House
Legislative
Analysis
Section

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RESPIRATORY THERAPISTS: REQUIRE REGISTRATION

House Bill 4647 (Substitute H-3)
First Analysis (6-13-01)

Sponsor: Rep. Stephen Ehardt
Committee: Health Policy

THE APPARENT PROBLEM:

Respiratory therapists have been seeking inclusion as health professionals under the Public Health Code at least since the 1978 recodification of the code in Public Act 368 of 1978. Although respiratory therapists work in a variety of settings, one traditional and ongoing setting is in acute care in hospitals, where respiratory therapists provide critical care services after major surgery, such as open heart surgery, and in intensive care units, including neonatal intensive care units. Legislation once again has been introduced to require that respiratory therapists be registered under the Public Health Code.

THE CONTENT OF THE BILL:

The bill would add a new part to the Public Health Code (Part 186, "Respiratory Care") to require respiratory therapists to be registered, to restrict various titles used by respiratory therapists, to implement application and registration fees, and to create a board of respiratory care in the Department of Consumer and Industry Services.

Restricted titles. The bill would restrict the titles (and initials) "respiratory therapist" ("R.T.") and "respiratory care practitioner" ("R.C.P.") to individuals registered under the bill as respiratory therapists. The bill also would prohibit individuals from using these titles (or similar words indicating that the individual were a respiratory therapist) unless they were registered under the bill as a respiratory therapist after the rules promulgated by the proposed Michigan Board of Respiratory Care took effect.

Definitions. The bill would define "respiratory therapist" to mean an individual who was responsible for providing patient care services under the prescription of a physician to individuals with disorders and diseases of the cardiopulmonary system, including, but not limited to, life support and cardiopulmonary resuscitation, and who was registered under the bill as a respiratory therapist.

Michigan Board of Respiratory Care. The Public Health Code (MCL 333.16126) requires registration boards to have a majority of members registered in the profession which that board registers and to include at least one public member. In addition, the director of the department is an ex officio, non-voting member, though not for determining a quorum nor for the constitutional requirement that a majority of the members of an appointed examining or licensing board of a profession be members of that profession (Article V, section 5).

The bill would create a seven-member "Michigan Board of Respiratory Care" in the Department of Consumer and Industry Services whose members met the general requirements for health profession board members. One of the seven members would have to be a physician (see below), two would have to be public members, and the remaining four presumably would have to be registered respiratory therapists.

General requirements for all members of health profession boards include being at least 18 years old, of good moral character, a resident of the state, and, for the board's professional members, currently licensed or registered in the state. In addition, the bill would require that four of the proposed board members would have to meet the requirements of section 16135 of the health code (which sets forth the above-enumerated general requirements). [Note: Presumably, this requirement should be that four members, in addition to meeting the code's general requirements for board members, also be registered respiratory therapists.] One of the seven board members would have to be a "medical director," which the bill would define to mean a licensed physician (either M.D. or D.O.) who was responsible for the quality, safety, appropriateness, and effectiveness of the respiratory care provided by a respiratory therapist; who assisted in quality monitoring, protocol development, and competency validation; and who met all of the following:

- Was the medical director of an inpatient or outpatient respiratory care service or department within a health facility, or of a home care agency, durable medical equipment company, or educational program;

- Had special interest and knowledge in the diagnosis and treatment of cardiopulmonary disorders and diseases; and,

- Was qualified by training or experience, or both, in the management of acute and chronic cardiopulmonary disorders and diseases.

Rules promulgation. The Public Health Code (MCL 333.16145) allows health profession licensing and registration boards to adopt and have an official seal and to promulgate rules necessary or appropriate to fulfill its functions, and allows only boards (or task forces) to promulgate rules specifying requirements for licenses, registration, renewals, examinations, and required passing scores. The bill would require the proposed board of respiratory care, in promulgating rules to establish requirements for registration, to adopt the following specified requirements:

- Successful completion of an accredited respiratory therapist training program approved by the board;

- Having at least a two-year associate's degree from an accredited college or university approved by the board; and

- Having the credential conferred by the National Board for Respiratory Care (or its successor organization) as a respiratory therapist (or its successor credential), as approved by the board.

