KS 66603	(913) 296-7413
Kentucky	Kentucky Board for Respiratory Care	P.O. Box 456, Frankfurt, KY 40602	(502) 564-3296
Louisiana	Board of Medical Examiners, Adv. Committee on Respiratory Care	830 Union St., Suite 100, New Orleans, LA 70112	(504) 524-8721
Maine	Div. of Licensing and Enforcement, Board of Respiratory Care Practitioners	State House, Station 35, Augusta, ME 04333	(918) 582-8723
Maryland	Department of Health/Mental Hygiene, Physicians Board for Quality Assurance	4201 Patterson Ave., 3rd Fl., Baltimore, MD 21215	(301) 764-4764
Massachusetts	Board of Respiratory Care, Division of Registration	Saltonstall Bldg., Room 1513, 100 Cambridge Street, Boston, MA 02202	(617) 727-3090
Minnesota	Minnesota Department of Health	717 Delaware, Minneapolis, MN 55455	(612) 623-5131
Mississippi	State Department of Health, Professional Licensure – Respiratory Care	P.O. Box 1700, Jackson, MS 39215	(601) 987-4154
Missouri	Office of Health Care Providers, Division of Professional Regulation	P.O. Box 471, Jefferson City, MO 65102	(314) 751-0877
Montana	Professional and Occupational Licensing	111 N. Jackson, Helena, MT 59620	(406) 444-3737
Nebraska	Board of Examinations in Respiratory Care Practice	P.O. Box 95007, Lincoln, NE 68509	(402) 471-2115
New Hampshire	Board of Regulation and Medicine	6 Hazen Drive, Concord, NH 03301	(603) 271-1203
New Jersey	New Jersey Board of Respiratory Care	P.O. Box 45031, Newark, NJ 07101	(201) 504-6331
New Mexico	Respiratory Care Advisory Board	P.O. Box 25101, Santa Fe, NM 87504	(505) 827-7164
New York	Department of Education	Education Bldg., Albany, NY 12234	(518) 474-5844
North Dakota	North Dakota State Board of Respiratory Care	P.O. Box 2223, Bismarck, ND 58502	(701) 222-1564
Ohio	Ohio Respiratory Care Board	77 S. High St., 18th Fl., Columbus, OH 43266	(614) 752-9217
Oregon	Oregon Board of Medical Examiners	1500 SW 1st Ave., Suite 620, Portland, OR 97201	(503) 229-5770
Rhode Island	Rhode Island Department of Professional Regulation	3 Capitol Hill, Room 104, Providence, RI 02908	(401) 277-2827
South Carolina	State Board of Medical Examiners	P.O. Box 12245, Columbia, SC 29211	(803) 734-8901
Tennessee	Tennessee Medical Examiners, Council for Respiratory Care	283 Plus Park Blvd., Nashville, TN 37219	(615) 367-6393
Texas	Texas Department of Health	1100 W. 49th Street, Austin, TX 78756	(512) 834-6632
Utah	Business Regulation, Department of Professional Licensing	160 E. 300 South, Salt Lake City, UT 84117	(801) 530-6628
Virginia	Department of Health Professions, State Board of Medicine	1601 Rolling Hills Dr., Richmond, VA 23229	(804) 662-9908
Washington	Department of Licensing, Respiratory Care Section	1300 SE Quince St., EY-21, Olympia, WA 98504	(206) 586-8437
Wisconsin	Bureau of Health Professions, Respiratory Care	P.O. Box 8935, Madison, WI 53708	(608) 266-2811

IV. A. What will be the economic advantage of licensing to the public?

Appropriate use of credentialled RCP decreases costs both to the patient (and third-party payers) and to the hospital and decreases length of stay for the patient. This is due to increased productivity, increased appropriateness of therapy (a decrease in unnecessary procedures), increased utilization of RCP's skill and judgement, and a decrease in RCP turnover. No increase in salaries of licensed RCP over unlicensed RCP has ever been shown. See attached studies.

B. What will be the economic disadvantages of licensing to the public?

None; see above.

C. What will be the economic advantages of licensing to the practitioners?

Probably none. The numbers of graduate RCP equals the number of positions open. According to the 1990 Human Resources Survey mentioned earlier, the projected RCP need and graduate projections for five years balance each other. A point could be made that licensing would eliminate the displacement of trained RCP by those who are not trained, but are hired because of their acceptance of below market pay. However, the proposal's "grandparent" clause should minimize or negate this.

D. What will be the economic disadvantages of licensing to the practitioners?

The only economic disadvantage to the RCP will be the costs of licensing fees and, perhaps, the cost of completing continuing educational requirements.

E. Please give other potential benefits to the public of licensing that would outweigh the potential harmful effects of licensure such as a decrease in the availability of practitioners and higher cost to the public.

