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<tr><td>Appeal from the District Court, City and County of Denver
Case No. 2010CV7731
Honorable Ann B. Frick, District Judge</td></tr>
<tr><td>Plaintiff-Appellants: COLORADO MEDICAL SOCIETY, a Colorado nonprofit corporation, and THE COLORADO SOCIETY OF ANESTHESIOLOGISTS, a Colorado nonprofit corporation

Defendant-Appellees: JOHN HICKENLOOPER, in his official capacity as the Governor of Colorado

Intervenor-Appellees: COLORADO ASSOCIATION OF NURSE ANESTHETISTS; COLORADO NURSES ASSOCIATION; and COLORADO HOSPITAL ASSOCIATION</td></tr>
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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with all requirements of C.A.R. 28 and C.A.R. 32, including all formatting requirements set forth in these rules. Specifically, the undersigned certifies that:

1. The brief complies with C.A.R. 28(g).

   Choose one:

   ☒ It contains 6,928 words.

   ☐ It does not exceed 30 pages.

2. The brief complies with C.A.R. 28(k).

   ☒ For the party raising the issue:

   It contains under a separate heading (1) a concise statement of the applicable standard of appellate review with citation to authority; and (2) a citation to the precise location in the record (R.__, p.__), not to an entire document, where the issue was raised and ruled on.

   ☐ For the party responding to the issue:

   It contains, under a separate heading, a statement of whether such party agrees with the opponent's statements concerning the standard of review and preservation for appeal, and if not, why not.

/s/ Joseph J. Bronesky

Joseph J. Bronesky, Attorney for The Colorado Society of Anesthesiologists

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STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Did the District Court err in granting a C.R.C.P. 12(b)(5) motion to dismiss by rejecting factual allegations of the Complaint that the delivery of anesthesia by a certified registered nurse anesthetist (a "CRNA") is a delegated medical function that requires physician supervision?

2. Did the District Court err when, after recognizing that delivery of anesthesia by a "registered professional nurse" requires physician supervision under C.R.S. § 12-38-103(4), it overlooked the fact that a CRNA *is* a "registered professional nurse" under the Colorado Nurse Practice Act?

3. Did the District Court err in failing to consider the extensive legislative history from 2009 that establishes the intent of the Colorado General Assembly that CRNAs should not practice independently of physician supervision?

4. Did the District Court err in failing to consider Colorado's Captain of the Ship Doctrine, which requires physician supervision of the delivery of anesthesia services by a CRNA?

STATEMENT OF THE CASE

This appeal raises the issue whether Colorado law requires physician supervision of the delivery of anesthesia to patients. In September 2010, former Governor Bill Ritter exempted Colorado from federal regulations that require

anesthesia in hospitals, ambulatory surgery centers,[1] and critical access hospitals[2] to be administered by, or under the supervision of, a physician. The process of seeking exemption from the federal anesthesia supervision requirement is called an "opt-out," and it requires certification by a governor that such an exemption is "consistent" with state law.

Because the opt-out is actually inconsistent with Colorado law, the Colorado Medical Society and the Colorado Society of Anesthesiologists filed this action on September 28, 2010, seeking a declaration that Colorado law requires physician supervision of anesthesia services and a mandatory injunction for rescission of the opt-out. ("CMS Complaint," CD Bookmark #33285742[3]) The Colorado Hospital Association (CD #33594239), the Colorado Nurses Association (CD #33637315),

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[1] An ambulatory surgical center is a facility that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. 6 CCR 1011-1, Chapter 20.

[2] Critical access hospitals offer emergency services and limited inpatient care. They may also offer limited surgical services and/or obstetrical services including a delivery room and nursery. 10 CCR 2505-10, § 8.300

[3] The disk containing the record has bookmarks that consist of an eight-digit number for each pleading, followed by an abbreviated title that in many cases is not adequately descriptive of the pleading. For the sake of clarity, this brief refers to the bookmarked pleadings by the eight-digit number that this Court assigned when it prepared the disk.

and the Colorado Association of Nurse Anesthetists (CD #33644966) intervened as Defendants to support the opt-out.

