April 29th, 2026
The Honorable Melissa A. Murray, Chair,
and members of the committee
Rhode Island House Health and Human Services Committee
RI General Assembly
RI State House
82 Smith St.
Providence, RI 02903

Re: Written Testimony in OPPOSITION to S-3184 – Safe Administration of Sedation

To the Honorable Members of the House Health & Human Services Committee:

My name is Amanda Pascua, MSN, APRN, AGACNP-BC, and I am a licensed Pulmonary and Critical Care Nurse Practitioner practicing in the state of Rhode Island. I write to express my strong opposition to S-3184, which seeks to

impose statutory restrictions on the administration of sedation and anesthetic agents by registered nurses (RNs) and advanced practice registered nurses (APRNs).

While presented as a patient safety measure, this legislation is **clinically misinformed, internally inconsistent, and operationally unsafe** in real-world care settings.

Section (a) broadly prohibits APRNs and RNs from administering commonly used agents such as propofol and etomidate across all levels of sedation, regardless of training, credentialing, or clinical setting. This sweeping restriction directly conflicts with modern standards of care. In intensive care units and emergency departments, APRNs are extensively trained in pharmacology, airway management, and procedural sedation. Many are formally

credentialed by their institutions to safely administer and titrate these medications in highly monitored environments. Removing this ability by statute does not improve safety—it **removes experienced providers from critical moments of care**.

Equally concerning is the language in Section (b), which reduces the RN to a "third hand" to a physician or APRN during emergent airway management. This terminology is not only dismissive of nursing expertise—it is **clinically unrealistic and potentially dangerous**. Emergency airway management depends on highly skilled team members who must act decisively within their scope. Embedding vague and hierarchical language into statute introduces hesitation and liability in time-sensitive situations.

Section (c) attempts to create an emergency exception, allowing anesthetic

administration in situations involving imminent threat to life or limb. However, this provision is **legally ambiguous and clinically impractical**. It forces providers to make real-time legal determinations under pressure, potentially delaying care due to fear of professional or regulatory consequences. Patient deterioration is rarely binary, and early intervention is often what prevents true emergencies.

Section (d) further underscores the internal contradictions within this bill. While Section (a) broadly prohibits administration of anesthetic agents, Section (d) permits their use in intubated, mechanically ventilated patients in critical care settings. This creates **confusion, inconsistency, and unnecessary legal exposure** for providers and institutions attempting to comply with conflicting statutory directives.

It is also important to recognize a troubling pattern. For the past several years, legislation has repeatedly been introduced in Rhode Island attempting to restrict the scope of practice of highly trained RNs and APRNs in the area of sedation. Notably, in prior legislation in the house side such as (2024) H 8237, entirely different medications—including ketamine—were specifically targeted. In the current version, the list of prohibited agents has changed again. This evolving and inconsistent approach underscores a fundamental issue: **these decisions are being made through legislation rather than through appropriate clinical and regulatory channels**.

If prior legislation had been enacted as written, it would have statutorily restricted medications that, by today's standards and practice patterns, are clearly not the issue

being debated. The same can be said of the current bill—what is being restricted today could very well be reconsidered a year from now as clinical practice, evidence, and standards continue to evolve. This cycle creates instability, confusion, and risk for both providers and patients.

Medical practice is dynamic and evidence-driven. It requires **continuous review, expert input, and flexibility**—all of which are inherently incompatible with rigid statutory language. Decisions regarding which medications are appropriate, who may administer them, and under what circumstances should be made by qualified regulatory bodies and institutional credentialing committees with the ability to adapt over time—not by legislation that is, by design, slow to change and disconnected from real-time clinical practice.

Beyond these clinical concerns, S-3184 reflects a fundamental misunderstanding of how modern healthcare systems function. Hospitals already maintain rigorous credentialing, privileging, and oversight processes to ensure providers practice safely within their scope and competency. These determinations are best made by institutions, licensing boards, and the Rhode Island Department of Health—not codified into rigid statutory prohibitions that cannot adapt to evolving evidence or patient needs.

This bill will also have **serious workforce implications**. Rhode Island is already facing significant healthcare staffing shortages. Restricting APRN scope of practice will further strain the system, delay care, and reduce access—particularly in high-acuity and underserved settings. It

risks driving highly trained providers out of the state at a time when recruitment and retention are critical.

If there are concerns regarding sedation practices, the appropriate response is **targeted regulatory oversight, standardized credentialing, and continued education**—not sweeping legislative bans. Existing regulatory bodies are fully capable of addressing these issues in a manner that is evidence-based and responsive to clinical realities.

I would also like to bring to your attention a letter submitted to the House by the RIDOH in response to companion legislation being considered in the house. In it, the RIDOH explains that it is currently undergoing the rule-making process regarding this specific practice and how it should apply across the

respective healthcare disciplines. This established regulatory pathway, as outlined in RIGL 42-35-2.7, is the appropriate mechanism for addressing such matters and should be allowed to proceed without interference.

I respectfully urge this Committee to **reject** S-3184. Patient safety is best served by empowering qualified providers—not restricting them through inflexible and contradictory statutory language.

Respectfully submitted,

Amanda Pascua, MSN, APRN, AGACNP-BC
Pulmonary & Critical Care Nurse Practitioner