As pointed out in C above, there should be no decrease in the availability of RCP. It has never been shown that licensing of RCP will result in higher costs to the public: in fact, it has been demonstrated repeatedly that the utilization of trained respiratory care personnel reduces costs to patients and the hospital. See attached summaries.

V. A. Please detail the specific specialized skills or training that distinguish the occupation or profession from ordinary labor. How is each justified?

Briefly, respiratory is the allied health profession which, under medical direction in accordance with the order of a physician, is responsible for the treatment, management, diagnostic testing, and care of patients with pulmonary and/or cardiac problems. This includes administration of medical gases, drugs, breathing treatments, establishing and maintaining airways, CPR, instituting and managing life support systems (also called ventilators or respirators), arterial blood sampling , and pulmonary and cardiac testing. I also refer you to the video "Life and Breath" which should have been delivered to you by one of your constituent RCP. RCP deliver care 24 hours a day and, especially in the critical care areas of the hospital, have more patient contact than any other member of the health care team except the nurse.

The best detailed description of the skills and knowledge required of entry-level RCP is the NBRC Entry-level Certification Examination Content Outline-attached. This exam is used by all states for licensure purposes. The NBRC continuously validates the content by surveying hospitals and other health care agencies to determine how respiratory is delivered. They have been doing this since 1969.

Training of RCP involves both didactic and clinical instruction in an approved respiratory care program (approved by the Joint Review Committee for Respiratory Care Education of the American Medical Association). There are one-, two-, and four-year programs; the one-year program (a core of science and math plus one year of respiratory courses) allows the graduate to take the NBRC's entry-level examination. This is the level of competency which our proposal would require to be demonstrated to ensure safety.

B. What are other qualities of the profession or occupation that distinguish it from ordinary labor?

To deliver safe, competent respiratory care requires great individual judgement as well as technical skill and knowledge. RCP are being increasingly relied upon by physicians to evaluate patient situations and initiate and modify therapy, thus saving time and money and avoiding potentially hazardous situations.

VI. A. Will licensing requirements cover all practicing members of the occupation or profession? If any practitioners of the profession or occupation will be exempt, what is the rationale for the exemption?

Exemptions include persons in the military services working in federal facilities. This is so as not to interfere with federal policies and regulations; however, the federal government has recognized the profession of respiratory care and employs credentialled RCP.

B. What is the approximate number of persons who will be regulated and the number of persons who are likely to utilize the services of the occupation or profession?

There are approximately 2200 persons practicing respiratory care in NC. Approximately 30% or all hospital admissions require the services of a RCP. There are approximately 2000 home care patients requiring respiratory care. It is expected that respiratory home care will increase by 10% per year.

VII. What kind of knowledge or experience does the public need to have to be able to evaluate the services offered by the occupation or profession?

Due to the often highly technical nature of respiratory care and due to the often decreased level of consciousness of patients requiring respiratory care, especially in the critical care unit, there is no way that the average individual could evaluate the care delivered by the RCP.

VIII. Does the occupational group have an established code of ethics, a voluntary certification program, or other measures to ensure a minimum quality of service? Please document.

Please see the attached code of ethics stated by the American Association for Respiratory Care (established 1954).

Respiratory care has a voluntary certification (entry-level or technician) and registration (advanced practitioner or therapist) examination process administration by the National Board for Respiratory Care. There are 130,000 credentialled RCP nationally and 1700 in the state.

AARC CODE OF ETHICS

The principles set forth in this document define the basic ethical and moral standards to which each member of the American Association for Respiratory Care should conform.

1. The respiratory care practitioner shall practice medically acceptable methods of treatment and shall not endeavor to extend his practice beyond his competence and the authority vested in him by the physician.
2. The respiratory care practitioner shall continually strive to increase and improve his knowledge and skill and render to each patient the full measure of his ability. All services shall be provided with respect for the dignity of the patient, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
3. The respiratory care practitioner shall be responsible for the competent and efficient performance of his assigned duties and shall expose incompetence and illegal or unethical conduct of members of the profession.
4. The respiratory care practitioner shall hold in strict confidence all privileged information concerning the patient and refer all inquiries to the physician in charge of the patient's medical care.
5. The respiratory care practitioner shall not accept gratuities for preferential consideration of the patient. He shall not solicit patients for personal gain and shall guard against conflicts of interest.
6. The respiratory care practitioner shall uphold the dignity and honor of the profession and abide by its ethical principles. He should be familiar with existing state and federal laws governing the practice of respiratory therapy and comply with those laws.
7. The respiratory care practitioner shall cooperate with other health care professionals and participate in activities to promote community and national efforts to meet the health needs of the public.