The Governor moved to dismiss pursuant to C.R.C.P. 12(b)(1) for lack of standing and C.R.C.P. 12(b)(5) for failure to state a claim. (CD #33896332) The Colorado Hospital Association later moved for judgment on the pleadings, contending that the District Court lacked jurisdiction under the Separation of Powers Doctrine, and that Plaintiffs failed to exhaust administrative remedies before the Board of Nursing. (CD #34030600)

Plaintiffs recognized that the statutory interpretation issues raised by the Governor's Motion to Dismiss would be dispositive. To position the case for a ruling in their favor, they filed a combined Response in Opposition to the Governor's Motion to Dismiss and a Cross-Motion for Summary Judgment on November 22, 2010. (CD #34715566) They also opposed the Colorado Hospital Association's motion. (CD #34715670)

On November 27, 2010, presiding Judge Morris B. Hoffman recused himself from this case because he was a neighbor of the Director of Public Affairs for Plaintiff Colorado Medical Society. (CD #34478331) The Chief Judge reassigned the case to Judge Herbert L. Stern III, who, on December 3, 2010, issued an order striking Plaintiffs' combined Response and Cross-Motion for Summary Judgment

because it violated the Omnibus Pre-Trial Order that he had entered the same day. (CD #34982119) Plaintiffs timely filed their separate Response to the Governor's Motion to Dismiss (CD #35046465) and a Motion for Summary Judgment on statutory interpretation issues (CD #35046546).

In a written Order dated April 8, 2011, the District Court denied the Hospital Association's C.R.C.P. 12(c) motion. (CD #38323168) The Order determined that the judiciary had the power to review the Governor's determination of Colorado law in his opt-out decision and that there were no administrative remedies that Plaintiffs were required to exhaust. The Order further rejected the Governor's C.R.C.P. 12(b)(1) motion by concluding that Plaintiffs alleged tangible and intangible injuries to establish their standing. But the Court dismissed Plaintiffs' claims under C.R.C.P. 12(b)(5) because it concluded that the Colorado General Assembly intended to allow CRNAs to deliver anesthesia without physician supervision. Notably, the Court did not consider Plaintiffs' Motion for Summary Judgment, which contained an extensive analysis of the legislature's intent in amending and re-enacting the Nurse Practice Act in 2009, because it determined that the Motion was moot.

Plaintiffs timely filed their Notice of Appeal.

STATEMENT OF FACTS

The Colorado Medical Society (the "Medical Society") is a Colorado nonprofit corporation whose membership includes the majority of physicians practicing in Colorado. (Complaint, CD #33285742, pp. 1-2, ¶ 1) The Colorado Society of Anesthesiologists (the "Anesthesiologist Society") is a Colorado nonprofit physician organization committed to patient safety, educational advancement, and providing the best anesthesia care to patients. (*Id.*, p. 2, ¶ 2)

Medicare regulations promulgated pursuant to the Social Security Act have established requirements, known as Conditions of Participation, for certain medical facilities to fulfill in order to participate in the Medicare program. (*Id.*, p. 2, ¶ 7) These medical facilities include ambulatory surgical centers, hospitals, and critical access hospitals. The Conditions of Participation establish standards for each of these facilities for the provision of anesthesia. These standards require that anesthesia be provided only by a qualified anesthesiologist, a physician qualified to administer anesthesia, a CRNA, or by an anesthesiologist assistant. (*Id.*)

Medicare Regulations require physician supervision of anesthesia provided by a CRNA. In a Medicare-certified ambulatory surgery center or critical access hospital, this supervision must be provided by the physician who is conducting surgery. 42 C.F.R. § 416.42, 42 C.F.R. § 485.639. In a Medicare-certified

hospital, supervision is provided by the operating practitioner or by an anesthesiologist who is immediately available if needed. 42 C.F.R. § 482.52.

Medicare Regulations give individual states the option to opt-out of the physician supervision requirement for CRNAs who deliver anesthesia in these facilities if "the State in which the facility is located submits a letter to the Centers for Medicare and Medicaid Services, signed by the Governor of the State, following consultation with the State's Board of Nursing and Medicine, that requests exemption from physician supervision of CRNAs." The letter must attest that "the opt-out is consistent with State law." *See* 42 C.F.R. §§ 416.42(c), 482.52(c), and 485.639(e).

On July 29, 2010, Governor Ritter directed a letter to the Colorado Medical Board and the Colorado Board of Nursing that declared his understanding that "the Colorado Nurse Practice Act allows CRNAs to practice without direct supervision from a physician." (*Id.*, p. 3, ¶ 10) He requested each Board to inform him whether it believed that the termination of physician supervision of CRNAs was "consistent with State law," and whether the termination was in the best interests of Colorado residents. He stated that he would opt Colorado out of the physician supervision requirement unless the Boards provided "compelling arguments against such action." (*Id.*)

The Colorado Medical Board considered the Governor's request at its August 19, 2010, meeting. It voted 7-6 in favor of a motion to determine that the opt-out was in the best interests of Colorado residents, and 8-5 in favor of a motion to opine that the opt-out was consistent with state law. (*Id.*, p. 3, ¶ 11) The Board considered only the Colorado Medical Practice Act, and did not attempt to determine the general application of Colorado law to supervision of CRNAs by physicians. In reaching its decisions, the Board noted that it had not obtained a legal assessment. (*Id.*)

