

**House Committee on Health and Human Services RI State House,  
82 Smith Street Providence, RI 02903**

**April 13, 2026**

**Re: Testimony in Opposition to House Bill 7740**

Dear Chairperson Donovan and members of the HHS Committee,

My name is Alexander Cohen, MD, and I live in East Greenwich, RI. I am an anesthesiologist at Brown University Health and the Brown University Department of Anesthesiology. I hold roles as Vice Chair and Medical Director of Perioperative and Periprocedural services at Rhode Island Hospital, and I am currently the President of the Rhode Island Society of Anesthesiologists (RISA).

I am writing to strongly oppose House Bill 7740. While I recognize that this year's bill includes revisions intended to address concerns raised during the 2025 session, the fundamental issues remain unresolved. Regardless of changes to specific language or drug lists, the core impact of this bill is reduced patient access and an unnecessary intrusion into clinical practice.

For decades, Rhode Island has successfully used a model in which appropriately trained non-anesthesiologists administer sedation within well-defined clinical protocols and escalation pathways. This approach has been safe and effective when supported by the robust oversight and infrastructure already in place across our state's healthcare system.

My continued opposition centers on three primary points:

1. **Clinical regulation vs. legislation:** Clinical practice evolves rapidly. Statutory law is not well suited to regulating medical care because it cannot keep pace with peer-reviewed evidence and changes in standards of care. Patient safety is best advanced through clinical guidance and institutional protocols that can be updated as evidence evolves.
2. **Existing oversight and safety standards:** The concerns raised by this bill are regulatory and are already addressed through existing federal and accreditation requirements. CMS Conditions of Participation and Joint Commission standards require health systems to create and evaluate sedation services and to monitor outcomes. Oversight belongs to the Rhode Island Department of Health, which has specialized expertise in implementing and enforcing these standards.
3. **Decreased patient access:** By imposing rigid statutory constraints on a model that has been safe for decades, HB 7740 would create avoidable barriers to care. It risks disrupting high-volume sedation services that allow patients to receive timely procedures close to home.

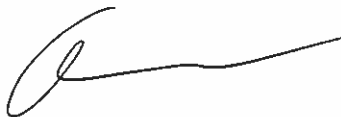
Attached to this written testimony are the following support documents:

1. Support Document #1: Propofol vs. fentanyl package inserts (images). Demonstrates that propofol has no FDA black box warning, while fentanyl does.
2. Support Document #2: Society for Pediatric Sedation (SPS) home page (image). Illustrates that many well-known institutions nationally use similar non-anesthesiologist sedation models.
3. Support Document #3: SPS publication on adverse events during pediatric sedation/anesthesia (abstract/image). Summarizes adverse event incidence and nature in non-operating-room settings.
4. Support Document #4: "Non-anesthesiologist administered propofol sedation for endoscopic procedures: A worldwide safety review" (2008) (abstract/image).
5. Support Document #5: CMS regulations and guidance on moderate sedation for procedural services (April 14, 2017) (excerpt/image).
6. Support Document #6: American Society for Gastrointestinal Endoscopy (ASGE) position statement on non-anesthesiologist administration of propofol for GI endoscopy (2009) (excerpt/images).

These attached materials demonstrate that Rhode Island's current regulatory framework aligns with widely accepted national standards and safe practice models. HB 7740 would disrupt systems that already work and would decrease access for patients who rely on timely procedural care.

Thank you for your time and for considering the negative impact this bill will have on healthcare access in our state. I respectfully urge the committee to vote against House Bill 7740.