IX. Please cite and document the extent to which any other licensing board in North Carolina regulates similar or parallel functions to the profession or occupation.

The NC Board of Physical Therapy regulates the administration of chest physiotherapy. The NC Board of Nursing allows for the administration of oxygen, suctioning of airways, tracheostomy care, and CPR.

The proposal does not limit, preclude, or otherwise interfere with the practices of other persons and health care providers licensed by appropriate agencies of North Carolina.

North Carolina Hospital Association

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Position Statement of
North Carolina Hospital Association
on
Licensure of Respiratory Therapists

April 12, 1993

On behalf of its 150 member hospitals, the North Carolina Hospital Association (NCHA) appreciates the opportunity to express the views of its membership on the licensure of respiratory therapists to the Joint Legislative Commission on New Licensure Boards.

NCHA has consistently supported standards that improve the quality of health care delivery. Hospitals hire health care professionals who are certified or registered as qualified to practice in their area of expertise. Currently, hospital respiratory therapists do have to prove expertise in their field through the certification and registration process of the National Board for Repiratory Care. NCHA feels the hospitals' practice of hiring registered or certified respiratory therapists is a benefit and a protection to the public. Implementation of a double standard by requiring licensing of respiratory therapists who practice in some settings but not all establishes inconsistency in the quality of respiratory care services. The public will not know what to expect when going to other providers.

NCHA believes that implementation of a licensure program for respiratory therapists will drive up hospital costs and exacerbate the personnel shortage, especially in rural areas. Hospitals are labor intensive businesses that allocate 54 per cent of their budgets for employee salaries and benefits. Health care is already expensive, accounting for more than 13 per cent of the nation's gross national product. The public is demanding ways to curb costs and improve access to health care. One of the reasons hospital costs have increased is the shortage of health care professionals. Licensing respiratory therapists will limit the number of qualified persons available; therefore increasing costs without improving quality or access to health care. More than 30 per cent of a hospital patient's bill goes to cover the hospital's losses. Limiting the number of respiratory therapists will increase the cost shifted to paying patients.

Licensure of respiratory therapists would worsen the plight of rural hospitals, which are already faced with the shortages of physicians, physical therapists and other health care professionals to provide primary care. More than half of North

Carolina's community hospitals are located in rural areas and provide primary care. The health of North Carolina's rural community is dependent upon the health of the rural hospital. NCHA is opposed to any measure which would make the survival of rural hospitals more difficult.

NCHA Position Statement

HB 488 would require the licensure of those respiratory therapists who practice in the hospital setting and exempt those providers named in Chapter 90 of the General Statutes. NCHA believes the quality of respiratory care by the registered or certified therapists who work in North Carolina hospitals is exemplary. Requiring licensure of these practitioners adds additional costs to a health care system fraught with annual increases of more than 15 per cent and restricting the suppy of respiratory therapists in rural and underserved areas. Therefore, the North Carolina Hospital Association is opposed to the licensure of respiratory therapists.

DUKE UNIVERSITY MEDICAL CENTER

Respiratory Care Services

April 6, 1993

Mary Seymour
1105 Pender Lane
Greensboro, NC 27408

Dear Ms. Seymour,

I am writing in strong support for the Respiratory Care Practice Act (HB488). I am doing this because respiratory care practitioners are relied upon throughout our state to provide the expertise in managing complex pulmonary life support systems as well as guiding physicians in appropriate cost effective general respiratory care. Because of this, we in the medical community must expect that rigorous training standards are upheld. The Respiratory Care Practice Act is an important step in providing this assurance not only to us but to the patients we care for. I am a member of a number of national medical organizations that support respiratory care licensure (e.g. American Lung Association, American College of Chest Physicians, and Society for Critical Care Medicine). In addition I am the past President of the North Carolina Thoracic Society (Medical Branch of the American Lung Association in North Carolina) that has repeatedly endorsed licensure for respiratory care practitioners.

I realize that the North Carolina Medical Society has repeatedly voiced opposition to this bill. This has been rooted in a fear that respiratory care practitioners will become "independent practitioners" and that this bill will increase medical care costs. I disagree strongly with both of these points. Specifically, the Respiratory Care Practice Act mandates that medical direction be present. Secondly, because a fee is attached and because a national certifying exam already in existence would be used, administrative costs would be non-existent. Moreover, the use of properly trained individuals can help physicians manage complex respiratory procedures and thus make delivery of this type of care more cost effective.

I will be happy to answer any questions you have regarding this and would be pleased to meet with you personally if that would be beneficial.

Sincerely,

Neil R. MacIntyre, M.D.
Associate Professor of Medicine
Medical Director, Respiratory Care Services

NRM/jj

c: PNRs

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