Approved 2-27-86
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on February 25, 1986 in room 313-S of the Capitol.

All members were present except:

Committee staff present:
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Secretary to Committee

Conferees appearing before the committee:
Rita Wolf, Director of Division of Policy & Planning, Health & Environment
Steve Curtis, CRTT, RTT, Ks. Respiratory Therapy Society
Mrs. Geralyn Ervin, Consumer from coffee county, Kansas
Bill May, Administrator of Allen County Hospital
Susan Hanrahan, American Physical Therapy Association
Marla Williams, President of Kansas Society of Medical Technology

Visitor's register, (see Attachment No. 1.)

Chairman called meeting to order and asked all to take note to a letter he had received just prior to 1:30 meeting time this date from the Board of Healing Arts. He read, " Dear Representative Littlejohn: In light of comments made at your committee meeting yesterday, I thought you might be interested in the following excerpt taken from the February 9, 1986 Board of Healing Arts Mintues: "Licensure of occupational therapists and respiratory therapists- Both of these groups have gone through the credentialing program of the department of Health and Environment and both groups have been approved by the secretary of the department of Health and environment for licensure or registration under the Board of Healing Arts. The Board agreed that they would be willing to license these two groups." Sincerely, Charlene K. Abbott, executive Secretary.

Chair gave same admonishment to conferees this date as those who had testified on the Occupational Therapy Bill. The main spokesperson for the Physical Therapy Association will be given 15 minutes for presentation, the following conferees will be given 5 minutes, and both will be allowed time for questions. He thanked all for cooperation.

Hearings began on HB 2533:--

Rita Wolf, Director of Division of Policy & Planning in department of H&E gave handout to members, (see Attachment No.2), for details. Their department supports the provision for the licensure of respiratory therapists and outlined required criteria for such licensing. They had received an application from the Ks. Respiratory Therapy Society in 1983 for review through the credentialing process. Her testimony lists specifics in meeting criteria, and the rationale for their position on criteria 3 in disagreeing with SHCC and technical Committee on criteria 3. The Secretary feels the applicant has met all three criteria for need of credentialing, and therefore does support HB 2533 which provides for licensure of RT's.

Steve Curtis, Kansas Respiratory Therapy Society, gave hand-out to members, (see Attachment No 3), for details. He stressed their point is to make committee aware of their concerns and find where their profession fits into the picture. He said they will present their case and he detailed a demonstration on a Respirator, giving technical information of what takes place as breathing inhalation of air and the exhalation of air from the lungs. He gave specifics in x number of liters per minute in case to case basis. He explained there are 3 generations of venilators, and each newest one developed is more sophisticated and more expensive. He stressed one Therapist to 4 patients is ideal situation in a medical setting,; the safety devices were explained in case electrical current fails; explanation of when and why brain damage or cardiac arrest can occurr; explained use of drugs used in connection with venilator; stressed all persons using

Hearings continue on HB 2533:--

this equipment and other treatment forms should be skilled personnel.

Mr. Curtis called attention to specifics in the attachment in regard to safe practices noted in newspaper articles. He stated licensure will not stop all unsafe practices, but it would not permit persons who are negligent to continue to practice. He spoke to cost increases to tax payers if HB 2533 is passed, i.e, there will be annual fees charged for licensure to ensure self-support; an examination system already available eliminating that cost; and no evidence to suggest salaries for RT's will increase, however, he said it is hard to say for certain there will be no increases at all. He noted it is difficult for a patient or others to identify the competent practitioner, so they feel it is in the public's best interest to have legal requirements established in order to maintain safe practice of the Respiratory Therapist. They do not wish to exclude any groups from licensure. He answered questions from members, i.e., RT's in rural areas are general practicing in medical centers only; he defined high-level, and lowlevel respitory care. He also pointed out that they know there are technical aspects of HB 2533 that would need Revisor Mr. Furse to guide them to make this better legislation.

Mrs. Gerolyn Ervin, a consumer, gave (Attachment No.4) as testimony. This attachment encludes news articles about her infant son Lucas. Mrs. Ervin noted their child has heart and respiratory defects and after many months was able to go home with the aide of a venilator. Had it not been for the use of the venilator he would have died. She spoke to the training she received from the Respitory therapists in order to monitor her son's breathing, and explained how difficult it is to have to make judgements daily in regard to their son's condition. Nurses at the hospital knew nothing about the venilator, so all information came from RT's, and they are most grateful for their help. It would be very beneficial if a RT could come to their house, (as visiting nurses do), and help in the care of little Lucas. She urged for support of HB 2533.

Mr. Bill May, Iola, Kansas, a hospital administrator gave hand-out to members, (see Attachment NO.5), for details. He spoke this date in behalf of the Kansas Hospital Association in opposition of HB 2533. He stated the occupation of RT is practiced almost solely in a medical setting, it is unclear to them what could be gained by the additional regulatory process. It is the hospital's responsibility for setting out specific procedures by which they consider applicants for technical positions, and pay into the Health Care Stabilization Fund to insure such technicans are competent. They feel the passage of HB 2533 may increase health care costs and decrease the availability of qualified personnel. Licensure of RT's would restrict hospital flexibility to hire and train employees as well as limit the pool from which employers may draw. They feel licensure is not warranted.

Susan Hanrahan, American Physical Therapy Association gave hand-out to members, (see Attachment No.6), for details. She spoke to their concerns on HB 2533. They do support credentialing for RT's as their duties and responsibilities justify the need for regulation in order to protect the consumer. They ask members to look closely at a major concern, i.e., they believe some form of delineation should exist for some highly technical and life threatening procedures included in this profession. The RT's operate at 3 levels and the practice act currently does not differentiate the various levels of service, in respect to the education background required for each. Respiratory Therapy is suggesting in this bill that clinical competency can be guaranteed with minimal standards of education, on-the-job-training, and passing of an exam, however minimum standards of education are not specificied. She suggested the following: to modify new Sec. 7, to be consistent with other health care professions, and that appointments be made on a staggered basis; replace the word physician with "physician licensed to practice medicine and surgery" in New Sec. 2, line 52 and line 65. She urged committee to recognize relationship between the various levels of education and the services performed by RT's.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 313-S, Statehouse, at 1:30 a.m./p.m. on February 26, 1986.

Hearing continued on HB 2533:--

Marla Williams, Kansas Society for Medical technology gave hand-out to members, (see Attachment No.7), for details. She stated they generally support licensure of other health professionals, but take exception to certain wording in HB 2533, finding it to be restrictive and exclusionary to their own profession. She made specific references, i.e., line 61-63, that speaks to collection of blood specimens, and other duties, is a duty of the practice of the clinical laboratorian, and further in lines 73-77 language states that no person shall practice respiratory therapy unless licensed in accordance with this act. They feel this will exclude their profession. Further, to bring HB 2533 into more accurate alignment with actual practice patterns, they would suggest the addition of a new Section 5, (g) to read, "persons employed in the clinical laboratory who are performing collection and analysis functions similar or identical to those performed in an independent Respiratory Therapy department but which would not restrict the practice of respiratory therapy in that facility. She then urged committee to consider their recommended changes to HB 2533. She answered a few questions from members, i.e., no, she said she did not believe this concern was voiced to the Technical Committee during their meetings, but were voiced informally to an RT who is actively involved in this issue.
Chairman stated all conferees scheduled this date have presented their testimony, and the balance of conferees will conclude testimony tomorrow on HB 2533.

Chair then directed attention to discussion and action on bills we have previously heard.

HB 2788, speaks to advance notice on hearings for medical assistance programs for the mental health facilities. Rep. Buehler moved HB 2788 be passed out favorably for passage, seconded by Rep. Runnels. Discussion ensued, vote taken, motion carried.

HB 2808 speaks to smoking sections being made available at request in restaurants. Rep. Runnels made a motion to amend HB 2808 in lines 23 and 29, to increase the number of customers from 10 to 50, and to pass out favorably for passage. Motion seconded by Rep. Pottorff. Discussion ensued. Rep. Neufeld made a substitute motion to amend on line 30, to strike "NON", motion seconded by Rep. Williams. Discussion ensued, i.e., many agreed with this concept. It was felt there would be too much responsibility of the restaurant owner. Rationale suggests the restaurant would be changed to the concept that the restaurant is a non-smoking place, but that a smoking area could be made available if smokers so wished. Discussion continued. Vote taken, substitute motion failed. Chair drew attention back to the original motion by Rep. Runnels, and Rep. Pottorff, vote taken, motion carried, HB 2808 passed out favorably as amended.

HB 3015 was reviewed by Norman Furse, Revisor. He explained this is a companion bill to psychologists bill and it changes throughout the bill, "registration" to license" or "licensee", where related only to teh pharmacists. It is a lengthy bill, but this is the main thrust of changes. There were other technical changes necessary and he explained them as well. At this point, Rep. Hassler made a motion to pass HB 3015 out favorable for passage, seconded by Rep. Green. Question called by Rep. Runnels, vote taken, motion carried.

It was announced there will be a sub-committee meeting on HB 2756 immediately after adjournment of this Public Health and Welfare meeting.

Meeting adjourned at 3:00 p.m.