The Colorado Board of Nursing considered the Governor's request at its August 25, 2010, meeting. It unanimously voted in support of the opt-out. It did not attempt to determine the general application of Colorado law to supervision of CRNAs by physicians. (*Id.*, p. 3, ¶ 12)

On September 27, 2010, Governor Ritter notified the federal Centers for Medicare and Medicaid Services by letter that he was exercising the option to exempt all critical access hospitals in Colorado, as well as thirteen "rural general hospitals" that he identified by name, from the requirement of physician supervision for CRNAs. (*Id.*, pp. 3-4, ¶ 13) The letter asserted that "the opt-out is consistent with Colorado state law." He issued a second, very similar letter on September 28, 2010, that identified a fourteenth "rural general hospital" that he

decided to exempt. His second letter added his opinion that the opt-out was in the best interests of Colorado citizens. (*Id.*)

The Medical Society and the Anesthesiologist Society filed their Complaint for Declaratory and Injunctive Relief on September 28, 2010. The Complaint alleged that, as a matter of fact, the administration of anesthesia by a CRNA was a "delegated medical function" that could be conducted only under physician supervision, not an "independent nursing function." It referenced various provisions of the Colorado Nurse Practice Act that supported these factual allegations. Of prime importance, the Complaint explained that delivery of anesthesia was a delegated medical function because it necessarily "implements and is consistent with the medical plan as prescribed by a licensed or otherwise legally authorized physician, podiatrist, or dentist and is delegated to a registered professional nurse or a practical nurse by a physician, podiatrist, dentist, or physician assistant." (*Id.*, p. 4, ¶ 18, *citing* C.R.S. § 12-38-103(4)).

The Complaint also alleged that the Captain of the Ship Doctrine, as adopted by the Colorado Supreme Court in 1957 and subsequently applied by the Colorado Court of Appeals, required physician supervision of CRNAs. (*Id.*, p. 5, ¶¶ 28-29)

Motion practice in the trial court concentrated on provisions of the Nurse Practice Act and the Captain of the Ship Doctrine, with the Governor making his

case in his Motion to Dismiss (CD #33896332), and the Medical Society and Anesthesiologist Society setting out their analysis of the Nurse Practice Act and its legislative history, and the Captain of the Ship Doctrine, in their Response in Opposition to Governor Ritter's Motion to Dismiss and their Cross-Motion for Summary Judgment. (CD #34715566) The Governor and Intervenor Colorado Hospital Association also made jurisdictional arguments that the other Intervenors adopted. (CD #34030600)

The District Court's "Order Re Motion for Judgment on the Pleadings and Motion to Dismiss" granted the Governor's Rule 12(b)(5) Motion and determined that Plaintiffs' Motion for Summary Judgment was moot. (CD #38323168) The Court concluded:

- Provisions of the Nurse Practice Act governing "delegated medical functions" apply only to a registered professional nurse, not to an "advanced practice nurse" such as a CRNA. (*Id.*, p. 4)

- A CRNA, engaging in what she or he has been specially trained and licensed to perform, performs an "independent nursing function," and not a "delegated medical function" when delivering anesthesia. (*Id.*)

- The Colorado General Assembly intended CRNAs to independently deliver anesthesia, as demonstrated by provisions of the Nurse Practice Act that

exempt the delivery of anesthesia by a CRNA from "heightened physician interaction requirements." (*Id.*)

- Provisions of the Nurse Practice Act requiring physician supervision of nurses when implementing a physician's medical plan, would be interpreted "way too broadly" if they were applied to CRNAs. (*Id.*)

- Regulations promulgated by the Colorado State Board of Health allow anesthesia to be administered either by a qualified physician or by a CRNA. (*Id.*)

The Order also rejected the Rule 12(b) arguments that the Governor and Intervenors had made about jurisdiction, standing, and exhaustion. It did not address the arguments made by Plaintiffs about the Captain of the Ship Doctrine.

This appeal followed.

SUMMARY OF ARGUMENT

A physician who develops a medical plan for a surgical procedure is required to ensure that the plan is faithfully executed. A necessary component of the physician's responsibility is the ability to supervise all who take part in the surgical procedure. Because anesthesia is performed pursuant to a medical plan and a surgeon requests anesthesia as part of such a plan, the ordering and delivery of anesthesia falls within the definition of a delegated medical function under the Nurse Practice Act. Delegated medical functions, in turn, require physician

supervision. The Captain of the Ship Doctrine, which embodies the public policy of the State of Colorado, imposes the same obligation.

The legislative history of the 2009 re-enactment and amendment of the Nurse Practice Act re-enforced the requirement that physicians supervise delegated medical functions and rejected the very notion that the Governor and the District Court accepted—that CRNAs are authorized to always practice independently of any physician supervision.