Fees. The bill would establish a $20 application processing fee and an annual $75 registration fee for individuals registered or seeking registration as respiratory therapists.

Third party reimbursement. The bill would specify that it would not require new or additional third party reimbursement or mandate worker's compensation benefits for services rendered by someone registered as a respiratory therapist under the bill.

MCL 333.16186 et al.

BACKGROUND INFORMATION:

Licensure and registration. Licensure and registration were distinctly different concepts under the Public Health Code as it was enacted by Public Act 368 of 1978. Wayne State University Law School Professor Richard Strichartz further explained these concepts, in a valuable commentary on the five-year process that resulted in the passage of the enacting legislation. Strichartz' C*ommentary on the Michigan Public Health Code* was funded by a grant from the W.K. Kellogg Foundation and published in 1982 by the Institute of Continuing Legal Education. Despite the many changes to the Public Health Code since 1978, the Strichartz *Commentary* still is very useful in understanding certain basic concepts that went into the drafting of the code, including the very important distinction between the licensure, registration, and certification of health occupations.

One distinction the health code still makes is that between "health occupations" and "health professions." Strichartz comments that "[t]he distinction is made between a person in a health occupation (one who works in the health field) and a health professional (one who is licensed or registered under this article." (See MCL 333.16105.) Thus, anyone currently working in a health field, like respiratory therapists, who is neither registered nor licensed, would fall under the code's classification of a "health occupation." Health *professionals*, however, must be either licensed or registered, and the distinction between licensure and registration is the distinction between a licensed health profession, which has a "restricted" (in the sense of protected) scope of practice and a registered health profession, which only restricts (that is, protects) the use of a designated title. The health code's distinction between "licensure" and "registration" has been somewhat blurred by the repeal in 1993 of sections of the code that set forth the criteria for deciding whether a health occupation should be licensed or registered. The "freeze" on any new licensing of health occupations imposed by the current and past administrations has further contributed to less general understanding of the health code's original rationale for distinguishing between health occupation licensure and registration.

As enacted, the Public Health Code placed "primary emphasis on promoting safe and competent health care for the public as justification for licensure", and limited registration "to situations in which it served a public purpose [such as] consumer information." This distinction was reflected in two sections of the health code that have since been repealed, but which still are useful for understanding this distinction.

Sections 16155 and 16156 of the health code, that were repealed by Public Act 79 of 1993, clearly delineated criteria for identifying health occupations

that should be licensed and those that should only be registered. Section 16155 (MCL 333.16155) stated, in part, that "[l]icensure of health personnel shall be judged by its single purpose of promoting safe and competent health care for the public" and that "[t]he public cannot be effectively protected by means other than licensure." Strichartz' comments that "[t]he priority for making judgments about the need for licensure is 'promoting safe and competent health care for the public.' If this requirement is not met there is doubt about the need to license that health occupation. After this barrier is overcome the other requirements of the section come into play. A very difficult problem with various occupations in the health field is the issue of a distinguishable scope of practice. An example of this is the scope of practice for psychologists where provision had to be made for the activities of other professionals. Another factor to be considered was the requirement of independent judgment based on a substantive body of knowledge. Many persons work in an institutional setting where this requirement of independent judgment may not be a crucial one. A critical requirement is that the public can only be effectively protected through licensure. These stiff requirements were placed in the Code to prevent the proliferation of licensed health occupations creating a monopoly of those who are authorized to practice the occupation. Licensure defines an exclusive scope of practice, and persons who are not licensed are prohibited from performing any of the acts reserved to the licensee. Proliferation of licensed occupations is believed to contribute to an escalation in the costs of health services."

In contrast, criteria for registering health occupations focus on consumer information and minimum practitioner qualifications. Section 333.16156 stated, in part, that "Registration of health personnel shall be judged by its purpose of establishing and identifying the basic minimum qualifications of the professional", where "minimum qualifications are established by acquisition of a prescribed body of skill and knowledge." The section concludes by saying, "Recognizing that the public has limited ability to evaluate the qualifications of an individual related to a category of health professional, registration is a means of providing essential information to the public to increase its ability to make informed choices about the consumption of health services." Thus, as Strichartz comments, "[t]he definition of 'registration' [in MCL 333.16108] specifies that this type of regulation is limited to the protection of the title against use by others who are not registered. A non-registered individual may perform the same tasks as a registered individual but may not represent him/herself as a member of a registered health profession."