GUEST REGISTER

DATE 2/25/86

HOUSE

PUBLIC HEALTH AND WELFARE

Date 2/25/86

NAME	ORGANIZATION	ADDRESS
Mike Hinds RRT	Kansas Respiratory Therapy Society	Topeka, KS
Steve Curtis	Ks. Resp. Therapy Society	K.C. KS.
Nita Cross RRT	KS R.T.S	5326 Quivira Shawnee Ks 66216
Geralyn Erwin		Rt 1 Waverly Ks 66871
Homer Rodriguez	Kansas Resp. Therapy Society	K. C. Ks.
John Hester	KS Respiratory Therapy Soc	PV, KS 66208
Bill May	ALLEN COUNTY HOSPITAL	101 S. 1ST
Melissa Hungerford	Ks Hospital Assn	Topeka
Marla Williams	KS Soc for Medical Technology	Topeka, KS
[illegible]	KS Physical Therapy Assoc.	Lawrence, Ks.
CAMILLA M. WILSON	KS. PHYSICAL THERAPY ASSOC.	OVERLAND PARK, KS.
Joanne Hill	Ks Physical Therapy Assoc	Topeka
Lynda Hayden	KS PT Assoc	Topeka
Tom Bell	KHA	Topeka
Mesha Hutcheson	KS Medical Society	Topeka

Attachment 1
2-25-85
Hs. PHW

attm #2
2-25-86

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON HOUSE BILL 2533

PRESENTED TO THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE, FEBRUARY, 1986

This is the official position taken by the Kansas Department of Health and Environment on H.B. 2533.

BACKGROUND INFORMATION:

In 1983, the Kansas Department of Health and Environment received an application from the Kansas Respiratory Therapy Society for review through the credentialing process (K.S.A. 65-5001 et seq.). The application seeks to license by the state of Kansas the practice of respiratory therapy.

The application has been reviewed according to K.S.A. 65-5001 et. seq. by a seven member technical committee, the Statewide Health Coordinating Council (SHCC), and the Secretary of Health and Environment. Both the technical committee and SHCC found that:

- The applicant has met Criterion 1 of the need for credentialing by demonstrating that "the unregulated practice of respiratory therapy can harm or endanger the health, safety, or welfare of the public" and that "the potential for such harm is recognizable and not remote or dependent upon tenuous argument."

- The applicant has met Criterion 2 of the need for credentialing by demonstrating that "respiratory therapists require specialized skill and training", and that "they provide the public with the assurance of the initial and continuing ability necessary for the practice of respiratory therapy."

- The applicant has not met Criterion 3 of the need for credentialing since the public is effectively protected from harm by the practice of respiratory therapy through supervision and laws governing the occupation's devices and substances. (Criterion 3 states that the applicant must demonstrate that there are no other means other than credentialing exists to protect the public.)

The Secretary of Health and Environment reviewed the application, information obtained through the technical committee meetings and public hearing, and the report and recommendations submitted by the technical committee and SHCC and concluded:

- The applicant has met all three criteria for need of credentialing.

- The rationale for non-concurrence with the technical committee's and SHCC's recommendation on Criteria 3 is as follows:

attm. #2
2-25-86
Hs. PHW

1. No laws govern the standard of practice of respiratory therapy and effective enforcement in Kansas;

2. Standards for professional performance are not enforceable because organization involvement is on a voluntary basis;

3. Certification, licensing or accreditation of facilities is not necessarily correlated to employing competent respiratory therapist staff;

4. No federal government credentialing mechanisms exist;

5. All members of the applicant group are not required to graduate from an accredited educational institution or training program;

6. There are no legal or professional requirements for on-the-job training progams for respiratory therapists; and

7. A previous application for credentialing by occupational therapists was approved by the technical committee and SHCC. The practices of respiratory therapists could lead to untoward health effects at least as serious as those of occupational therapists.

- Therefore, the Secretary forwarded to the legislature a recommendation that respiratory therapists be licensed by the State of Kansas.

DEPARTMENT'S POSITION:

KDHE supports the provisions of H.B. 2533 which provides for the licensure of respiratory therapists.

Presented by: Barbara J. Sabol, Secretary
Kansas Department of Health
and Environment

Kansas
Respiratory
Therapy
Society
P.O. Box 3357 / Kansas City, Kansas 66103

LEGAL CREDENTIALING FOR RESPIRATORY THERAPY

Attm. #3
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Hs. PHW

LEGAL CREDENTIALING FOR RESPIRATORY THERAPY

CONTENTS PAGE:

COMMENTS and QUESTIONS:

RESPIRATORY THERAPY LEGAL CREDENTIALING

INTRODUCTION

Need for Legal Credentialing

The practice of Respirtory Therapy poses a substantial risk to the patient's health and safety regardless of whether care is delivered in an acute care facility, a chronic care facility or in a patient's home. Procedures that pose significant risk include:

1. The administration of potent drugs that may produce significant reactions in vital organs including changes in blood pressure, heart rhythm, mental condition, and function.
2. Physically invading vital organ systems (pulmonary and cardiovascular) with instruments and materials which can cause injury or damage to the tissues, structures, or the function of those organs.
3. The application and maintenance of life support equipment which is used to assist, control, or otherwise augment ventilation (breathing) for extended periods of time. Failure of such equipment or inappropriate use could cause permanent brain damage or even death.
4. Performing tests and reporting laboratory data which form the basis for treatment decisions made by physicians relating to vital organs. Inaccurate lab data can cause inapporpriate treatment to be ordered and administered, with potential for serious harm or death.

Although government regulation is often considered an intrusion, the precedent of governmental regulation of health care practitioners for consumer protection is well established. When one considers how Respiratory Therapy has grown in the past ten years, there are virtually no allied health professions that perform services with greater risk and responsibility.

The Kansas Respiratory Therapy Society requests that the Legislature mandate a legal credentialing mechanism for Respiratory Therapist in Kansas. The mechanism to institute this legal requirement is available through the examination system of the National Board for Respiratory Care (NBRC). The state would not have to embark on the costly and time consuming project of developing examinations.

RESPIRATORY THERAPY LEGAL CREDENTIALING

GENERAL BACKGROUND OF RESPIRATORY THERAPY AND NATIONAL ORGANIZATIONS

(AART) Respiratory Therapy began evolving as profession in the early years of the twentieth century. Its development paralleled the development of methods of administering oxygen and mechanical ventilation. During the mid-1940s a group of interested physicians and "inhalation therapists" established a national association, "Inhalation Therapy Association" with 59 members. Since that time, Respiratory Therapy has continued to develop, especially in the areas of critical care and most recently, home care. The "American Association for Respiratory Therapy (AART)" has evolved from the original ITA and the number of Respiratory Therapy personnel has soared to nearly 100,000 nationally according to the results of the AART Manpower Survey in 1981.

(JRCRTE) During the 1950s, schools for Respiratory Therapy began to develop under specific guidelines or "Essentials". A group of physicians spearheaded the development of these essentials and promoted the need for education of Respiratory Therapy personnel through the A.M.A.s Council on Medical Education. In the 1970s a formal body, the Joint Review Committee for Respiratory Therapy Education (JRCRTE), was organized to survey education programs and make recommendations through the Committee on Allied Health Education and Accreditation of the American Medical Association. Sponsoring organizations included (and still include) the American College of Chest Physicains, American Thoracic Society, the American Society of Anesthesiologists and the American Association for Respiratory Therapy. (see position statements) At the present time JRCRTE reviews over 400 Respiratory Therapy programs in the country and provides "Essentials" for the programs.

RESPIRATORY THERAPY LEGAL CREDENTIALING

GENERAL BACKGROUND OF RESPIRATORY THERAPY AND NATIONAL ORGANIZATIONS

(NBRC) An individual "voluntary" credentialing (examination) system began development in the 1960s for identifying "CRTTs", Certified Respiratory Therapy Technicians and "RRTs", Registered Respiratory Therapists. The organization, the National Board for Respiratory Care (NBRC), has now grown to become one of the most respected health care credentialing organizations; "The respiratory therapy exam has greater validity than many comparable evaluation instruments in other health care professions".[1] The exams given by the NBRC are based on a job analysis of Respiratory Therapy.

The NBRC has agreed to allow individual states to use the "CRTT or Entry Level" examination for registry purposes. This facilitates the licensing process by providing a valid examination for use without requiring the states to embark on the costly and time consuming project of developing their own exams.

In summary, the Respiratory Therapy field has a strong national framework through:

1. The American Association for Respiratory Therapy (AART) of which the Kansas Respiratory Therapy Society is a Chartered Affiliate
2. Joint Review Committee for Respiratory Therapy Education (JRCRTE)
3. National Board for Respiratory Care (NBRC)

1. Weisfield N, Falk D, "Professional Credentials Required". Hospitals, February 1, 1983. (article included in NBRC section)

RESPIRATORY THERAPY LEGAL CREDENTIALING

QUESTIONS AND ANSWERS

1. "What will be the cost to the taxpayers of Kansas if this proposed legislation is enacted?"

   a. The legislation proposed by the KRTS for enactment has been developed and written with the intent of levying sufficient annual fees for licensing of Respiratory Therapy practitioners to ensure self-support via said fees.

   b. An examination system is already available through the NBRC so the state will not have to develop exams which are costly to prepare.

   c. There exists no evidence to suggest that salaries for Respiratory Therapy practitioners will increase as a result of this proposed legislation being enacted. In fact, a comprehensive study entitled "Has Occupational Licensing Reduced Geographic Mobility and Raised Earnings?" was published in 1980 by B. Peter Pashigian in Occupational Licensure and Regulation; the author of which made the following observations relative to data collected for 157 occuaptions:

      "The failure to find a significant effect of licensing on earnings is surprising."

