Steven Sepe

From: Spencer Gilfeather <spencer@gilfeather.net>
Sent: Tuesday, May 14, 2024 12:12 PM
To: House Health and Human Services Committee
Cc: Rep. Cortvriend, Terri-Denise; Rep. Donovan, Susan R; Rep. Abney, Marvin L.; Rep. Finkelman, Alex S.
Subject: House Bill 8237

Re: Testimony in Opposition to House Bill 8237 entitled"An act relating to the business and professions- nurse anesthetists"

Dear Chairperson Donovan, members of the HHS Committee and representatives of Middletown, Rhode Island.

I am Samuel Spencer Gilfeather, Acute Care Nurse Practitioner from Middletown, Rhode Island. I work for Lifespan at Rhode Island Hospital in the Cardiothoracic ICU within the Department of Cardiac Surgery.

As a Registered Nurse of ten years and Acute Care Nurse Practitioner in my fourth year of practice, I am writing in opposition to the proposed bill 8237 restricting the use of Propofol and “like” medication.
Regarding my background, I have practiced in the Emergency Department setting and multiple intensive care units, from Boston Medical Center, MGH, UMASS-Worcester, Oschner/New Orleans, and currently in the Cardiothoracic ICU at Rhode Island Hospital. I am also an associate professor in the Acute Care Nurse Practitioner program at Northeastern University.
The proposed legislation has both malicious intent, through either unintentional or purposeful vague language,and likely demonstrates a misunderstanding about the role of Acute Care NursePractitioners in the ICU, the medications in question, and the treatment of patients in other acute care inpatient settings.
As a bedside nurse in the ICU setting, sedatives are routinely administered for things like procedural sedation, dangerous situations with violent/agitated patients, and for things as common as dressing changes. At MGH for example, doses of medications like midazolam, fentanyl, propofol, dexmedetomidine and ketamine are administered by nurses to facilitate care in burn patients.

This bill’s intention is reasonable in that it aims to avoid “scope creep”, with CNRAs feeling threatened in losing their autonomy. They argue that their training is specific to these medications, when it is obviously not. My team, for example, utilizes medications like propofol, paralytics and other dissociative agents. We are trained and credentialed to do procedures that require these medications, including cardioversions and heaven forbid, opening a chest or abdomen at the bedside.
Regarding their post-graduate training regarding these medications, I attended the same anesthesia pharmacology course that my CRNA peers attended, in addition to other

pharmacology classes as required by the graduate curriculum. Our NP cohorts also study airway anatomy and intubation techniques. And while rare, my in-hospital team will intubate patients in extremis when anesthesia services are unavailable.
The proposed language argues that nurse practitioners are not licensed to administer these medications for even minimal sedation, let alone general anesthesia. We utilize some of these medications like ketamine and dexmedetomidine on awake non-intubated patients safely for pain control and agitation, with minimal risk to airway compromise. This is not unusual or illegal throughout the country, but individual hospitals do dictate their own policies that determine who can and cannot administer these medications.
Imagine resource-poor settings with limited staffing, or highly skilled tertiary teams. The situation, training and credentialing should dictate the practice, not this overreaching legislation.

The argument against my stance will primarily be through the lens of patient safety. The patients we care for in the cardiac surgery team are continuously monitored through many invasive and non-invasive modalities, much like ICUs and ERs across the country. Taking away these medications would be a step backward, and not keeping with the standard of excellence we uphold in New England as a healthcare "mecca".
As Acute Care Nurse Practitioners, we don't want the CRNA's jobs. Their concern for practice creep, while meaning well, will infringe on our ability to maintain patient safety. The legislation additionally ignores the identical role of Physician Assistant vis-a-vie ICU management, while not prohibiting them from administering these same medications and services. The bill will essentially chop our team in half, leading to a service of PA's who can administer propofol, for example, and an NP who cannot. This makes zero sense, especially as nurse practitioners have more experience with dosing these medications by the nature of our educational background and clinical practice.
In closing, the bill, with good intentions, will have many negative consequences, including patient safety, increased healthcare costs, staffing restrictions, and a regression in practice excellence. Please feel free to contact me for further discussion.

Respectfully,
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