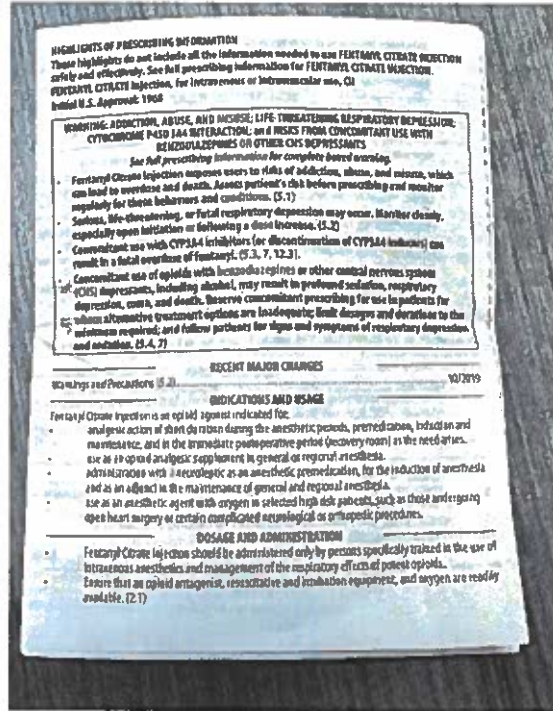
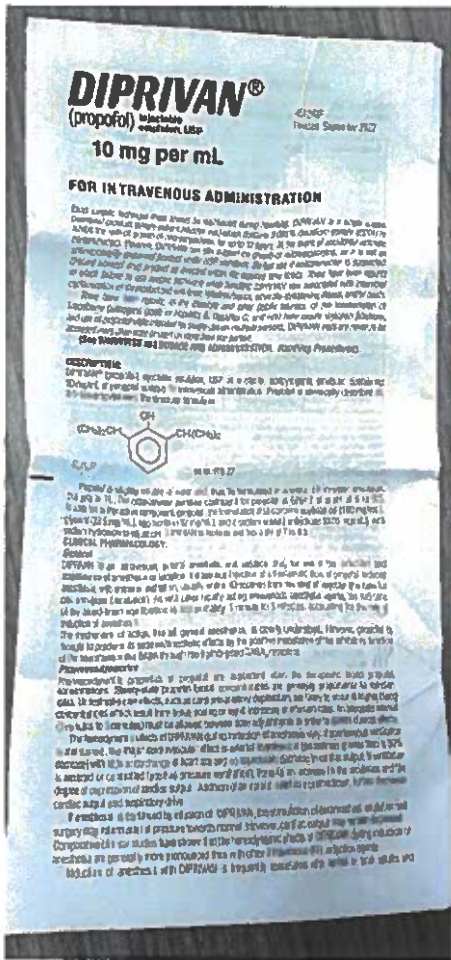
Sincerely,

A handwritten signature in black ink, appearing to read 'Alexander Cohen', with a long horizontal flourish extending to the right.

Alexander Cohen, MD East Greenwich, RI House District 30

# Support Documents (Attachments)

Support Document #1. Images of actual propofol package insert (opened 5/8/2024) showing no black box warning (left) and actual fentanyl package insert (opened 5/8/2024) showing a black box warning (right). A black box warning is the first item on a package insert and is literally surrounded by a "black box."



**Support Document #2. Society for Pediatric Sedation (SPS) home page with well-known member institutions.**

**SPS** Society for Pediatric Sedation  
Safe and Sound

About SPS | Annual Conference | Education | Research | Quality & Safety | Membership | Resources

### Our Mission

- EDUCATION**
- QUALITY & SAFETY**
- GET INVOLVED**
- RESEARCH**

**SPS** Society for Pediatric Sedation  
**Center of Excellence**  
in Pediatric Sedation  
**2024-2028**

**Cincinnati Children's**  
Changing the children's experience

**Connecticut Children's**

**dell children's**  
Ascension

**St. Jude Children's Research Hospital**  
Fighting Cancer. Saving Lives.

**LWHealthKids**

**Children's**

**Children's Hospital LOS ANGELES**

**CH** Children's Hospital of Philadelphia

**UPMC CHILDREN'S**  
HOSPITAL OF PITTSBURGH

**Yale New Haven Health**  
Yale New Haven Children's Hospital

## Support Document #3. Society for Pediatric Sedation (SPS) publication on adverse events during pediatric sedation/anesthesia.

### ABSTRACT

**OBJECTIVE.** We sought to use a large database of prospectively collected data on pediatric sedation and/or anesthesia for diagnostic and therapeutic procedures to delineate the nature and the frequency of adverse events that are associated with sedation/anesthesia care for procedures that are performed outside the operating room in children.

**METHODS.** Data were collected by the Pediatric Sedation Research Consortium, a collaborative group of 35 institutions that are dedicated to improving sedation/anesthesia care for children internationally. Members prospectively enrolled consecutive patients who were receiving sedation or anesthesia for procedures. Data on demographics, primary illness, coexisting illness, procedure performed, medications used, outcomes, airway interventions, and adverse events were collected and reported on a Web-based data collection tool.

**RESULTS.** A total of 26 institutions submitted data on 30 037 sedation/anesthesia encounters during the study period from July 1, 2004, to November 15, 2005. Serious adverse events were rare in the institutions involved in this study; there were no deaths. Cardiopulmonary resuscitation was required once. Less serious events were more common with O<sub>2</sub> desaturation below 90% for >30 seconds, occurring 157 times per 10 000 sedations. Stridor and laryngospasm both occurred in 4.3 per 10 000 sedations. Unexpected apnea, excessive secretions, and vomiting had frequencies of 24, 41.6, and 47.2 per 10 000 encounters, respectively.

**CONCLUSIONS.** Our data indicate that pediatric sedation/anesthesia for procedures outside the operating room is unlikely to yield serious adverse outcomes in a collection of institutions with highly motivated and organized sedation services. However, the safety of this practice depends on the systems' ability to manage less serious events.