      "The second-stage estimates also indicate that licensing... has little direct effect on either the intrastate migration rate or on earnings."

      "Average earnings in licensed occupations have not been found to be significantly higher than in unlicensed occupations."

      The author finished with the following conclusion:

      "Members of licensed occupations do not have significantly higher earnings."

   d. The use of qualified Respiratory Therapy practitioners is commonly acknowledged as very cost-effective. Mac McIntyre, Maternal Child Health Consultant to the Medical Center of Tarzana, California testified as follows during licensure hearings held in California, December, 1981.

      "One of the things that happens...is that generally they (nurses) are relegated to one-to-one care, which means one nurse to one patient on the most acutely ill ventilator patients. Where (Respiratory) Therapists are used in intensive care units, it has been found that one nurse to two patients can be used, and one therapist to four patients can be used. The savings is one whole person to four patients."

RESPIRATORY THERAPY LEGAL CREDENTIALING

QUESTIONS AND ANSWERS

1. d. continued

A recent study from the University of California at San Diego found a significant drop in mean mechanical ventilation time per patient ventilated occurred concurrent with the presence of trained (neonatal) Respiratory Therapists.

The assurance of the presence of qualified Respiratory Therapy practitioners has been shown repeatedly to be effective in reducing costs to the patient through effective staff utilization and reduced hospital stay.

2. "What effect will this proposed legislation have on current Respiratory Therapy practitioners?"

Those practitioners holding the NBRC credentials will be able to receive registration to practice by endorsement (without taking an examination). Those practitioners not holding an NBRC credential (OJTs and school graduates who have not passed NBRC examinations) will have a 2 year period during which time they may obtain a license by examination. Those individuals who do not obtain a license prior to the end of the "grandfather" period may not practice Respiratory Therapy until they do so.

3. "How can practitioners without NBRC credentials prepare for their registry examination?"

There are a number of well developed self-assesment examinations available. Particulary, the NBRC itself offers a "self-assessment" examination at a reasonable fee and provides a detailed description of strengths and weaknesses following completion of the examination. The same is true of commercially available examinations.

In addition, Respiratory Therapy schools, as well as the Kansas Respiratory Therapy Society offer periodic review programs and symposiums to assist in preparation of examinations and provide continuing education seminars to keep Therpaists abreast of current developments in Respiratory Care.

4. "Where will this registry examination come from? Who will develop it?"

The NBRC has agreed to allow access to its Entry-Level Examination for use as state administered licensing examinations. This exam has been carefully developed and validated, and is considered in the health care community as a standard against which others are measured. The state will not need to bear the cost of developing a new examination. This test was constructed to determine a minimal competence for Respiratory Therapists.

5. "How will the licensing of Respiratory Therapy practitioners effect other allied health practitioners?"

The proposed legislation has been developed with the intent of being "non-restrictive". It has been written to recognize the respective regulation of other professions whose scope of practice may "overlap" that of Respiratory Therapy and exempt these individuals from regulation by the proposed legislation.

6. "How will this proposed legislation permit the public to identify qualified Respiratory Therapy practitioners?"

At the hospital bedside, the public at present has no assurance of the qualifications of the practitioner providing treatment, and no resonable means of choice. By virtue of enactment of the proposed legislation, the public is assured the practitioner at the bedside has met the minimal competency requirements to practice, as employment will be illegal without a registration. In the home care setting, if Respiratory Therapy services are to be applied, the public may request the practitioner to produce evidence of registration. This will provide reasonable assurance of competency to practice.

RESPIRATORY THERAPY LEGAL CREDENTIALING

SUMMARY

In examining the health care team that commonly provides patient care at the bedside, whether it is in an acute care facility, a chronic care facility, or in a patient's home, four primary members of the team can easily be identified: the physician, the nurse, the physical therapist, and the respiratory therapist. Of the four groups, the Respiratory Therapist is the only one in Kansas who has no legally mandated minimal requirements for entry into practice. The type of care being given by Respiratory Therapy practitioners is of a curcial and often life sustaining nature.

Potent drugs are administered, vital organ systems are invaded, life support equipment is utilized (including mechanical ventilation and in some hospitals intraortic balloon counterpulsation), and diagnostic testing performed by Respiratory Therapy practitioners.

It is difficult, if not impossible, for the patient and other members of the health care team to identify the competent practitioner: several lawsuits have involved Respiratory Therapy departments due to poor care delivered by Respiratory Therapy practitioners. The cost of health care has been rising partially due to the increase in malpractice claims and the unregulated practice of Respiratory Therapy may be adding to this increase.

The Kansas Respiratory Therapy Society believes it is in the public's best interest to establish legal requirements for the safe practice of Respiratory Therapy. Legal requirements are necessary for entry into practice as well as to provide a recourse in the case of incompetent practitioners. The mechanism to institute this legal requirement is available through the examination system of the NBRC. The state would not have to embark on the costly development of an examination.

The Kansas Respiratory Therapy Society asks that the legislature ensure safe practice by legal credentialing Respiratory Therapy practitioners via state licensure.

Tuesday morning, December 11, 1984

Panel probing death of VA hospital patient

By Anne Waukau

A medical panel at Veterans Administration Medical Center is investigating whether a patient died Friday because a respiratory therapist forgot to turn on an alarm that would have warned nurses when the patient's respirator was disconnected, officials said Monday.

Franklin D. Cole, 49, of Fargo, N.D., was pronounced dead at the hospital at 6:03 p.m. Friday, according to the medical examiner's report.

William Matousek, the hospital's chief of staff, attributed the death to respiratory failure caused by disconnection of the respirator, the report said.

"We're talking about uncertain elements until the investigation is conducted," Matousek said during an interview Monday night.

After a preliminary review by him and another hospital official, he said, it was believed the respiratory therapist might have forgotten to turn on the alarm Friday after servicing the respirator.

Matousek said Cole might have had a coughing episode that dislodged the tubes connecting him to the respirator. Because the alarm did not go off, hospital personnel did not know the machine was disconnected, Matousek said.

The alarm was on when a nurse checked on Cole earlier in the day, about 4:30 p.m., he said. It is standard procedure for the alarm to be turned off during servicing, he said.

A panel made up of a physician, a registered nurse and a representative of the hospital administration is investigating the circumstances surrounding the death, according to the medical examiner's report. A preliminary finding is expected Wednesday.

Death Turn to Page 8

SENTINEL Tuesday, December 11, 1984

Panel probing patient's death

Death From Page 1

and will be forwarded to the district attorney's office for review.

What disciplinary action, if any, will be taken against the therapist will be determined after the investigation is completed, Matousek said.

Cole was admitted to the hospital July 30 after being involved in a car accident May 26 in North Dakota. Cole was not expected to live when he was admitted, the report said.

Dist. Atty. E. Michael McCann said Monday night that based on available information, "We anticipate there will not be a criminal charge" filed in the case.

McCann said he would discuss with Medical Examiner Chesley P. Erwin whether an autopsy should be performed by Erwin's office.

The medical examiner's office was not notified of Cole's death until Monday because it was under investigation at the hospital, according to the report.

A spokesman for the medical examiner's office said hospitals were allowed a reasonable time to inform the office of a patient's death.

2 to participate in Senate program

Washington, D.C. —AP— Sen. Robert W. Kasten Jr. (R-Wis.) has announced that two Wisconsin high school students — Georgie Holder Boge, of Three Lakes, and PaSoua Juliette Yang, of Eau Claire — have been named to participate in the Senate Youth Program in the first week of February.

Participants study US government, especially involving Senate operations, and receive $2,000 college scholarships from the William Randolph Hearst Foundation.

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MILWAUKEE SENTINEL **Local News**

Thursday, December 20, 1984 Page 5, Part 1

Probe of death finds no foul play

An investigation into the death of a comatose patient at the Veterans Administration Medical Center revealed no evidence of criminal wrongdoing, an official said Wednesday.

Medical Examiner Chesley P. Erwin said his office concluded its investigation into the Dec. 8 death of Franklin D. Cole, 49, of Fargo, N.D.

The office was unable to determine how Cole's respirator tube became disconnected, Erwin said.

Dist. Atty. E. Michael McCann said he would ask the hospital for additional information about Cole's death.

According to the medical examiner's report, the hospital determined Cole died from respiratory failure, which occurred when a tube from an artificial respirator was disconnected from a tracheotomy tube in Cole's neck.

An alarm that would have warned hospital personnel the tube was disconnected was found in the "off" position after Cole was discovered dead, the report said.

Hospital personnel responsible for Cole's care denied to investigators they had anything to do with turning off the alarm or disconnecting the tube, according to the report.

They also gave conflicting accounts of whether it was standard practice for personnel to switch off the alarm when servicing Cole, then turn it on before leaving his room, according to the report.

"I think we've gone about as far as we can go," Erwin said. "I think in all probability, it (Cole's death) was accidental. There was no evidence of any intention to disconnect the tube."

Erwin said Cole could not have accidentally disconnected the tube since he was paralyzed.

Two nurses told the investigator the tube "popped off" by itself several times in the past after fluid buildups, the report said.

One of the nurses said a rubber band normally was used to keep the tubes connected, according to the report.

The nurses said they checked Cole regularly, clearing away any fluid buildup when necessary, the report said.

McCann said that without further information from the hospital he would be unable to decide whether an inquest into Cole's death was warranted.