ARGUMENT

Standard of Review

Motions to dismiss under C.R.C.P. 12(b)(5) are viewed with disfavor by Colorado courts. *Story v. Bly*, 217 P.3d 872, 876 (Colo. App. 2008), *citing Rosenthal v. Dean Witter Reynolds, Inc.*, 908 P.2d 1095, 1099 (Colo. 1995). Such a motion should not be granted unless it appears beyond doubt that a plaintiff can prove no set of facts that would entitle it to relief. *Sweeny v. United Artists Theater Circuit, Inc.*, 119 P.3d 538, 539 (Colo. App. 2005). All allegations of material fact must be accepted as true, and must be viewed in the light most favorable to the plaintiff. *Lambert v. Ritter Inaugural Committee, Inc.*, 218 P.3d 1115, 1119 (Colo. App. 2009). Plaintiffs recited these standards of review in their Response to the Governor's Motion to Dismiss. (CD #35046465, pp. 2-3)

An appellate court reviewing a C.R.C.P. 12(b)(5) dismissal must do so on a *de novo* basis. *Paredes v. Air-Serv Corp., Inc.*, 251 P.3d 1239, 1242 (Colo. App. 2010); *Fluid Technology, Inc. v. CHJ Axles, Inc.*, 964 P.2d 614, 616 (Colo. App. 1998).

I. DELIVERY OF ANESTHESIA IS A DELEGATED MEDICAL FUNCTION THAT REQUIRES PHYSICIAN SUPERVISION.

Defendants have contended that advanced practice nurses like CRNAs perform only independent nursing functions and, accordingly, are not subject to physician supervision. The District Court agreed, finding that "both the Colorado statutes and regulations authorize the delivery of anesthesia by a CRNA without physician supervision." (CD #38323168, p. 4) This conclusion is misplaced. Both the longstanding provisions of the Nurse Practice Act and recently-enacted revisions to the Act recognize that among the services provided by advanced practice nurses are delegated medical functions that must be performed with physician supervision. Anesthesia services are medical functions that may be delegated. Accordingly, the District Court erred when it concluded that the Colorado Legislature intended to permit CRNAs always to deliver anesthesia independently of physician supervision.

A. Delivery of Anesthesia Is a Delegated Medical Function.

The delivery of anesthesia involves a number of specific services, including without limit:

- Developing a perioperative medical plan for anesthesia;
- Preoperative evaluation involving diagnostic preparation for the patient;
- Anesthesia care during the procedure;
- Interpretation of intra-operative laboratory tests;
- Administration of intravenous fluids including blood and/or blood products;
- Monitoring such as electrocardiogram (ECG), temperature, blood pressure, pulse oximetry, capnography, end-tidal infrared gas analysis, mass spectrography, bispectral electroencephalography, and transcranial Doppler, when indicated);
- Management of inter-operative complications;
- Immediate post-anesthesia care; and
- A post-anesthesia evaluation, if applicable.

CD #35046589 (Affidavit of Randall Clark, M.D.), Ex. 2, p. 3, ¶ 8; Medicaid Benefits Collaborative Policy Statement, http://www.colorado. gov/cs/Satellite?

blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251682381396&ssbinary=true.

Anesthesia is not a therapy unto itself. It is a component of a medical plan of treatment for an individual. A common example occurs when a surgeon requests anesthesia to facilitate surgery as part of the surgical plan. (CD #35046589, Ex. 2, p. 2, ¶ 4)

Because anesthesia is a part of a physician-prescribed therapeutic or diagnostic plan, it is, by definition, a "delegated medical function" that may be performed by a professional nurse under the Nurse Practice Act, specifically C.R.S. § 12-38-103(4):

> (4) "Delegated medical function" means an aspect of care that implements and is consistent with the medical plan as prescribed by a licensed or otherwise legally authorized physician, podiatrist, or dentist and is delegated to a registered professional nurse or a practical nurse by a physician, podiatrist, dentist, or physician assistant. For purposes of this subsection (4), "medical plan" means a written plan, verbal order, standing order, or protocol, whether patient specific or not, that authorizes specific or discretionary medical action, which may include but is not limited to the selection of medication. Nothing in this subsection (4) shall limit the practice of nursing as defined in this article.

Advanced practice nurses such as CRNAs are classified as "professional nurses" by the Act. C.R.S. § 12-38-111.5(2) ("'advanced practice nurse' means a professional nurse who is licensed to practice pursuant to this article"). Therefore,

the provisions of C.R.S. § 12-38-103(4) concerning delegated medical functions apply to CRNAs.