Certification. Although some people sometimes use "registration" and "certification" interchangeably, in the Public Health Code these are two distinct, and distinctly different, concepts. Although the health code perhaps rather confusingly refers to "certificate of licensure" and "certificate of registration" [MCL 333.16103(2) and (3)], *certification* refers to "*specialty* certification," which applies only to *licensed* health professionals and which the code defines as "an authorization to use a title by a *licensee* [emphasis added] who has met qualifications established by a board for registration in a health profession specialty field" (MCL 333.16109). Examples of specialty certification would include, for example, board certified specialties in medicine. Thus (specialty) certification not only is not equivalent to registration, it actually requires prior licensure in a health profession.

Regulated health professions. The Department of Consumer and Industry Services (which, among other departments, encompasses the regulatory duties of the old Department of Licensing and Regulation) houses, among other things, the Bureau of Health Services. According to the department, the bureau regulates over 340,000 licensed or registered health professionals in Michigan under the Public Health Code. There currently are sixteen such state-recognized health professions (seventeen, including the "subfield" of physicians assistants): chiropractic, counseling, dentistry, marriage and family therapy, medicine (i.e. M.D.s), nursing, occupational therapy, optometry, osteopathic medicine and surgery (i.e. D.O.s), pharmacy, physical therapy, podiatric medicine and surgery, psychology, sanitarians, social work, and veterinary medicine. Of these sixteen state-recognized health professions, thirteen are licensed (fourteen, if the health profession "subfield" of physicians assistants is included) and three are registered. The three registered health professions are occupational therapy, sanitarians, and social work.

Respiratory therapy and the Public Health Code. When the recodified Public Health Code was being written in the 1970s, attempts to add respiratory therapists to the code were rejected.) Instead, the Health Occupations Council created under Public Act 368 of 1978 (and repealed by Public Act 79 of 1993) was directed to study various health occupations – including not only respiratory therapy, but also social work, audiology, speech language pathology, and myofunctional therapy – to determine the appropriateness of including them in the code. While

social work eventually was moved from the Occupational Code to the Public Health Code (as a registered, not licensed, health profession), repeated legislative attempts to include respiratory therapy under the health code have been unsuccessful to date. For example, last session, House Bill 4085 was reported from the House Committee on Health Policy, but died on second reading. The session before, House Bill 5986 passed both houses of the legislature, but was never enrolled.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bill would result in indeterminate increases in revenues and costs to the state. More specifically, the bill's requirements for respiratory therapists to register with the state, and the creation of a seven-member Michigan Board of Respiratory Care to establish registration requirements, would increase costs to the state by an amount dependent on the number of applicants for registration. The costs would be at least partially offset by the $20 application processing fee and the $75 annual registration fee. (6-12-01)

According to the Department of Consumer and Industry Services, which would be the state agency responsible for regulating respiratory therapists, there would be an initial administrative cost of about $80,000 to implement the new registration category, though these costs would be offset by the fees collected. (6-11-01)

ARGUMENTS:

For:

It is long past time for Michigan to recognize respiratory therapy for the health profession that it is and to provide some basic state protections for its citizens needing the services of respiratory therapists. Reportedly, Michigan is one of only six states that do not require respiratory therapists to be licensed or registered, and respiratory therapists reportedly are the only direct patient care providers in Michigan who are not statutorily required to have a minimum level of education, training, and clinical competence. Respiratory therapists are an integral part of the modern high-tech health care team, both in and outside of hospitals, and their work requires not only specialized training but a high level of clinical skill as well. Nothing in Michigan law currently requires this, even though the state has an obligation to protect the health, safety, and welfare of its citizens.

