April 30, 2026

Hon. Melissa Murray
Chair, Senate Committee on Health and Human Services
Rhode Island State House
Providence, RI 02903

Re: Support for S3184 Substitute A - Safe Administration of Anesthesia

Dear Chair Murray and Members of the Committee:

The Rhode Island Association of Nurse Anesthetists (RIANA) supports Senate Bill 3184 Substitute A as amended. The amended legislation is a good compromise that supports patient safety while preserving necessary flexibility for emergency, critical care, and other appropriate clinical settings. By focusing on the administration of medications classified as general anesthetics in elective procedures, the amended bill addresses RIANA's core concern: ensuring that patients receiving anesthesia-level medications in planned procedures are protected by clear safeguards and the involvement of properly trained anesthesia professionals.

RIANA's support for this bill is grounded in the daily clinical reality of anesthesia practice. Propofol and similar medications classified as anesthetic agents are powerful drugs that require specialized education, training, judgment, and experience to administer safely. The question is not whether nurse practitioners are valuable providers. They are. The question is whether elective administration of anesthesia-level medication should be performed by clinicians who are not educated, licensed, certified, and clinically trained as anesthesia providers. RIANA believes the answer must be no.

Senate Bill 3184 Substitute A draws the appropriate line. It does not interfere with emergency medicine, rapid sequence intubation, cardiac arrest, respiratory failure, ICU care, mechanically ventilated patients, or other urgent clinical circumstances. It simply says that when a procedure is elective and anesthesia-level medications are used, Rhode Island patients deserve the protection of trained anesthesia providers.

I. How Did We Get Here?

This legislation is the result of a long and serious patient-safety discussion that began well before the introduction of S3184. RIANA first raised these concerns with the Rhode Island Department of Health in 2024 after becoming aware that nurse practitioners were being used to independently administer propofol, a powerful anesthetic agent, for elective procedures at Brown University Health, including in gastrointestinal and pediatric sedation settings. RIANA's concern

was not theoretical. In its June 2024 letter to the Department of Health, RIANA explained that propofol has no reversal agent, can quickly move a patient from moderate sedation into deep sedation or general anesthesia, and should be administered only by professionals trained and credentialed to manage that level of anesthesia care.

RIANA also made clear from the beginning that this was not an attack on nurse practitioners or on their important role in Rhode Island's health care system. Nurse practitioners are essential providers in hospitals, emergency departments, intensive care units, primary care practices, and specialty settings across the state. The issue here is much narrower: whether non-anesthesia providers should independently administer medications classified as general anesthetics for elective procedures, particularly when those medications may require immediate recognition and management of deep sedation, loss of airway, respiratory depression, or cardiovascular instability.

The concern became more acute because RIANA understood this practice to be limited to one health system and not a generally accepted standard of care in Rhode Island. RIANA's June 2024 letter stated that no other Rhode Island hospital was allowing nurse practitioners to independently administer propofol for elective procedures, and that the practice raised serious scope-of-practice and patient-safety questions. RIANA also noted that the Department of Health and Board of Nursing had reviewed the matter and, in April 2024, ***determined that the administration of propofol by certified nurse practitioners was not supported within the nurse practitioner scope of practice.***

After the Senate voted to pass similar legislation last year, the Rhode Island Department of Health stated that it would address the issue through regulation before the end of that year. Unfortunately, that did not occur. It was not until April 2026 that RIDOH issued an Advance Notice of Proposed Rule for the Administration of Anesthetic Agents for Sedation. The timing and substance of that advance notice are important because the proposed regulations appear to stand in tension with the Department's own prior stated position on this issue.

That is why legislation remains necessary. Rhode Island patients, providers, hospitals, and regulators need clear statutory direction that protects patient safety and prevents the elective administration of anesthesia-level medications by professionals who are not educated, trained, licensed, and board-certified as anesthesia providers.

The clinical concern is not merely the name of the medication; it is what the medication does.