The Nurse Practice Act requires physician supervision when treatment by a nurse involves executing delegated medical functions:

> (12) "Treating" means the selection, recommendation, execution, and monitoring of those nursing measures essential to the effective determination and management of actual or potential human health problems and to the execution of the delegated medical functions. *Such delegated medical functions shall be performed under the responsible direction and supervision of a person licensed under the laws of this state to practice medicine, podiatry, or dentistry.*

C.R.S. § 12-38-103(12) (emphasis added). The definitions of "medical plan" and "delegated medical function" in the Nurse Practice Act at C.R.S. § 12-38-103(4) provide for accountability and discretion. A physician who establishes a surgical plan has the obligation to ensure that the plan is carried out for the benefit of the patient. The physician may delegate performance of aspects of the plan to a professional nurse, including a CRNA. The functions that a physician delegates may include discretionary activities to be performed by the CRNA, such as the selection of an anesthetic and the timing of its administration. Such discretionary activities are consistent with the longstanding expectation that professional nurses may select and administer medications and therapies under the supervision of a physician. The direction and supervision to be exercised by the physician over

delegated functions may depend upon the complexity of the function and the experience of the practitioner to whom the medical function is delegated, as long as the supervision is "responsible."

B. The Nurse Practice Act Recognizes That Certified Registered Nurse Anesthetists Perform Delegated Medical Functions Such as the Delivery of Anesthesia.

A CRNA is an advanced practice nurse under the Nurse Practice Act. C.R.S. § 12-38-111.5(3) (recognizing that certified nurse midwife, clinical nurse specialist, CRNA, and nurse practitioner are advanced practice nurses). An advanced practice nurse, in turn, is classified by the Act as a professional nurse. C.R.S. § 12-38-103(8.5)(a) (defining "advanced practice nursing" to "include[] the practice of professional nursing"). An advanced practice nurse is licensed as a professional nurse under C.R.S. § 12-38-111.

The Nurse Practice Act recognizes that a professional nurse performs both delegated medical functions and independent nursing functions.

> (10) (a) *"Practice of professional nursing" means the performance of both independent nursing functions and delegated medical functions in accordance with accepted practice standards.* Such functions include the initiation and performance of nursing care through health promotion, supportive or restorative care, disease prevention, diagnosis and treatment of human disease, ailment, pain, injury, deformity, and physical or mental condition using specialized knowledge, judgment, and skill involving the application of biological, physical, social, and behavioral science principles required for licensure as a professional nurse pursuant to section 12-38-111.

> *(b) The "practice of professional nursing" shall include the performance of such services as:*
>
> > (I) Evaluating health status through the collection and assessment of health data;
> >
> > (II) Health teaching and health counseling;
> >
> > (III) Providing therapy and treatment that is supportive and restorative to life and well-being either directly to the patient or indirectly through consultation with, delegation to, supervision of, or teaching of others;
> >
> > (IV) *Executing delegated medical functions*;
> >
> > (V) Referring to medical or community agencies those patients who need further evaluation or treatment;
> >
> > (VI) Reviewing and monitoring therapy and treatment plans.

C.R.S. §12-38-103 (emphasis added). For purposes of understanding legislative intent, it is important to note the final qualifying phrase in this definition: "involving the application of . . . principles required for licensure as a professional nurse." As applied to other phrases in that paragraph, it makes clear that actions such as "diagnosis and treatment" must be interpreted in the context of what *all* professional nurses are qualified to do. It does not equate the diagnosis and treatment by a professional nurse to that of a physician.

C. The District Court Misread the Nurse Practice Act and Read Provisions Into It That Are Not Contained in Its Text.

The District Court's reliance upon provisions of the Nurse Practice Act to infer that CRNAs perform only independent nursing functions, and never perform delegated nursing functions, is misplaced. The Court cited no provision of the Act that specifically provided for independent practice. Instead, it read provisions into the Act, or drew unwarranted inferences.

1. An "advanced practice nurse" *is* a "professional nurse."

The District Court recognized that a professional nurse who implements a "medical plan" pursuant to C.R.S. § 12-38-103(4) must be supervised by a physician because she or he is performing a "delegated medical function." However, the Court went on to erroneously exempt advanced practice nurses from the requirements that apply to all professional nurses.

The definitional distinction that the District Court attempted to draw is without support in the Act. Advanced practice nurses are classified as "professional nurses" by the Act. C.R.S. § 12-38-111.5(2), and the definition of "medical plan" applies to them. The Colorado General Assembly has not incorporated any language in the definition of "delegated medical function" to exempt advanced practice nurses from the reach of its terms. It is also difficult to comprehend the thrust of the Court's reasoning. When a physician promulgates a

medical plan for a patient, may an advanced practice nurse disregard it? Conversely, doesn't a physician who develops a medical plan have the right to supervise those who implement it to ensure that its details are followed?

2. The Definition of "Advanced Practice Nursing" in C.R.S. § 12-38-103(8)(a) does not contemplate an exclusively independent practice.

