

Overview of the Bill

S 3184A seeks to statutorily restrict the administration of medications classified as *general anesthetics* for elective procedures to CRNAs, carving out limited exceptions for emergency and critical care settings. While intended to standardize “safe administration of sedation,” the bill introduces scope-limiting language that exceeds national norms, creates clinical ambiguity, and risks unintended patient-care consequences.

Impact on Rhode Island’s Nursing Workforce and Care Delivery Capacity

Rhode Island currently licenses more than 27,000 registered nurses, approximately 4,000 nurse practitioners, and only about 100 certified registered nurse anesthetists (CRNAs). **Senate bill 3184A** proposes to concentrate authority for elective administration of commonly used sedative and anesthetic agents almost exclusively within this very small subset of the nursing workforce.

This shift is neither operationally viable nor consistent with contemporary health system design. Expecting a workforce of roughly 100 CRNAs to absorb responsibilities currently distributed safely across tens of thousands of appropriately trained RNs and NPs would create immediate bottlenecks, delays in care, and reduced procedural capacity statewide. Such a model is particularly untenable in procedural areas, cardiac catheterization laboratories, emergency departments, and intensive care units where timely sedation is essential to patient care flow and outcomes.

Inappropriate and Inefficient Use of Anesthesia Services

Mandating CRNA involvement for elective sedation where it is not clinically required represents an inappropriate use of anesthesia services. CRNAs are highly specialized clinicians whose expertise is best reserved for cases requiring general anesthesia or advanced anesthetic management—not routine, protocolized sedation already managed safely by RN- and NP-led teams.

Requiring anesthesia services in these settings would:

- Increase costs without improving safety
- Reduce access to timely procedures
- Divert scarce anesthesia resources away from patients who truly require them

This approach is not remotely a viable option for a healthcare system already strained by workforce shortages and growing patient demand.

1. Misalignment with National Practice Standards

A. National Regulation Is Setting- and Competency-Based, Not Profession-Exclusive

Nationally, the administration of sedative and anesthetic agents is governed by:

- **Setting of care** (OR vs ICU vs ED)
- **Patient acuity**
- **Provider education, competency, and credentialing**

- **Institutional policies and privileging**

Professional and accrediting bodies (e.g., CMS, Joint Commission, AHA, SCCM) do not categorically prohibit APRNs or RNs from administering agents such as propofol or etomidate when:

- The provider is appropriately trained and credentialed
- The activity occurs within approved protocols
- Medical oversight and rescue capability exist

By contrast, S 3184A introduces a profession-exclusive statutory restriction rather than deferring to clinical governance structures that already exist and function safely nationwide.

B. Conflation of “General Anesthesia” with Procedural and ICU Sedation

The bill relies on medication class rather than intent, depth of sedation, or clinical context, conflating:

- General anesthesia (loss of consciousness with airway intervention)
- Deep sedation
- Procedural sedation
- ICU sedation for mechanically ventilated patients

In national practice:

- Medications such as propofol and etomidate are routinely used by APRNs and RNs in EDs, ICUs, cath labs, and procedural areas
- Safety is determined by monitoring, airway readiness, and rescue capability, not by the title of the clinician alone

This bill risks codifying a clinical oversimplification that does not reflect real-world care delivery.

2. Infringement on RN and APRN Scope of Practice

A. APRN Practice Is Defined by Education, Certification, and Board Authority

APRNs are:

- Educated at the graduate level
- Nationally certified
- Regulated by boards of nursing
- Credentialed and privileged by healthcare institutions

Many APRNs (e.g., ACNPs, AGACNPs, FNPs in hospital roles) are already trained in airway management, procedural sedation, and ICU pharmacology.

By legislatively excluding non-CRNA APRNs from elective administration—regardless of training, privileging, or competency—this bill:

- Overrides Board of Nursing authority
- Undermines institutional credentialing processes
- Establishes scope by statute rather than competence

This approach is out of step with national advanced practice regulation, which emphasizes role delineation and competency validation, not blanket exclusions.

B. RN Practice Is Already Safely Governed by Protocols and Supervision

RNs nationwide:

- Titrate propofol and other anesthetic agents in ICUs and procedural areas
- Act under standing orders, protocols, and provider supervision
- Are trained in sedation assessment, monitoring, and escalation

S 3184A introduces unnecessary legal rigidity by:

- Restricting elective practice rather than unsafe practice
- Creating ambiguity about nurse-driven sedation protocols in procedural areas
- Risking inconsistency across units and hospitals

3. Impact on Patient Care and Health System Operations

A. Reduced Access and Procedural Delays

The bill may:

- Limit availability of appropriately trained APRNs in procedural settings
- Create reliance on CRNAs even for low-risk, protocolized sedation
- Increase case delays or cancellations, particularly in:
 - Cardiac cath labs
 - Endoscopy
 - Interventional radiology

This is particularly concerning amid national workforce shortages.

B. Increased Cost Without Demonstrated Safety Benefit

Restricting sedation to CRNAs for elective procedures may:

- Increase staffing costs
- Reduce procedural flexibility
- Shift care to higher-cost staffing models

The bill offers no data demonstrating improved safety outcomes from profession-exclusive restrictions compared with competency-based models currently in place nationwide.

C. Legal and Ethical Ambiguity in “Emergency” Carve-Outs

While the bill allows emergency exceptions, it:

- Places clinicians at legal risk when clinical urgency is subjective
- Forces retrospective judgment of what constitutes “life-saving”
- May delay care due to uncertainty about statutory compliance rather than clinical need

This legal ambiguity conflicts with ethical obligations to act decisively in patient care.

4. Internal Inconsistencies and Redundancy

The bill:

- Duplicates language across Chapters 5-34 and 5-34.2
- Simultaneously restricts and permits the same medications depending on setting
- Acknowledges safe RN/APRN use in ICUs and EDs, undermining the rationale for elective restrictions

This suggests the issue is not medication safety, but practice turf, which is not an appropriate basis for statute.

Summary Assessment

S 3184A is not aligned with national practice norms, infringes upon established RN and APRN scope of practice, and risks:

- Reduced access to timely care
- Increased costs
- Clinician confusion and liability
- Unintended patient harm through delays or inefficiency

Best practice nationally is to regulate sedation through:

- Education and training requirements
- Credentialing and privileging
- Clear institutional policies
- Outcomes-based quality monitoring

—NOT **profession-exclusive legislative bans**.