[www.pediatrics.org/cgi/doi/10.1542/peds.2006-0313](http://www.pediatrics.org/cgi/doi/10.1542/peds.2006-0313)

doi:10.1542/peds.2006-0313

#### Key Words

pediatric sedation, adverse events, complications

#### Abbreviations

AAP—American Academy of Pediatrics

PSRC—Pediatric Sedation Research Consortium

ASA—American Society of Anesthesiologists

NPO—nil per os

CPR—cardiopulmonary resuscitation

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**Support Document #4. Abstract: “Non-anesthesiologist administered propofol sedation for endoscopic procedures: A worldwide safety review.” Published 2008 (Gastrointestinal Endoscopy).**

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**Non-anesthesiologist Administered Propofol Sedation for Endoscopic Procedures: A Worldwide Safety Review**

Viju P. Deenadayalu, Emely F. Eid, John S. Goff, John A. Walker, Lawrence B. Cohen, Ludwig T. Heuss, Shajan Peter, Christoph Beglinger, James Sinnott, Patrick D. Gerstenberger, Anthony C. Clarke, Harold Munnings, Magdy Z. Rofail, Iyad M. Subei, Rodger A. Sleven, Akira Horiuchi, Kuklip Sandhu, Paul A. Jordan, Douglas K. Rex

**Background.** Propofol administration for endoscopic procedures by anesthesia specialists is costly. Non-anesthesiologist administered propofol sedation (NAP) is rapidly evolving but is controversial due to concerns about safety, mainly respiratory depression. Our goal was to determine the overall number of endotracheal intubations, neurologic injuries, and deaths and mask ventilations associated with NAP for endoscopic procedures. **Methods.** We reviewed all published abstracts and papers utilizing NAP for endoscopic procedures. To the best of our knowledge, we also contacted all gastroenterologists performing NAP for endoscopy to participate in our safety review. All contacted gastroenterologists submitted their updated data on safety. To perform our literature search, we queried Ovid Medline (1966-August 2007). The following complications were available in all patients: endotracheal intubations, neurologic injuries, and death. We also investigated whether mask ventilation was more frequent with EGDs versus colonoscopies, when available. **Results.** A total of 456,918 (213,527 published and 243,391 unpublished) NAP procedures were collected in our database. Endotracheal intubations, neurologic injuries, and deaths were 4, 1, and 3, respectively (data available for all patients). The deaths occurred in a patient with widely metastatic pancreatic cancer, a severely handicapped patient with mental retardation, and a patient with an extensive history of polysubstance abuse. In 2 of the 3 deaths, a decision to withdraw life support was made by the families of the patients. The overall number of cases requiring mask ventilation was 322 out of 400,769 cases with data available. Mask ventilation rates were compared between EGDs and colonoscopies for studies and sites specifying risk by procedure type. Fifty of 123,768 patients and 11 of 97,429 patients required mask ventilation during their EGD or colonoscopy, respectively ( $p < 0.001$ , chi-square test). In the remaining 261 patients requiring mask ventilation, the type of endoscopic procedure performed was unclear. **Conclusions.** The administration of propofol by non-anesthesiologists for endoscopic procedures is safe. Mask ventilation was required more frequently with EGDs compared to colonoscopies. NAP is one feasible solution to the high costs associated with anesthesiologist delivered sedation for endoscopy.

**Support Document #5. CMS regulation and guidance: descriptions of moderate sedation for procedural services (April 14, 2017).**

***J. Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services***

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care.

**Support Document #6.** Excerpts from the American Society for Gastrointestinal Endoscopy (ASGE) position statement: non-anesthesiologist administration of propofol for GI endoscopy. Published 2009 (Gastrointestinal Endoscopy).

### **Recommendations**

1. The safety profile of NAAP is equivalent to that of standard sedation with respect to the risks of hypoxemia, hypotension, and bradycardia for upper endoscopy and colonoscopy (grade 1B).
2. The safety profile of NAAP when it is administered during ERCP and EUS appears to be equivalent to that of standard sedation. However, the worldwide experience with NAAP during these procedures is insufficient to draw definitive conclusions about its use in these settings (grade 1C).

### **Summary**

1. The administration of propofol and standard sedation by nonanesthesiologists is comparable with respect to their efficacy and safety profiles. Proper training and patient selection are crucial for the safe practice of NAAP sedation.
2. Gastroenterologists and registered nurses in many countries have successfully acquired the skills necessary to safely administer propofol-based sedation. Both didactic and hands-on experience as well as airway training and a preceptorship are currently believed to be important elements of a training program.
3. Most studies show that NAAP sedation is superior to standard sedation regimens regarding time to sedation and time to recovery. Patient satisfaction with propofol sedation ranges from equivalent to slightly superior when compared to standard sedation.
4. The use of anesthesiologist-administered propofol for healthy individuals undergoing elective endoscopy without risk factors for sedation-related complications is very costly, with no demonstrated improvement in patient safety or procedural outcome.
5. Further comparative trials of NAPS and BPS are warranted.