McCann said he would ask hospital officials for a report on the autopsy conducted by their staff.

He said he also would request a report on an internal investigation conducted by a hospital medical panel. The investigation probably would not be completed until next week, a hospital spokesman said.

Nurse deactivated alarm on respirator

(Nov. 1979 Milwaukee Journal)

By KENNETH STOFFELS

A nurse at St. Luke's Hospital disabled an alarm on a respirator machine sometime before the machine's oxygen supply was cut off to a terminally ill cancer patient, it was learned Sunday.

The patient, Alvin J. Gall, 67, of 1312 E. Seeley St., was found dead in his bed on the eighth floor of the hospital at 6 a.m. Saturday.

The alarm on the respirator was designed to provide a warning if a breathing tube linking the patient to the respirator became disconnected or the patient stopped breathing.

However, a nurse at the hospital, worried that the alarm would awaken other patients while she treated Gall, wedged a small plastic cap into the respirator to hold the switch in the off position, according to a medical examiner's investigator.

The nurse then forgot to remove the plastic cap after she was through drawing fluid from the patient's tracheal tube, the investigator said.

Dr. Lawrence Clowry, who performed an autopsy on Gall Sunday, said the results gave no sign of suffocation. The results showed Gall died of cancer and pneumonia, Clowry said.

Gall, a widower, was admitted to St. Luke's Sept. 25 and placed on a respiratory machine, a device that aided his breathing by pumping oxygen through a tube inserted in a hole cut in his throat.

At 3 a.m. Saturday, the nurse deactivated the alarm while working on Gall.

Gall was checked at 4:45 a.m. by a respiratory therapist and again at 5:15 a.m. by a second nurse, both of whom failed to notice the plastic cover in the alarm switch, according to a medical examiner's report.

At 6 a.m., respiratory therapist Regina Shutta found Gall dead in bed and saw that his tracheal tube was not connected to the respiratory machine.

Gall's hands were restrained by

Turn to Page 18, Col. 3

Nurse deactivated alarm

Continued From Page 1

wrist straps because earlier Saturday morning Gall, irritated by feeding tubes in his nose, had pulled them out.

It was not explained how the tube became disconnected, but one medical source said that a patient coughing could cause that to happen.

Ms. Shutta also found the plastic cap used to deactivate the alarm. She then summoned a nursing supervisor and doctor.

Clowry told a reporter, "I think he was on the verge of dying and would have died about the same time as the incident anyway."

A St. Luke's spokesman said the hospital would take no disciplinary action against the nurse who deactivated the alarm.

"The nurse is aware of the implications of what transpired and certainly felt the weight of the situation," the spokesman said.

The spokesman stressed that the practice of bypassing the alarm switch on a respirator was not condoned by the hospital, was contrary to normal procedure and was not a common practice at St. Luke's.

ror from page A1 (2)

from Bacha's office contacted them. By that time, Lucas had been embalmed and laid out at a Canonsburg funeral home.

"It's been rough. I'm very, very, very upset about the whole thing," said Joseph Jr.

Lucas, 32, said his father had been suffering from amyotrophic lateral sclerosis, a nerve affliction more commonly known as Lou Gehrig's Disease, for the past two years.

The elder Lucas entered the nursing home Jan. 8 to participate in a respiratory care program that Murray Manor operates in conjunction with the Forbes Health System.

Bacha said Lucas, formerly a self-employed auto mechanic, was unable to breathe on his own and had to be placed on a respirator.

According to a report filed by Johns, Ms. Akers of Jeannette and respiratory technician Elizabeth Petrulak of White Oak were making rounds early on the morning of Feb. 6.

At 4:20 a.m., the women stopped to suction fluid from Lucas's trachial tube.

"After the procedure was finished," Johns said, "they both left the room and went to attend to another patient."

Both women said that when they left, they were unaware that the respirator was not operating. Twenty minutes later, Lucas's intravenous bag had emptied and an alarm sounded. Ms. Akers told Johns she returned to Lucas's room to change the bag.

She found Lucas "unresponsive and noticed the ventilator was off. She immediately turned it on, and called for assistance," Johns said.

Murray Manor records filed with Johns' report indicate that before the incident, Lucas's condition had deteriorated to the point where he could not move anything but his eyes.

"He was completely dependent on the machine," Bacha said. "He was in pretty bad shape."

A Plum Borough physician, Dr. K.Y. Ou, pronounced Lucas dead at the scene at 5:30 a.m.

Under state law, suspicious or accidental deaths must be reported to the county coroner. But Murray Manor officials waited two days before contacting Bacha.

Murray Manor is owned by Beverly Enterprises of Pasadena, Calif., one of the nation's largest nursing home chains, with more than 900 homes.

Jane Redicker, director of communications for Beverly Enterprises, said administrators investigated the incident, but assumed the doctor had notified Bacha. "When we found out that the doctor had not notified the coroner, we did."

Ms. Redicker said Ou is not employed at Murray Manor, and Lucas's son said Ou was not his father's doctor

Ou declined to comment. A receptionist in his office, however, said the doctor was at the home Feb. 6 treating other patients.

Joseph Lucas Jr. said Murray Manor administrators did not explain the circumstances surrounding his father's death. He said when Frank Sciorilli, the home's acting administrator, called to tell him his father was dead, he "wouldn't tell me what had happened."

But, Ms. Redicker said: "We didn't know then what had happened. We didn't have all of our facts together."

On Feb. 8, Murray officials asked Lucas's widow and son to come to the home so that they could explain the incident. "We did not want to tell them what had happened over the phone," Ms. Redicker said.

Lucas refused, explaining that his father had been laid out at a Canonsburg mortuary and that he had to make funeral arrangements.

The family did not learn the whole story until an official from the coroner's office contacted Lucas, gave the details, and said that an autopsy was necessary.

The coroner's office claimed the body after a funeral service Feb. 9. An autopsy was conducted by Dr. Cyril H. Wecht, former Allegheny County Coroner. Bacha's staff then returned Lucas's body to Washington County for burial.

Ms. Akers told investigators that this was the first time she had turned off a ventilator.

"She should never have turned it off. They are taught never to turn it off," Bacha said. The coroner decided not to file criminal charges, because Ms. Akers had promptly reported her mistake.

"When she walked back into the room, she could've turned the machine back on, and she could have walked away. No one would have known. I give her credit for her honesty."

Beverly Enterprises placed Ms. Akers on administrative leave until the coroner completed his investigation. She is now back on the job.

"She has a superior record at the facility," Ms. Redicker said. "This was a tragic accident. We train our people the best way we possibly can, so that accidents don't happen. But we hire human beings."

A spokeswoman for the Forbes Health System said Ms. Petrulak, an employee of the system, also was placed on a two-day administrative leave.

Lucas said he had last seen his father three weeks before he died, being unable to visit after that time because of bad weather. "We had known he was doing fine. We had called (the home) the day before" the incident, Lucas said.

Nearly six weeks after the incident, Lucas said he is "miserable" over the circumstances surrounding his father's death.

Fatal error on patient kept quiet for 2 days

(1)

By Tim Vercellotti
The Pittsburgh Press

The family of a Washington County man who died in a Murrysville nursing home after his respirator was accidentally turned off did not learn of the circumstances of his death until a coroner's deputy told them two days later.

Joseph Lucas, 65, of Canonsburg, was found dead early Feb. 6 in the Murray Manor Convalescent Center, 3300 Logans Ferry Road, after a nurse turned off the man's respirator and forgot to restart it.

"During the procedure, she (registered nurse Karen Akers) said she turned off the ventilator because of the disturbing noise it produced," Deputy Coroner Dennis A. Johns said. "After the procedure was finished, they both left the room and went to attend to another patient."

Westmoreland County Coroner Leo Bacha has ruled the death accidental, labeling it "a therapeutic misadventure." He said no criminal charges will be filed.

Officials at the nursing home did not report the incident to Bacha until two days after it had happened, and did not explain the circumstances to Lucas's widow, Mary, and son, Joseph Jr., when they called to tell them Lucas had died.

The family did not learn of the mistake until officials

Please see Error, A19

p. 11

Hospital, insurer ask court to lower award to patient

By AVRAM GOLDSTEIN
Herald Staff Writer

Attorneys in Florida's most spectacular medical malpractice suit — a $16.9-million Broward case that touched off a liability insurance crisis and a physician revolt last year — clashed again Friday.


Schlesinger

For four hours they argued at the Fourth District Court of Appeal in West Palm Beach about whether the $12.47-million jury award and a $4.4-million court-ordered fee for Fort Lauderdale lawyer Sheldon Schlesinger were excessive.

Attorneys for Florida Medical Center and its insuror, the state Patient's Compensation Fund (PCF), were outraged that the trial judge reimbursed Susan Ann Von Stetina for so huge an attorney's fee. She now lies semi-comatose and helpless in a Broward nursing home.

Broward Circuit Judge Robert Lance Andrews presided over the two-week trial last year.

The defendants fear that if the court affirms Andrews' decisions, it could strain the solvency of the state fund and force Von Stetina to take over the hospital to collect her judgment.

Precedents set in this case could shape the future of malpractice litigation in Florida, several lawyers said.

Von Stetina, 27, was taken to Florida Medical Center in Lauderdale Lakes in November 1980 after a severe car accident.