In elective endoscopy, pediatric imaging, biopsies, and other diagnostic or therapeutic procedures, the clinical goal is often to keep the patient still, comfortable, and able to tolerate a procedure that may be painful, frightening, or physically stimulating. In practice, that frequently

requires a level of sedation deeper than what is commonly described as "moderate sedation." If a patient is truly responsive to verbal commands and light tactile stimulation, that patient may move during a painful or stimulating procedure. In many of these settings, the practical objective is immobility and tolerance of stimulation, which is much closer to deep sedation or anesthesia-level care.

There is no fixed dose of propofol that guarantees a patient will remain at one level of sedation and will not progress to deep sedation or general anesthesia. Even experienced anesthesia providers must constantly titrate, reassess, and intervene. The difference is that anesthesia providers are trained to anticipate and manage airway obstruction, apnea, oxygen desaturation, hemodynamic instability, and other cardiorespiratory events in real time.

Experienced CRNAs have explained this point to the General Assembly in practical terms. Nurse anesthesia graduates complete thousands of hours of clinical anesthesia experience, including airway management, anesthetic titration, induction and emergence, and maintenance of anesthetics across hundreds of cases involving patients of all ages and acuity levels. That is the training model Rhode Island patients should be able to rely upon when anesthesia-level medications are administered in elective procedures.

The warning language associated with propofol reinforces RIANA's position. For general anesthesia or monitored anesthesia care sedation, propofol labeling states that it should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical or diagnostic procedure. That warning is not a technicality. It reflects the real risk that propofol can cause hypotension, apnea, airway obstruction, oxygen desaturation, and rapid progression to a deeper level of sedation than intended.

In the elective setting, where care can be planned, RIANA believes patients should not be placed in a position where anesthesia expertise is only summoned after deterioration has occurred. The safest time to involve an anesthesia-trained provider is before the anesthetic agent is administered, not after the patient loses an airway or stops breathing.

II. What About the Proposed Regulations?

The Committee may hear that legislation is unnecessary because the Rhode Island Department of Health has now issued proposed regulations on this issue. Respectfully, RIANA disagrees. RIDOH's April 2026 advance notice of proposed rulemaking is an important development, and RIANA appreciates that the Department has finally begun a formal regulatory process. However, the proposed regulations also demonstrate why S3184 Substitute A remains necessary.

While the draft regulations reflect some principles that RIANA has advanced for several years,

they materially diverge from RIANA's position and from the clearer patient-safety framework contained in the amended legislation in five important ways.

1. Eliminate conditional elective sedation authority for non-CRNA APRNs.

The draft regulation would allow certified nurse practitioners with "training and experience" to administer anesthetic agents for sedation to patients without a protected airway, including for "moderate to deep sedation," so long as a practitioner privileged by the facility to intubate is present at the bedside or immediately available. RIANA believes this is the central flaw in the draft rule. In elective procedures, there should be a clear prohibition on the administration of medications classified as general anesthetics by non-CRNA APRNs. Elective care is planned care. Patient safety demands that anesthesia-level medications be administered by providers whose education, licensure, certification, and clinical training are grounded in anesthesia practice.

2. Clarify that elective propofol use constitutes anesthesia-level care.

The proposed regulation correctly recognizes that sedation exists on a continuum and defines deep sedation as a drug-induced depression of consciousness in which patients cannot be easily aroused, may have impaired ventilatory function, may require assistance maintaining a patent airway, and may have inadequate spontaneous ventilation. But the draft does not go far enough. RIANA believes the rule must state clearly that elective administration of anesthetic agents such as propofol, particularly in patients without a protected airway, constitutes anesthesia-level care regardless of whether a facility chooses to label it "moderate sedation." Without that clarity, the same medication, same procedure, and same clinical risk may be characterized differently depending on the provider administering it. That creates confusion, weakens enforcement, and undermines uniform patient-safety standards.