The District Court correctly noted that a CRNA is classified by the Nurse Practice Act as an advanced practice nurse with specialized training who is listed on the advanced practice registry. It concluded that classification as an advanced practice nurse meant that "[a] CRNA performing what she or he has been specially trained and licensed to perform, *i.e.*, the administration of anesthesia, is performing an 'independent nursing function' and not a 'delegated medical function.'"

The Court's reading of C.R.S. § 12-38-103(8)(a) is myopic. Initially, CRNAs are not licensed as CRNAs, nor are advanced practice nurses licensed as such. They are licensed as professional nurses. This license does not allow them to practice independently. The Court's conclusion that all "advanced" functions performed by an advanced practice nurse should be regarded as independent nursing functions is unsupported by C.R.S. § 12-38-111.5 or any other provisions of the Nurse Practice Act. That section does not contain any language stating that an "advanced" function is always performed independently. At best, the Nurse

Practice Act recognizes that advanced practice nurses can perform functions that other nurses do not have the training and experience to accomplish. But it does not dispense with the necessity of physician supervision when implementing a medical plan. This conclusion is supported by the legislative history of Senate Bill 239 as discussed in Section I.D. of this Opening Brief.

3. Statutory provisions conferring prescriptive authority in C.R.S. § 12-38-111.6 do not contemplate an exclusively independent practice.

The District Court claimed that C.R.S. § 12-38-111.6(8)(c)(II) exempted "the delivery of anesthesia by a CRNA from the heightened physician interaction requirements imposed for a nurse to have the authority to prescribe prescription drugs." This observation conflates the authority to prescribe drugs with the ability of *any* registered nurse, whether or not an advanced practice nurse, to deliver an anesthetic that has been ordered by another. Specifically, C.R.S. § 12-38-111.6(8)(c) differentiates the "prescription" of anesthesia from "delivery":

> (I) Prescriptive authority by an advanced practice nurse shall be limited to those patients appropriate to such nurse's scope of practice. Prescriptive authority may be limited or withdrawn and the advanced practice nurse may be subject to further disciplinary action in accordance with this article if such nurse has prescribed outside such nurse's scope of practice or for other than a therapeutic purpose.
>
> (II) Nothing in this section shall be construed to require a registered nurse to obtain prescriptive authority to deliver anesthesia care.

Like other advanced practice nurses, CRNAs who possess the requisite qualifications and who pursue the mandated additional training can obtain authority to prescribe certain pharmacologic agents for their practice pursuant to subsection (I) of this statute. But Section 12-38-111.6(8)(c) simply makes it clear that a registered nurse is not required to obtain such prescriptive authority to deliver anesthesia care. It contains no language to suggest that the ordering of an anesthetic to assist in the implementation of a medical plan will be independent of supervision from the physician who promulgated the plan, or that the delivery of the prescribed agents in the operating room will not be subject to the supervision of a physician.

The "delivery" of anesthesia is addressed by subsection (II). It allows delivery by any "registered nurse." The Nurse Practice Act defines a "registered nurse" to include *any* "professional" nurse, and this definition is not limited to advanced practice nurses such as CRNAs. C.R.S. § 12-38-103(11). Professional nurses, by definition, perform both delegated medical functions and independent nursing functions. C.R.S. § 12-38-103(10)(a). Neither Governor Ritter nor the trial court has contended that the reference to the "delivery" of anesthetic care in § 12-38-111.6(8)(c)(II) allows professional nurses who are not advanced practice nurses to act independently of the supervision of a physician.

The proper construction of C.R.S. § 12-38-111.6(8)(c)(II) is that a registered nurse will never need prescriptive authority to delivery anesthesia care because such care is a delegated medical function supervised by a physician.

4. The "nothing shall limit" provision, C.R.S. § 12-38-103(4), does not refer to an exclusively independent practice.

The District Court's reliance upon the "nothing shall limit" language of C.R.S. § 12-38-103(4) is also unpersuasive. This section provides:

> (4) "Delegated medical function" means an aspect of care that implements and is consistent with the medical plan as prescribed by a licensed or otherwise legally authorized physician, podiatrist, or dentist and is delegated to a registered professional nurse or a practical nurse by a physician, podiatrist, dentist, or physician assistant. For purposes of this subsection (4), "medical plan" means a written plan, verbal order, standing order, or protocol, whether patient specific or not, that authorizes specific or discretionary medical action, which may include but is not limited to the selection of medication. *Nothing in this subsection (4) shall limit the practice of nursing as defined in this article.*

(Emphasis added.) The District Court concluded that the last sentence of this subsection means that its provisions cannot limit the right of CRNAs to practice free from physician supervision. This contention would be persuasive if C.R.S. § 12-38-103(4) conflicted with another provision of the Nurse Practice Act that stated that advanced practice nurses always practice independently. But there is no such provision in the Act. To the contrary, the definition of "nursing" in the Nurse Practice Act includes performance of delegated medical functions. The definitions

of the practice of practical nursing (§ 12-38-103(9)(a))), the practice of professional nursing (§ 12-38-103(10)(a))), and the practice of advanced practice nursing (§ 12-38-103(8.5))) all include the performance of delegated medical functions. The "nothing shall limit" language does not provide for the exclusive independent practice by CRNAs, as the District Court concluded.