She was recovering in the intensive care unit when her respirator failed. By the time nurses noticed,

Please turn to AWARD / 5BR

$16.9-million award is termed excessive

AWARD / *From 1BR*

some 15 or 20 minutes later, the lack of oxygen damaged her brain. Later, she also was blinded in one eye and suffered a broken leg at the hospital — both unrelated to the original injuries.

PCF lawyer Talbot D'Alemberte said the $12.47-million jury award was too high. Von Stetina, he said, is too far gone to enjoy the money. The jury awarded her $188,000 a year over her 40-year life expectancy for medical care.

"The money simply can't be appreciated or comprehended, and it's not going to help her at all," D'Alemberte said.

Schlesinger called that view callous and showed the three judges and 15 opposing attorneys a videotape of Von Stetina receiving physical therapy in her bed.

"I want to rebut the [portrayal] of Susan Ann Von Stetina as some mindless bit of protoplasm who is unable to appreciate her circumstances," he said. "She responds to the painfulness of the treatment itself. She reacts to a tender touch. She indeed feels."

The defense lawyers also asked the appellate judges to:

- Reduce the jury verdict.
- Rule that Andrews shouldn't have let Schlesinger read to the jury an emotional article in a nursing journal about what it might feel like to be a patient whose respirator failed. D'Alemberte said the article, used by the hospital to train its nurses, prejudiced the jury.
- Throw out the statute that requires the losing side in a medical malpractice case to pay the winner's attorney fees. The Florida Medical Association in 1980 shepherded the law through the Legislature to stem frivolous lawsuits. But because of Andrews' $4.4-million fee award in this case, the doctors now want to dump it.

D'Alemberte said Schlesinger spent no more than 1,000 hours working on the case, and labeled a $4,400-an-hour fee a "sham." The defense lawyers suggested a court-ordered fee of $500,000 and said the fee should be based on how much time Schlesinger devoted to the case.

But Schlesinger's appellate counsel, Joel Eaton, disagreed: "When you look at the economic reality of this case, it makes perfect sense. Unlike other kinds of cases, medical malpractice lawyers are not hired on an hourly basis."

On one issue the hospital and the insuror are split.

Andrews ruled that a state law limiting PCF payouts to no more than $100,000 was unconstitutional. Either way, one of the defendants is in big trouble.

Without the limit, the fund could be ruined financially by having to pay all the money at once.

But if the court allows the limit to stand, the hospital then might have to pay off the rest of the $16.9 million at once.

p. 12

O_2 ... delivered high O_2 concentrations with or without an O_2 reservoir. The Hope II, new Laerdal, and PMR2 units did not deliver high O_2 concentrations without O_2 reservoirs, but did deliver high O_2 concentrations with a reservoir and O_2 flow rates of 15 L/min or greater. The Hope I, old Laerdal, PMR1, and new and old Vitalograph units could not deliver high O_2 concentrations with or without O_2 reservoirs. The older Ambu Model NR unit without a reservoir delivered moderately high O_2 concentrations when the O_2 flow rate was as low as 15 L/min, but the patient valve began to stick in the inspiratory position at a flow rate of 20 L/min.

Source: Barnes TA, Watson ME. Evaluation of new and old designs to improve the oxygen delivery performance of adult resuscitation bags [Abstract]. 1981 Respiratory Care Open Forum Abstracts, AART Annual Convention, Anaheim. *Respir Care* 26:1132, 1134; 1981 Nov.

Comment: In ECRI's evaluation of current models of these resuscitators (*HEALTH DEVICES*, Vol. 8, p. 133), we found that oxygen concentrations greater than 0.9 could be delivered by most units by using a slow bag refill technique at an O_2 flow rate of only 15 L/min.

Accession No.: 04557

TRANSFUSION KITS [14-126]

Device: Transfusion Tubes

Abstract: Suit was filed, alleging that a disconnected transfusion tube was undetected, and an infant receiving a transfusion nearly died to death through negligence. The suit alleged that the duty nurse turned off the alarm system of the unit before the incident occurred.

Source: Alleged undetected disconnected transfusion tube leads to negligence suit. *Biomed Saf Stand* 11:128; 1981 Nov 15.

Accession No.: 04634

TUBES, TRACHEAL [14-085]

Device: Endotracheal and Esophageal Obturator Airways

Abstract: Endotracheal and esophageal obturator airways were compared in a review of 275 patients with prehospital cardiac arrest. The endotracheal airway was associated with a higher incidence of unsuccessful placements and immediate airway complications. 8.5% of patients autopsied who had esophageal obturator airways had esophageal lacerations.

Source: Campion BC, Beyer R, Smith G, et al. Evaluation of esophageal obturator airway and endotracheal tube in prehospital cardiac arrest [Abstract]. Abstracts of the Fourth Annual Conference on Cardiac Defibrillation and Cardiopulmonary Resuscitation, Purdue University, September 15-17, 1981. *Med Instrum* 15:321; 1981 Sep-Oct.

Accession No.: 04564

TUBES, TRACHEAL [14-085]

Device: Tracheal Tubes

Abstract: A case is reported of bilateral vocal cord paralysis following endotracheal intubation. The authors believe that the paralysis was caused by a pressure neuropraxia by the tracheal tube and use of a too large tracheal tube in relation to the subglottic region.

Source: Gibbin KP, Eggington MJ. Bilateral vocal cord paralysis following endotracheal intubation. *Br J Anaesth* 53:1091-1092; 1981 Oct.

Accession No.: 04565

VENTILATORS [15-613]

Device: Ventilators

Abstract: A case is reported in which a patient became disconnected from a ventilator, and no alarm sounded. The patient did not have a palpable pulse when discovered by a nurse. 3 members of the nursing and respiratory therapy staff had accidentally triggered the ventilator's alarm, and all 3 had the occasion to turn off the alarm temporarily in order to complete their care measures without the annoying sound of the alarm. Several questions are posed, the answers to which may have altered the outcome.

Source: Disconnected ventilator discovered on routine rounds. *Case Alerts* [Pennsylvania Hospital Insurance Company/Pennsylvania Casualty Company, Camp Hill, PA], No. 81-8, Nov, p 1

Accession No.: 04639

VENTILATORS [15-613]

Device: Ventilators

Abstract: Suit was filed, alleging that a malfunctioning ventilator caused a patient's death. The patient's husband was awarded an out-of-court settlement of $245,000 and received a verbal agreement that alarms would be installed on the machines to prevent future incidents.

Source: Malfunctioning ventilator allegedly causes death: Settlement to survivor. *Biomed Saf Stand* 11:127; 1981 Nov 15.

Accession No.: 04640

POLICY STATEMENT

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#1

...ive and could not be enforced.

Large award to patient upheld

Knight-Ridder Newspapers

West Palm Beach, Fla.—Florida's largest medical malpractice verdict—$12.47 million awarded to a Fort Lauderdale woman who suffered severe brain damage when a hospital respirator failed—has been upheld by the 4th Florida District Court of Appeal.

The damages jurors awarded to Susan Ann Von Stetina, 29, were not excessive, a three-judge panel has decided. However, the appellate judges ruled Wednesday that the record $4.4 million in fees that Judge Robert Lance Andrews awarded to Ms. Von Stetina's attorney was too much.

They ordered the fees awarded to a Fort Lauderdale lawyer, Sheldon J. Schlesinger, reduced to $1.5 million.

Talbot D'Alemberte, attorney for the Florida Patients Fund, a state-created malpractice insurance fund that would have to pay the award, said an appeal to the Florida Supreme Court is "highly likely."

Ms. Von Stetina went into a semicoma on Dec. 3, 1980, at Florida Medical Center in Lauderdale Lakes. She was in the hospital's intensive-care unit recovering from a severe automobile accident when a respirator failed, cutting off her oxygen.

1981 Book 583 pg 141

[redacted], a minor, by and through [redacted], his father and next friend, Plaintiff-Appellant, v.

[redacted] M.D., and St. Louis Children's Hospital, Defendants - Respondents
Supreme Court of Missouri

Medical Malpractice action brought against hospital and physician on behalf of minor patient. Negligent administration of oxygen causing patient to suffer from retrolental fibroplasia, total blindness of right eye.

At Circuit Court, City of St. Louis the case was in behalf of defendants but because the Court of Appeals believes the trial court committed prejudicial errors to the plaintiff's rights the decision was reversed and remanded.

Charge-negligent administration of oxygen to the minor while he was a patient in the hospital under the care of Dr. [redacted]

No jobless benefits for therapist who reported dead were alive

Iowa City Press Citizen 85

By The Associated Press

DES MOINES — A respiratory therapist who reported pulses on two dead people has been denied jobless benefits.

"I didn't know they were dead," said Eric Skuster, now of Coralville, who was fired from a job in Waverly last July when Medicaire investigators discovered the discrepancy.

The appeal board of Job Service of Iowa said it believed Skuster was unaware the patients were dead, but it said he should not have falsified the reports.

"It was an error in judgment," said Skuster, who now is a respiratory therapist at University Hospital. The appeal board decision upholds a hearing officer's finding that Skuster should pay back $1,700 in jobless benefits already collected. Skuster said he would appeal the decision.

Skuster blamed the situation on pressure from his former employer, the Inhalation Therapy Services Inc., a company formed by UC Consultants of Nashville, Tenn. UC Consultants declined comment on the case.

Skuster's job was to make home visits to ill people, taking pulses and making other medical checks, then forwarding the results to the Waverly Municipal Hospital, which would seek reimbursement from Medicare.