3. Remove "immediately available" as a substitute for scope of practice.

The proposed rule defines "immediately available" as a licensed practitioner located in the same clinical area, privileged by the facility to intubate, who may oversee up to two concurrent procedures. RIANA does not believe that framework is adequate for elective anesthesia-level care. Scope of practice cannot be expanded by placing another practitioner nearby. A patient who loses an airway, stops breathing, or rapidly progresses into deep sedation or general anesthesia does not need theoretical backup; that patient needs continuous, dedicated anesthesia expertise.

4. Prevent hospital credentialing from expanding scope of practice.

The draft regulation relies heavily on facility privileging. RIANA believes the regulation must be

explicit that hospital or facility credentialing may not expand a provider's lawful scope of practice. Credentialing is an institutional administrative process. It is not a substitute for anesthesia education, anesthesia licensure, national certification, minimum case experience, continuing specialty competency, or anesthesia-specific malpractice coverage. S3184 Substitute A properly treats this as a matter of law and patient safety, not as a facility-by-facility policy choice.

5. Explicitly address pediatric elective sedation.

The draft regulations do not contain a clear, specific prohibition on elective pediatric sedation involving anesthetic agents by non-CRNA APRNs. That omission is significant. Pediatric patients present heightened airway and respiratory risks, have less physiologic reserve, and can deteriorate rapidly. Failed airway management in a child often requires immediate advanced anesthesia intervention. For that reason, RIANA believes elective pediatric sedation involving medications classified as general anesthetics should be limited to CRNAs and anesthesiologists.

The proposed regulations also fail to account for the speed with which an airway emergency can develop. When a patient stops breathing, the brain begins to suffer from lack of oxygen within minutes. The safety issue is not whether someone may be somewhere nearby or theoretically available to intubate. The safety issue is whether the person administering the anesthetic agent has the anesthesia-specific training and experience to recognize the problem immediately, manage the airway immediately, and intervene before the patient is harmed.

That is the practical difference between an anesthesia provider and a non-anesthesia provider administering propofol in an elective procedure. CRNAs do not merely respond to emergencies; they are trained to prevent them, anticipate them, and manage them in real time while continuously titrating anesthetic drugs. "Immediately available" backup is not equivalent to continuous anesthesia care.

In short, RIDOH's proposed regulations are not a substitute for S3184 Substitute A. The amended legislation provides the clearer and safer rule: preserve necessary flexibility for emergencies, critical care, rapid sequence intubation, respiratory failure, cardiac arrest, and mechanically ventilated patients, while prohibiting the elective administration of medications classified as general anesthetics by providers who are not anesthesia professionals.

III. What Do Other States Do?

The experience of other states is important because it confirms that RIANA's position is not unusual, extreme, or protectionist. To the contrary, the practice that prompted this legislation - allowing non-CRNA APRNs to independently administer propofol or other anesthetic agents for

elective procedures - is what makes Rhode Island an outlier. The proposed RIDOH regulations would not correct that problem; they would legalize and institutionalize it.

Across the country, state boards of nursing and major health systems repeatedly recognize the same core principles: sedation is a continuum; propofol and similar agents can rapidly move a patient from moderate sedation into deep sedation or general anesthesia; these drugs lack reliable reversal agents; and the administration of anesthesia-level medications should be limited to anesthesia-trained providers, with narrow exceptions for emergencies, intubated and mechanically ventilated patients, critical care settings, palliative sedation, or situations where a nurse is assisting an anesthesia provider.