5. <u>A Colorado Board of Health regulation cannot negate state statutes</u>.

The District Court cited one administrative regulation for the proposition that a CRNA may operate independently of physician supervision: 6 CCR 1011-1, Chapter IV, Part 17.101(2). But this regulation does not provide for independent practice. It begs the question whether physician supervision is required. However, Part 17.102 requires that nurses shall have the ability to communicate with the attending surgeon, an anesthesiologist, or a qualified substitute during post-operative care. The intent of this provision is that a physician should supervise the nurses who are caring for a patient recovering after the delivery of anesthesia:

Part 17. ANESTHESIA SERVICES

17.100

17.101 ORGANIZATION AND STAFFING

(1) The hospital shall provide anesthesia services commensurate with the services provided by the hospital.

> (2) General or regional anesthesia or analgesia shall be administered only by a physician qualified by training, experience, and ability in anesthesiology; or a registered nurse anesthetist graduated from a certified school. In case of dental treatment, dentists may administer local anesthetics.
>
> **17.102 PROGRAMMATIC FUNCTIONS**
>
> (1) Patients recovering from anesthesia shall remain under continuous care of a registered nurse. Nurses shall have been instructed in the care of post-anesthetic patients, shall have no other duties during the time they are caring for such patients and shall have facilities for immediate communication with the attending surgeon, anesthesiologist, or qualified substitute present in the hospital.

But there is a more important rejoinder to the District Court's analysis. An administrative regulation cannot contradict or invalidate a statutory mandate. *See Miller International, Inc. v. State*, 646 P.2d 341, 344 (Colo. 1982) ("any regulation which is inconsistent with or contrary to a statute is void and of no effect"); *Adams v. Colorado Department of Social Services*, 824 P.2d 83, 86 (Colo. App. 1991) ("unless expressly or impliedly authorized by statute, administrative rules and regulations are without force and effect if they add to, change, modify, or conflict with an existing statute"). Thus, the provisions of the Nurse Practice Act requiring physician supervision of delegated medical functions takes precedence over administrative regulations.

D. The District Court Misconstrued the Intent of the Colorado General Assembly.

The District Court disregarded the intent of the General Assembly, as expressed in its definition of a "medical plan," when it concluded that the definition should not be applied to CRNAs because such an application "cuts way too broadly."

The intent of the General Assembly is apparent from the re-enactment of the Nurse Practice Act in 2009, as detailed in the Cross-Motion for Summary Judgment filed by the Medical Society and the Anesthesiologist Society.

In 2009 the Colorado General Assembly re-enacted the Nurse Practice Act and included certain amendments that were proposed by legislators, and by the Department of Regulatory Agencies during its sunset review of the State Board of Nursing. This re-enactment added a definition of "practice of advanced practice nursing" that is now part of C.R.S. § 12-38-103(8.5). As first proposed by Senator Lois Tochtrop, a registered nurse by profession, the definition (Amendment 006) did not include the performance of delegated medical functions by an advanced practice nurse. (CD #35046589, Ex. 3) Senator Morgan Carroll expressed reservations about this proposed definition, and offered an amendment (Amendment L.011) to make clear that advanced practice nurses would not always practice independently, but would perform both delegated medical functions and

independent nursing functions. (*Id*., Ex. 4) Senator Carroll explained the reasons for her amendment:

Madam Chair	Would you, Senator Carroll, tell us what you're intending to move in the other amendment?
Carroll	Thank you, Madam Chair, for the opportunity to do this. So with this amendment at least I personally become comfortable with Amendment 6 which is the nurses' definition of their own practice. *What we've done, what it would do, the subsequent amendment would take line 9 of Amendment 6 and we're saying it includes the practice of professional nursing and it would cross reference it with Section 12-38-103 sub (10) which is the existing definition of practice of practical[4] nursing which under that definition includes those independent and delegated medical functions*. . . . And the last piece it does is on lines 20 and 21, currently written it says nothing in the subsection shall limit the practice of professional nursing. The ambiguity on that is a fear that [unintelligible] remaining somehow by implication that we're having an unlimited practice which I don't think was the intent. In talking with the proponents on this, what they really meant is to make sure that there's nothing we're doing in here that messes with the definition, the current definition in 12-38-103 sub (10*). So we're not messing with the definition of professional nursing by the act of defining advanced practice nursing*. So these were things that I thought got myself clarity based on the issues that I heard on

[4] Senator Carroll's remarks twice referred mistakenly to the practice of "practical" nursing instead of "professional" nursing. The text of her amendment demonstrates that she meant to refer to professional nursing.

the testimony. I think it's consistent in my view with the aims of what we're trying to do in the practice act and with some of the concerns that were raised . . . . My sense from right now is that we actually have some agreement on it if we had stopped this but I'll let people decide for themselves if that's true.