On two occasions, once when he was on vacation, Skuster filled out reports on people who had died several days previously. "I should have just said that they hadn't returned from the hospital yet," he said.

He said he felt pressure from Inhalation Therapy to fill in the reports, even though he had not visited the patients. "They'd call and give a big hassle," he said.

Skuster said that as a result of the false reports, he received $40 that he wasn't entitled to get. He said he gave the hospital a check to cover the amount but that it was never cashed.

The hospital maintained Skuster's action jeopardized the hospital's financial status with Medicare and the appeal board agreed.

#1

Blue Cross
North Dakota

4510-13th Avenue S W
Fargo North Dakota 58121-4510
701 / 282-1100

January 30, 1985 #3.

Mr. Gary Brown
Respiratory Therapy
St. Luke's Hospitals
Fargo, North Dakota 58122

RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual.

Actual statistics for a past year for a particular bed-sized hospital were $7.04 per day for educated providers and $22.76 for the uneducated provider. Another bed-sized hospital statistic was $12.50 for the educated provider while $20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

Marlene Moderow R.N.

MARLENE MODEROW, R.N.
Medical Review Field Auditor

ge

ESSENTIAL ELEMENTS OF A BILL

TO LEGALLY CREDENTIAL

RESPIRATORY CARE PRACTITIONERS

IN KANSAS

Approved by the Board of Directors

Kansas Respiratory Therapy Society

February 24, 1986

1. A statement of purpose of the act, e.g.,

The purpose of the Respiratory Care Act is to safeguard life and health and promote the public welfare by regulating the practice of respiratory care in the state of Kansas.

2. The scope of practice defined, i.e.,

"Respiratory care" means a health care profession, under qualified medical direction, employed in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the cardiopulmonary system and associated aspects of other systems' functions, and includes, but is not necessarily limited to, the following:

(1) Direct and indirect pulmonary care services that are safe, aseptic, preventative and restorative to the patient.

(2) Direct and indirect respiratory care services, including but not limited to, the administration of pharmacological and diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative or diagnostic regimen prescribed by a person licensed to practice medicine and surgery.

(3) Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing; determination of whether such signs, symptoms, reactions, behavior or general response exhibit abnormal characteristics; and implementation

based on observed abnormalities of appropriate reporting or referral or respiratory care protocols; or changes in treatment regimen, pursuant to a prescription by a person licensed to practice medicine and surgery on the initiation of emergency procedures.

(4) The diagnostic and therapeutic use of any of the following, in accordance with the prescription of a physician and surgeon: Administration of medical gases, exclusive of general anesthesia; aerosols; humidification; environmental control systems and baromedical therapy; pharmacologic agents related to respiratory care procedures; mechanical or physiological ventilatory support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of the natural airways; insertion without cutting tissues and maintenance of artificial airways; diagnostic and testing techniques required for implementation of respiratory care protocols; collection of specimens of blood; collection of specimens from the respiratory tract; analysis of blood gases and respiratory secretions.

3. An operative clause. No person shall practice respiratory care or represent himself to be a respiratory care practitioner except in accordance with the provisions of the Respiratory Care Act.

4. A non-exclusionary clause:

Nothing in the Respiratory Care Act is intended to limit, prèclude, or otherwise interfere with the practices of other persons licensed or credentialed by appropriate agencies of the state of Kansas, self-care by a patient, or gratuitous care by a friend or family member who does not represent or hold himself out to be a respiratory care practitioner.

5. Allowance for students of accredited training programs to practice under supervision of legally credentialed practitioners.

6. Definition of accredited training programs. Only AMA-approved training programs should meet the educational requirement for legal credentialing.

7. A grandfather clause which would permit the Board, for a period of two years following the date of enactment of this bill, to waive the education requirement for persons who, as of a specified date of the year enacted, are engaged in the practice of respiratory care in Kansas and have at least one year full-time equivalent experience in the performance of respiratory care in Kansas as certified by documentation provided by the applicant from his medical director(s), supervising physician(s), or other source acceptable to the Board; and permit the Board to waive the education and examination requirement for any person who, prior to the effective date of this act, has been credentialed as a Registered Respiratory Therapist or Certified Respiratory Therapy Technician by the National Board of Respiratory Care or its successor organization.

8. An examination requirement. The appropriate level of competence would be reflected by passing the Entry-Level (CRTT) examination approved by the Joint Review Committee for Respiratory Therapy Education of the AMA. That examination is available for this purpose and is recommended by the KRTS.

9. Establishment of a Respiratory Care Board to promulgate regulations pursuant to the Act and to implement the provisions of the Act.

10. A reciprocity clause which would provide for waiver of the education and examination requirements for practitioners legally credentialed by other states which, in the judgment of the Respiratory Care Board, have credentialing requirements at least as rigorous as those in Kansas.

11. A continuing education clause requiring evidence that education is ongoing.

12. Lines 0095 and 0096 of the existing draft H.B. 2533 must go! It defeats the purpose of the legislation to allow practice by uncredentialed practitioners.

Needed changes to House Bill No. 2533

approved by the Board of Directors,
Kansas Respiratory Therapy Society
May 17, 1985

Line	Change
Throughout	Wherever "respiratory therapy" appears, change to "respiratory care" except as part of an NBRC credential.
Throughout	Wherever "respiratory therapist" appears, change to "respiratory care practitioner" except as part of an NBRC credential.
0028	Delete "supervision", substitute "qualified medical direction"
0029, 0041, 0049, 0050	Change "medicine and surgery" to "medicine and/or surgery"
Following line 0033	Add subsection 2(c) "Accredited educational program" means an educational program accredited or recognized by the American Medical Association's Committee on Allied Health Education and Accreditation in collaboration with the Joint Review Committee for Respiratory Therapy Education or their successor organizations.
0052	Change "and" to "and/or"
0065	Change "and" to "and/or"
0086	Insert "accredited" before the word "educational"
0087	Strike "approved by the board"
0088	strike "supervised"
0091	strike "supervised"
0095 and 0096	Delete entirely
0097	Delete subsection 5(e) (see new section 6)
Following 0112	Insert "New Section 6. The board may grant a limited permit to: (a) a person performing respiratory care services in this state who is not licensed under this act, if such services are performed for no more than 90 days in a calendar year in association with a respiratory care practitioner licensed under this act and if: (1) such person is licensed under the law of another state which has licensure requirements recognized by the board of this state as equal to or greater than the licensure requirements of this state, or (2) such person is credentialed as Registered Respiratory Therapist or Certified Respiratory Therapy Technician by the National Board for Respiratory Care or its successor organizations.

(b) licensure applicants who have completed the education and experience requirements of this act. This permit shall allow such persons to practice respiratory care in association with a licensed respiratory care practitioner and shall be valid until the date on which the results of the next qualifying examination have been made public. This limited permit may be renewed by appeal to the board if such an applicant has failed the examination.

(c) persons not eligible to practice under this act, to perform duties peripheral to the therapeutic and diagnostic functions herein listed. The qualifications, requirements, and limitations on such persons shall be determined by the board in consultation with the Secretary.

0121 — Change "respiratory therapist council" to "Respiratory Care Council"

0125 — Change "and" to "and/or"

0135 — Change organization name to "Kansas Respiratory Therapy Society or its successor organizations"

0141 — Change "treatment" to "practice"

0148 — Insert "accredited" before the word "educational"

0149 — Delete

Following 0155 — New Section 8(d). For a period of two years following the date of enactment of this bill the board shall waive the education requirement for persons who, as of October 1 of the year enacted, are engaged in the practice of respiratory care in Kansas and have at least one year full-time equivalent experience in the performance of respiratory care in Kansas as certified by documentation provided by the applicant from his medical director(s), supervising physician(s), or other source acceptable to the board.

0170 and 0171 — Omit "and may review their papers"

0174 through 0176 — Change to read: "grant a license to any person who, prior to the effective date of this act, has been credentialed as a Registered Respiratory Therapist or Certified Respiratory Therapy Technician by the National Board of Respiratory Care or its successor organizations."

0224 — Change "may" to "shall"

0227 — Delete "not"

0228 — Change "may" to "may not"

0258 and 0259 — Omit "respiratory therapist"

My name is Dan Johnson. I am currently Assistant Director of the Respiratory Care Department at Stormont-Vail Regional Medical Center in Topeka. I have been employed in respiratory care for approximately ten years. I received a certificate in respiratory therapy from the University of Kansas Medical Center in 1976 and was credentialed as a Registered Respiratory Therapist by the National Board for Respiratory Therapy in 1977. Before becoming Assistant Director at Stormont-Vail I was Education Coordinator for the same department from 1977 to 1981. From 1981 to 1983 I was Clinical Coordinator of Respiratory Therapy at Lawrence Memorial Hospital.

In 1984, as a member of the Legislative Committee of the Kansas Respiratory Therapy Society, I helped prepare the KRTS application for legal credentialing and participated in the hearings of the SHCC Technical Committee charged with reviewing that application. I have been interested in the question of credentialing ever since I learned as an RT student in 1975 that the only existing credentialing system was a purely voluntary one. I thought that that was remarkable, to say the least, given the highly sensitive nature of the work. I am pleased with the serious consideration that the Public Health Committee continues to give to the question of legal credentialing for respiratory care practitioners, and I would like a chance to answer questions the committee may have about the profession, the need for legal credentialing, or my experience with the credentialing process.