- Connecticut - Propofol for sedation/anesthesia should be administered only by persons trained in general anesthesia and not involved in the surgical or diagnostic procedure; critical-care ventilated patients are treated separately. Connecticut recognizes the same distinction in S3184A: elective anesthesia-level medication is different from intubated critical-care sedation.
- Massachusetts –For non-intubated patients receiving medications capable of producing deep sedation, Massachusetts requires that the RN's sole responsibility be airway management, that the RN act in the presence of a provider trained in anesthesia and proficient in airway management and advanced life support, and that another individual provide uninterrupted monitoring with no competing responsibilities. In other words, Massachusetts does not treat facility policy or general clinical experience as a substitute for anesthesia-trained presence and dedicated airway protection. That approach supports RIANA's position: elective anesthesia-level sedation requires heightened safeguards and should not be normalized as ordinary moderate sedation by non-anesthesia providers.
- Maine - Propofol for nonventilated patients is restricted to CRNAs, with limited exceptions for intubation, mechanically ventilated patients, emergency intubation, and palliative sedation. Maine's approach mirrors RIANA's request: maintain emergency and critical-care flexibility while prohibiting elective non-anesthesia propofol sedation.
- New Hampshire - When an anesthetic agent is used for sedation/anesthesia, only persons trained in general anesthesia and not simultaneously involved in the procedure should use it; anesthesia drugs are outside non-anesthesia nursing scope except for limited circumstances. New Hampshire recognizes that assistance, ICU care, emergencies, and palliative sedation are exceptions, not a basis for elective independent anesthesia practice.
- New York - Any drug considered an anesthetic agent must be administered by a trained anesthesia provider; propofol is not an appropriate agent for RN administration for conscious sedation unless the RN is a CRNA, with a critical-care ventilated-patient exception.

- Veterans Health Administration - Non-anesthesia providers may not administer sedative hypnotics such as propofol, methohexital, ketamine, or etomidate except for limited circumstances such as immediately securing the airway.
- Boston Children's Hospital - Advanced Practice Clinicians (NP and PA) and registered nurses are not privileged to administer deep sedation. This is stated on Page 5 of the Boston Children's "Patient Sedation for Procedures Policy/Procedure" - which Brown University Health distributed to the House Committee.

Taken together, these materials show a clear national pattern. Other jurisdictions and major health systems generally allow appropriately trained non-anesthesia providers to participate in moderate sedation, but they do not allow facility credentialing, institutional policy, or "immediate availability" of a backup provider to convert non-anesthesia clinicians into independent anesthesia providers for elective procedures involving propofol or other anesthetic agents.

That is precisely the concern with the current practice at Brown University Health. Rhode Island should not become the state that authorizes by regulation what other jurisdictions have rejected or limited. If RIDOH's proposed regulations are adopted as drafted, Rhode Island would not merely remain an outlier; it would become a further outlier by expressly legalizing the elective administration of anesthesia-level medications by non-CRNA APRNs based on facility privileging and backup availability rather than anesthesia education, licensure, and certification.

S3184 Substitute A brings Rhode Island back in line with the mainstream patient-safety approach reflected in other states. It preserves appropriate flexibility for emergencies, critical care, rapid sequence intubation, respiratory failure, cardiac arrest, and mechanically ventilated patients. But it draws a clear and necessary line for elective procedures: medications classified as general anesthetics should not be administered by providers who are not anesthesia professionals. That is not an unusual rule. It is the prevailing patient-safety standard.

IV. Conclusion

RIANA respectfully asks the Committee not to wait for a preventable adverse event before drawing a clear patient-safety line. Elective procedures are planned procedures. There is time to determine who should administer anesthesia-level medications, what level of monitoring is required, and what professional training is necessary to protect the patient. In that setting, Rhode Island should require the safest standard: medications classified as general anesthetics should be administered by anesthesia professionals.

S3184 Substitute A strikes the right balance. It does not interfere with emergency care, rapid sequence intubation, cardiac arrest, respiratory failure, ICU care, mechanically ventilated patients, or other urgent clinical circumstances. It simply says that in elective procedures, Rhode Island patients deserve the protection of trained anesthesia providers when general anesthetic medications are used.

For these reasons, RIANA respectfully urges passage of Senate Bill 3184 Substitute A.

Respectfully submitted,

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