Registration provides a mechanism not only for ensuring minimum levels of education and training, but also a mechanism for sanctioning respiratory therapists who, either by mistake or by deliberate action, wind up harming their patients. Registration of course will not prevent mistakes or deliberate harm by respiratory therapists, no more than licensure does for licensed health professionals; but it would provide the state with a means for ensuring that its citizens would not be repeatedly harmed by incompetent or malicious practitioners, including those who moved into Michigan from other states or countries. Moreover, by placing respiratory therapists under the health code, the bill also would apply to respiratory therapists the existing health code provisions that help impaired health professionals who currently are licensed or registered under the code. The state has an obligation to protect the health, welfare, and safety of its citizens, and the bill would do this by requiring respiratory therapists who engage in a range of health care services, including critical care services, to have a minimum level of education and training.

For:

Currently, 16 health professions (17, if the "subfield" of physicians assistants is included) are regulated under the health code. Of these, 13 are licensed (14, including physicians assistants) while only three – occupational therapy, sanitarians, and social work – are registered. Except for social workers, all other mental health professionals are required to be licensed, including counselors, marriage and family therapists, and psychologists. Surely if nonmedical mental health professionals – not to mention optometrists and physical therapists – must be licensed, respiratory therapist should at least be registered, given the serious consequences that a lack of minimum education and training could have on potential patients.

Against:

There already is a national certification process for respiratory therapists, so the bill is unnecessary. Moreover, as allied health care workers, respiratory therapists practice under the direction of licensed physicians, who bear the ultimate responsibility and liability for the patient's care. This physician oversight, plus the option of national certification, is adequate to protect patients' health and safety. Furthermore, although problems with respiratory therapists have been reported in other states, the Michigan regulatory agency for health care workers has not received any reports of problems in Michigan. So the bill is not needed to protect the

safety of state citizens. And, the cases of injury and death due to errors or actions of respiratory therapists reported from other states involved states that require the registration or even licensing of respiratory therapists, so obviously registration will not prevent mistakes or even malevolent actions by some respiratory therapists. Finally, some employers of respiratory therapists have expressed concerns that registration of respiratory therapists will simultaneously increase their costs (by driving up wages) while reducing the availability of respiratory therapists, thereby resulting in further increased costs, diminished access by patients to these providers, and decreased efficiency and flexibility in the health care delivery system.

Response:

First, it cannot be emphasized enough that the national certification available to respiratory therapists through the National Board for Respiratory Care is entirely voluntary, while the bill would make it mandatory. The vast majority of well-trained and clinically experienced respiratory therapists will seek such voluntary national certification. But the bill is not directed toward these respiratory therapists. Instead, it targets the undertrained or even untrained people who some hospitals reportedly hire in their attempts to remain financially viable. Anecdotally, some hospitals have actually hired high school graduates and trained them on the job to act as respiratory therapists. This must be stopped. Since Michigan does not currently have any registration requirements for respiratory therapists, anyone can call him- or herself a "respiratory therapist" even if totally unqualified for the kinds of work respiratory therapists are called on to do. Registration, which the bill would require, both protects the titles of health care workers and requires minimum education and training standards. Thus the bill would prohibit untrained or undertrained people from calling themselves "respiratory therapists" and employers from hiring such people as respiratory therapists – at an extremely nominal cost (not even $80,000) to the state.

Secondly, however, there seems to be a dismaying lack of understanding, even on the part of state regulatory agencies, about the differences between licensure, which addresses public safety issues, and registration, which ensures minimum levels of education and training. Those who argue against the registration of respiratory therapists on the grounds that there have been no documented safety problems confuse the difference between *licensure*, which directly addresses the issue of public safety, and *registration*, which merely guarantees that minimum education and training standards are met. As the now-repealed sections of the Public Health Code indicate (see BACKGROUND INFORMATION), *licensure* generally is used when there is no other way to protect the safety of the citizens of the state. Licensure is a more stringent regulatory device than registration partly because licensure provides "turf protection" for the professionals in question (no one else is allowed to do what falls exclusively under that professional's scope of practice) and partly because licensed professions are more expensive to regulate than those that merely require registration (in part because regulators must ensure that nonlicensed people do not infringe on the licensed profession's scope of practice). However, the bill is not proposing to *license* respiratory therapists, but to *register* them, which means requiring certain minimum levels of education and training which the citizens of the state – including other health professionals – can count on. Registration "protects" consumers by telling them that certain minimum background education and training requirements have been met, and it allows states to take away someone's right to practice the registered profession if the registered professional commits serious harm, whether in the state or in another jurisdiction, in the course of practicing their profession. In particular, given the recent newspaper criticisms of the state's track record in providing its citizens with adequate health care, it seems only prudent to require certain minimum education and training requirements of health care workers who literally can make life and death decisions (including executing "do not resuscitate" ["DNR"] orders) regarding their patients. The state owes it to its citizens to register respiratory therapists.