Dear (Nita copy)

We are writing to inform you of our support of the respiratory bill. We have a son who is one year old, who has Tracheal Malasia along with a severe heart defect. (Tracheal malasia is collapsing of the airway, it effects lungs & the airway.) Until he is big enough to have his heart surgery, we have had to have him on a ventilator (this keeps his airway open so someday he could outgrow the tracheal malasia & have the surgery.) If not for the ventilator, he would of died. We could of kept him in the hospital for a couple years but we wanted to bring him home to be with us. We have registered nurses come to our house to help take care of him, but not a one of them knew anything about the ventilator and the procedures we had to do to keep his lungs clear. (In KU & probably most large hospitals the RN's never deal with the ventilator or respiratory problems.

At the KU Medical Center ~~and~~ the respiratory therapist taught the nurses and us everything about the ventilator. This helped a lot but still to really get to know the ventilator, how it worked & what could go wrong with it, we needed someone more experienced. We learned everything we could to get through some of the problems by talking to the equipment company respiratory therapist and the respiratory therapist at KU. Together we have made Lucas get this far.

It would have been a lot easier and safer if we would have had someone who had some experience with the ventilator and Lucas's lung problems. If it hadn't been for the RT's at KU who taught us everything to do when different problems arised we wouldn't have made it. None of the nurses knew anything about what we really needed.

Even though our need for RT's might be ceased by the time this bill goes through we are supporting it for the parents and families like us, who really need someone who specializes in this area of the medical field. We would of had it a lot easier this last year if we would of been able to hire someone with more experience in what Lucas's main need was, respiratory care. Hopefully, someday RT's will be able to come into homes like RN's can. We know there are very few cases like Lucas's, but for these it would sure help out. Thank you.

Sincerely,

James R & Geralyn Ewin

attm. #4
2-25-84
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KANSAS CITY TIMES July 11

Winning the fight

Seven months of life have all been a struggle for baby

By Matt DeGalan
A Member of the Staff

Two months ago Lucas Ervin began to smile.

The infant had spent most of his short life hooked to a respirator in the University of Kansas Medical Center, clinging to life while doctors uncovered more and more problems in his tiny body. First it had been the ears, then the heart, and then breathing problems set in. Always, it seemed, there was something.

To the physicians, Lucas' afflictions were unique. Never before had they seen an infant with the combination of heart and respiratory defects plaguing Lucas. To the Ervin family from rural Coffey County, Kansas, the ordeal that began soon after Lucas' birth in January was a nightmare of grief and uncertainty.

"There were a lot of times when we thought we had lost him," said Geralyn Ervin, who had all but sacrificed living at home to be near a son.

Then in May, after returning to the hospital for the third time, Lucas began to grow stronger, laughing and smiling and playing with the nurses and doctors. On Wednesday, he kicked at the stuffed animals in his crib and waved a rattle in the air as his mother and nurses looked on.

In a few hours he would be going home — this time, perhaps, for good, although his recovery is far from complete.

While at home, Lucas will breathe with the help of a respirator and be attended to by nurses. Hospital officials say he is one of the youngest children on a respirator ever to be permitted to return home.

"It's kind of nervous going home like this," Mrs. Ervin said. "We hope he'll be able to stay for six weeks anyway." Then, in August, Lucas will return for tests that will determine whether he is ready for the first of two operations he still must undergo.

Lucas' problems began Jan. 13, 10 days after his birth, when his mother noticed that the shape of his ears seemed unusual. A battery of tests indicated that Lucas was deaf in one ear and that his hearing was impaired in the other. The tests also revealed that Lucas had a heart murmur. Surgery in March alleviated part of the heart murmur problem.

Soon afterward, respiratory problems developed. The infant's doctors, Leoni Mattioli and Kenneth Goertz, suspected that Lucas' abnormally small jaw and chin blocked air passages.

The doctors performed a tracheostomy, in which a small tube was placed in the neck below the vocal cords to create an air passage.

Initially, Lucas's breathing improved and he was able to return home. But the breathing difficulties returned — compounded by pneumonia, which caused the boy to turn blue.

Lucas was returned to the hospital and put back on the respirator. More tests were taken and doctors found that Lucas' trachea was abnormally narrow. The delicate operation required to widen it will be performed in about two months if tests in August go according to plan.

The second operation, involving open-heart surgery, will be performed within the next two years, possible as early as next summer to

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complete care for the murmur.

There has been another problem for the Ervins, aside from Lucas' medical difficulties: money. So far, the Ervins' insurance has covered the $100,000 in costs to keep Lucas alive. The policy will pay medical costs up to $250,000 associated with his treatment. If Lucas can stay at home, monthly care will cost about $7,000. But at the hospital, costs in intensive care can run more than $1,000 a day.

The Ervins have sought financial help from public and private sources but have not been successful. Mrs. Ervin said some source of money to supplement insurance payments will have to be found if Lucas continues to need expensive medical care for a prolonged period.

Dr. Goertz said he cannot tell yet whether Lucas will overcome his afflictions and develop into a normal child.

"The biggest plus is that now he's going home to be with the family," Dr. Goertz said. "They have the desire and they worked to acquire the skill to care for him at home."

Mrs. Ervin has spent most of the last six months in the Kansas City area, staying at the Ronald McDonald House, a special home for the relatives of hospital patients. She returns home about once a week. On weekends, her husband and other children, Jessica, 3, and Eric, 4, have made the two-hour drive from the family home near Waverly, Kan., to visit Lucas and Mrs. Ervin.

"I'd never left the kids before," Mrs. Ervin said. "They've taken it well, but the last few weeks they've been getting anxious."

In the meantime, the two children have grown protective of Lucas, Mrs. Ervin said. "They're ready to make sure no one hurts their little brother."

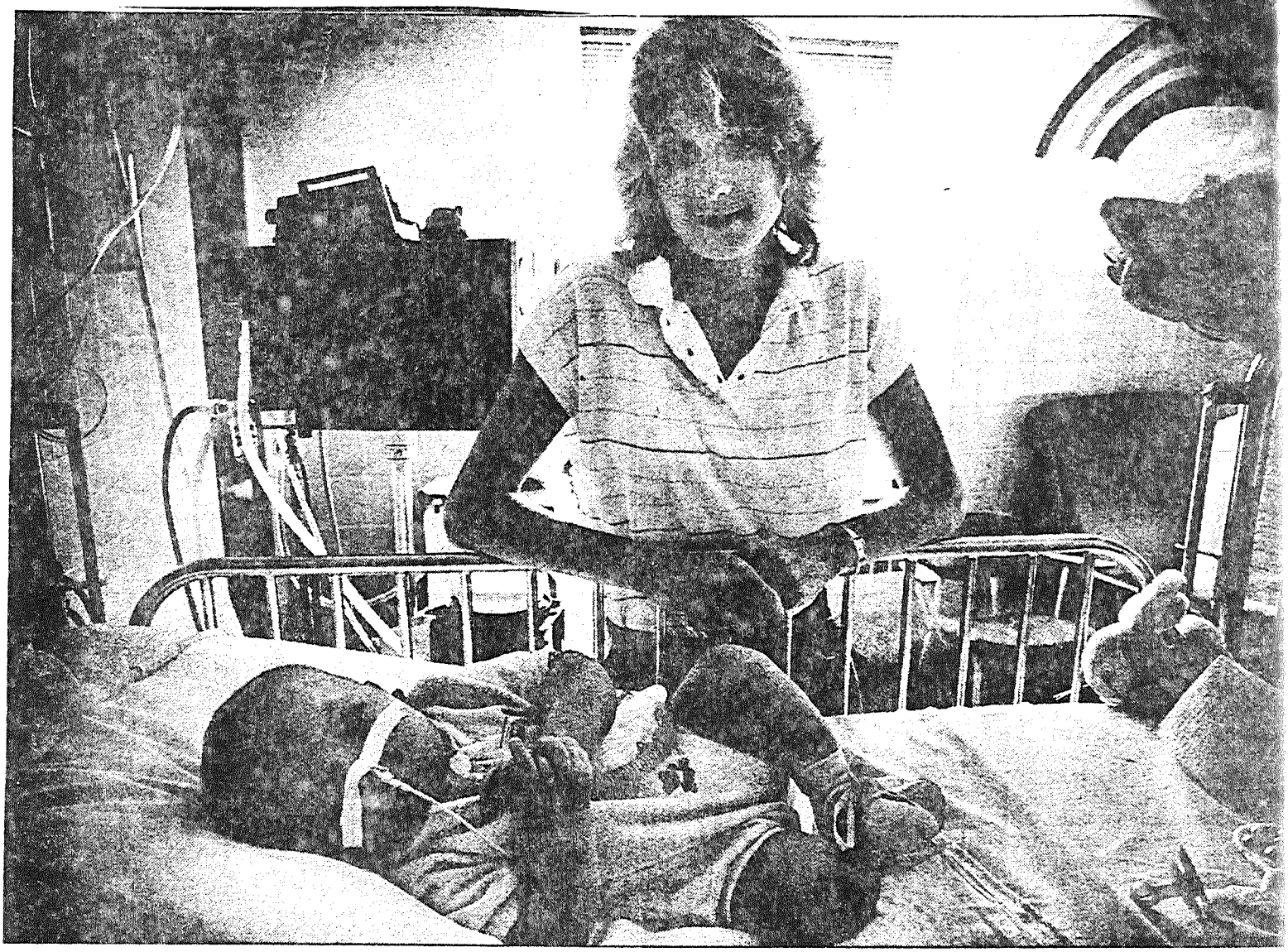
Nurses say Mrs. Ervin's devotion to her son is one reason he can return home. While Lucas struggled in the hospital, she immersed herself in learning about her son's problems and how to treat them.

"I can't help but think that the strong sense of family the Ervins have helped the baby," said Nita Cress, a respiratory therapist. "A lot of babies on respirators don't play like Lucas."

During Lucas' long stay, a special bond has formed between the Ervins and the hospital staff.

"We've learned a lot from Lucas. It's not been boring," said Phyllis Larimore, a pediatric nurse. "We've seen him develop from a newborn child to one with a real, definite personality. We all love him very much."

Picture on following page



John J. Gaps III/

Medical problems have plagued Lucas Ervin, but he was able to leave the hospital with his mother, Geralyn, Wednesday.

KANSAS
Wilson County Citizen
Fredonia, Ks.

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Lucas Ervin Back To Hospital

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Lucas Ervin, the 6-month-old son of Mr. and Mrs. Rusty Ervin of rural Burlington, was returned to KU Med Center last Wednesday after the respirator that was supposed to allow him to be at home malfunctioned.

His grandmother, Mrs. Herb Huser, said that he would be able to come home when the equipment is working properly. The Ervins are getting Lucas ready for major surgery for birth defects which keep him from breathing properly. If all goes well, he is scheduled to go to a hospital in Boston late in August for the surgery.

When Lucas is at home, he has to have 24-hour supervision to be sure his respiratory equipment is working properly. The Ervins have been helped with their other children, Eric and Jessica by grandparents, Jean Ervin of Severy, Herb and Ethel Huser, Lafontaine, brothers and sisters of both Rusty and Geralyn Ervin and by family friends.

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TESTIMONY OF THE KANSAS HOSPITAL ASSOCIATION

BEFORE THE

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

February 25, 1986

Mr. Chairman, members of the committee, I am Bill May. I am currently the administrator of the Allen County Hospital in Iola, and a respiratory therapist. I am speaking to you on behalf of the Kansas Hospital Association.

The Kansas Hospital Association appreciates the opportunity to comment on H.B. 2533, which would require licensure of respiratory therapists. Kansas hospitals employ approximately 500 personnel in their respiratory therapy departments or units. About 200 are in "respiratory therapist positions, 160 are respiratory therapy assistants and the remainder are employed in other capacities. Unlike the field of occupational therapy, the vast majority of this type of therapy is provided in an institutional setting.

The Kansas Hospital Association opposes the licensure of respiratory therapists. Since this occupation is practiced almost solely within a hospital or other institution, it is unclear what could be gained by the additional regulatory process. Most specifically, we believe that the public protection aspect will not be significantly increased. We remind the committee that, in the hospital setting, the hospital itself is

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responsible for the persons who have privileges to work in that hospital. Hospitals have specific procedures by which they consider applicants for technical positions. Again, we remind the committee that hospitals also pay monies into the Health Care Stabilization Fund to insure that those who have meritorious claims regarding treatment received at the hospital are adequately compensated. As such, KHA feels that this arrangement is more than adequate to protect the public.

The second major concern of KHA is that H.B. 2533 has the potential of increasing health care costs and decreasing the availability of qualified personnel. Licensure of this profession would clearly restrict hospital flexibility to hire and train employees, as well as limit the pool from which employers may draw. When the availability of personnel is restricted, the cost of such personnel is often inflated.

It is the position of the Kansas Hospital Association that H.B. 2533 will increase the regulatory constraints and health care costs without any corresponding increase in protection of the public. As such, we feel licensure is not warranted.

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KANSAS CHAPTER

AMERICAN PHYSICAL THERAPY ASSOCIATION

February 25, 1986

Susan Hanrahan, RPT
Legislative Chairperson
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Mr. Chairman and Members of the Public Health and Welfare Committee:

My name is Susan Hanrahan and I represent the Kansas Physical Therapy Association which serves over 400 practicing credentialed physical therapy personnel in this State. My purpose today is to address this committee on the concerns our Association has with HB # 2533, the credentialing of the profession of Respiratory Therapy.

Our Association has followed closely the activities of Respiratory Therapy through the entire credentialing process and has testified before the Technical Committee of Health and Environment on their behalf. We strongly support credentialing for the profession of Respiratory Therapy as their duties and responsibilities justify the need for regulation in order to protect the consumer. We do however, have one major concern that we hope your Committee will look at very closely.

If you review the definition of Respiratory Therapy, you will note that some highly technical and life threatening procedures are included in those performed by the profession. We believe that some form of delineation should exist for these procedures. Currently, Respiratory Therapists operate at three levels in health care facilities: 1) Registered Respiratory Therapists

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(RRT's) who **may** have anywhere from two to four years of academic education and have passed a national examination; 2) Certified Respiratory Therapy Technicians (CRTT's) who **may** have approximately one year of academic education and have passed a national exam; and 3) On-the-Job Trained personnel (OJT's) who have no formal classroom education. The practice act, as it currently exists, does not differentiate the various levels of service just mentioned according to the educational background required for each.

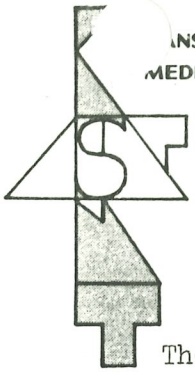
Based on the above stated information, you would **anticipate** that Respiratory Therapists who have four years of academic education would be providing the evaluative and diagnostic testing procedures as well as some of the more sophisticated techniques. The two-year personnel would be performing other treatment procedures under the supervision of a bachelor's level Respiratory Therapist. The CRTT and OJT would be completing miscellaneous palliative measures necessary to the operation of a Respiratory Therapy Department. Currently, this is not the case. Personnel may be performing services beyond the scope of their abilities and academic backgrounds. This situation could be rectified within the practice act by categorization of levels of competency in relation to the duties performed at each level.

Respiratory Therapy is suggesting in this bill that clinical competency can be guaranteed with minimal standards of education, on-the-job-training, and the passing of an examination. Minimum standards of education are not specifically stated, however, which leaves much speculation as to how existing Respiratory Therapy practitioners will be credentialed, and what the standard entry level for practice might be.

Our Association feels that one level of credentialing for all practitioners of respiratory care regardless of educational background is inappropriate. The credentialing of OJT personnel is especially inappropriate. We support delineation of functions, educational background, and specified testing at the RRT and CRTT levels as necessary to insure competent delivery of services.

In the interest of consistency, we would like to suggest: 1) modify New Section 7 to be consistent with other health care professions that are governed by regulatory boards and their appointment thereof. We would also recommend that appointments should be made on a staggered basis to facilitate implementation and transition for new members; 2) replace the word physician with **physician licensed to practice medicine and surgery** in New Section 2 line 0052 and line 0065.

We urge the Committee to recognize the relationship between the various levels of education and the associated services performed by the profession of Respiratory Therapy to insure that quality patient care is delivered in all health care facilities. At this time we would like to address any questions that you might have. Thank you for the opportunity to testify before your committee.



ANSAS SOCIETY FOR
MEDICAL TECHNOLOGY

Recommendations of the Kansas Society for Medical Technology
Regrading H.B. 2533 - Respiratory Therapy Practice Act
February 25, 1986

The Kansas Society for Medical Technology is an organization representing approximately 400 clinical laboratory practitioners in the State of Kansas. We generally support the licensure of other health professionals and have worked actively to promote the Kansas program for Credentialing of Health Professions. We also support the licensure of Respiratory Therapists in this state, however we must take exception to certain wording in H.B. 2533, finding it to be restrictive and exclusionary to our profession.

Specific reference is made to lines 0061-63 which state that the practice of respiratory therapy includes "the collection of blood specimens; collection of specimens from the respiratory tract;analysis of blood gases and respiratory secretions." While this is indeed included in the practice of respiratory therapy it is also a component of the practice of the clinical laboratorian who collects blood and performs analyses of blood gases as well as respiratory secretions. This section alone does not constitute exclusion of the clinical laboratory practitioner, however later in the bill, lines 0073-77 state that no person shall practice respiratory therapy unless"licensed in accordance with this act".

The Kansas Society for Medical Technology suggests that this bill should clearly state that clinical laboratory practice may also include collection and analysis functions common to respiratory therapy practice. In support of this position, you will find that certain accrediting agencies such as the Joint Commission on Accreditation of Hospitals require that Respiratory Therapy services comply with the standards governing the Pathology and Laboratory Services in the Accreditation Manual for Hospitals. These standards include quality control, collection of specimen and reporting issues.

The Respiratory Therapy department structure may vary from acute care setting to acute care setting depending upon the size of the operation of each organization. The testing, collection and analysis functions may be solely the responsibility of the Respiratory Therapy department, a shared responsibility of the Respiratory Therapy department or solely the perview of the Clinical Laboratory.

To bring H.B. 2533 into more accurate alignment with actual practice patterns, we are suggesting addition of a new Section 5 (g):

> persons employed in the clinical laboratory who are performing collection and analysis functions similar or identical to those performed in an independent Respiratory Therapy department but which would not restrict the practice of respiratory therapy in that facility.

I thank you for this opportunity to provide testimony on this bill and strongly urge that you implement our recommended changes prior to introduction of H.B.2533 for vote of the House of Representatives.

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