Finally, although no evidence has been presented to support claims that registration will drive up the costs of hiring respiratory therapists (whether through higher wages commanded by "registered" health care workers or by their supposed increased scarcity), surely it is to an employer's advantage in terms of customer service and protection from legal liability to hire only qualified people to work as respiratory therapists. And while it probably is true that requiring registration will cost those employers who have hired untrained or undertrained people to work as respiratory therapists more money, surely the state has an interest in ensuring that its citizens are not exposed to such workers and that employers in the state are not allowed to hire such workers. Moreover, the bill contains a provision that explicitly says that it would not require new or additional third party reimbursement (which registration generally does not confer anyway) nor mandated worker's compensation benefits for services rendered by registered

respiratory therapists, thereby providing for built-in cost containment.

Against:

The bill does not go far enough. Given the highly specialized nature of the work of respiratory therapists in critical care settings (like neonatal, pediatric, or adult intensive care units), the bill should require licensure, not just registration. According to the state respiratory therapists' association, respiratory therapists engage in a range of services, including managing critically-ill patients' life support functions; operating ventilators (breathing machines) for adults, children, and infants; performing cardiopulmonary resuscitation in health care facilities; performing assessments of patients' vital functions; and having the authority to independently implement "do not resuscitate" ("DNR") orders.

Cosmetologists ("beauticians"), for example, although not health professionals nevertheless are required to be licensed under the Occupational Code because the chemicals they use in the course of working on people's hair can cause significant injuries if misused. However, while a mistake made by a cosmetologist might result in hair loss and burns to the scalp, certain mistakes made by respiratory therapists could result in death or serious injuries (including permanent vegetative states) to their patients because of the crucial role that oxygen plays in life support.

Response:

Both the current and past governors have indicated that they will not support new licensed health professions; there is no point in passing a bill that will be vetoed anyway.

Against:

Rather than adding health professions piecemeal to the Public Health Code, whether licensed or registered, a more general mechanism for deciding whether and when to license or register a health profession should be put into place. When the Public Health Code was enacted by Public Act 368 of 1978, just such a mechanism was included in the form of a Health Occupations Council, which was deleted by Public Act 79 of 1993. One of the most important tasks proposed for the council was that of evaluating "proposals as to licensure and registration of existing and emerging health occupations and recommend[ing] the appropriateness of, and the mechanisms for, regulation of those health occupations to the department, other state agencies, and the legislature" (repealed section 16152) in accordance with the criteria (now also repealed) for licensure and regulation. (See BACKGROUND INFORMATION.) One of the reasons given for abolishing the Health Occupations Council was that it was never used. Instead, health occupations wishing to be registered or licensed routinely bypassed the council and went directly to legislators to present their cases directly to the legislature. This, of course, meant that the case for licensure or registration often was not heard on its merits in terms of protection of public safety or ensuring minimum quality of service but instead was subject to such factors as the group's lobbying power or the administration's predetermined policy. Public safety and minimum qualifications ought to be paramount in considering whether or not to license or register highly skilled health occupations, many of which often are driven or even created, by new medical technology. Some general mechanism for rationally making such decisions would ultimately be in the best interests of public health, welfare, and safety.

POSITIONS:

The Michigan Society for Respiratory Care supports the bill. (6-13-01)

The American Lung Association of Michigan supports the bill. (6-13-01)

The Michigan Thoracic Society (a physician group consisting of critical care and pulmonary physicians) supports the bill. (6-13-01)

The Michigan Association of Health Plans indicated support for the bill. (6-12-01)

The Department of Consumer and Industry Services opposes the bill. (6-12-01)

The Michigan Health and Hospital Association submitted written testimony opposing the bill. (6-12-01)

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■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.