Madam Chair	Senator Tochtrop. First did you [*unintelligible*]
Tochtrop	Thank you, and I consider that a friendly amendment to L006.
Madam Chair	Thank you. Senator Newell.
Newell	Thank you, Madam Chair, and yes, in speaking with both the docs and the nurses they are both in agreement with this.
Madam Chair	Is there, then I would rule that let's, let's act on Amendment 006 first. And is there objection to 006? Seeing none 006 is adopted. Senator Carroll.
Carroll	Thank you, Madam Chair. I move Amendment 11. And Amendment 11 is basically what I explained. It's starting with the frame of the nurses' definition of their own practice. It does give us a very concrete statutory cross reference to this. *It includes the independent and delegated for the practice of practical nursing. Makes sure we're within our scope. And it rephrases the last part of it to be clear we're not changing the definition instead of an implication of an unlimited scope.* So that is what Amendment 11 does and with it I need this to frankly be comfortable with what I already voted on. I'm asking for a yes vote.

(Emphasis added.) (CD #35046603, pp. 4-5)

Further proceedings on the floor of the Colorado Senate—which deleted proposed language suggesting that APNs had an independent practice—also demonstrate that the Colorado Legislature did not intend advanced practice nurses to be engaged solely in independent practice. Senator Tochtrop's Amendment L.006 that was approved in committee (as modified by Senator Carroll's Amendment L.011) also included a change to C.R.S. § 12-38-111.5 to recognize that an advanced practice nurse would be a "licensed *independent* practitioner" who would only "consult" with other healthcare providers such as physicians. This portion of Amendment L.006 provided:

> (b) AN ADVANCED PRACTICE NURSE *IS EXPECTED TO PRACTICE AS A LICENSED INDEPENDENT PRACTITIONER* WITHIN THE STANDARDS ESTABLISHED OR RECOGNIZED BY THE BOARD. AN ADVANCED PRACTICE NURSE IS ACCOUNTABLE TO PATIENTS, THE NURSING PROFESSION, AND THE BOARD FOR THE FOLLOWING:
>
> (I) COMPLYING WITH THE REQUIREMENTS OF THIS ARTICLE;
>
> (II) THE QUALITY OF ADVANCED PRACTICE NURSING CARE RENDERED;
>
> (III) RECOGNIZING LIMITS OF KNOWLEDGE AND EXPERIENCE AND PLANNING FOR THE MANAGEMENT OF SITUATIONS BEYOND THE ADVANCED PRACTICE NURSE'S EXPERTISE; AND
>
> (IV) *CONSULTING WITH OR REFERRING TO OTHER HEALTH CARE PROVIDERS AS APPROPRIATE.*

(Emphasis added.) (CD #35046614, pp. 2-3) The Colorado Senate deleted this language in its entirety during the second reading of the Senate Bill 239 on April 17, 2009. (CD #35046629, Ex. 7 at p. 2, line 58) Senator Tochtrop explained that the deletion was intended to clarify the definitions of the Act. (*Id*., Ex. 8, p. 2) The "clarification" removed any doubt about the expectation of the legislature that advanced practice nurses were to perform delegated medical functions, supervised by physicians.

Proceedings in the Colorado House of Representatives confirmed the expectation of the Colorado Legislature that advanced practice nurses should perform both delegated and independent nursing functions. Representative Jim Riesberg, the House sponsor of Senate Bill 239, presented the bill to the House Health & Human Services Committee for a public hearing on April 23, 2009. Representative Cheri Gerou confirmed Riesberg's understanding of the bill, as its co-sponsor, that advanced practice nurses, including CRNAs, would continue to perform delegated medical functions:

> Gerou: Thank you, Madam Chair. Representative Riesberg, I appreciate this, I've learned a lot. The system works. I have one question for you. On page 16 of the bill, the definition that was added in the Senate, all I'd like to know is would I be correct in the understanding that the definition means that advanced practice nursing includes professional nursing which, in turn,

includes the performance of delegated medical functions?

Riesberg: Yes.

(CD #35046638, p. 27)

Both the provisions of the Nurse Practice Act and the legislative history of the Act demonstrate that advanced practice nurses are expected to perform delegated medical functions. Both reject the notion that advanced practice nurses are always independent practitioners, acting without physician supervision. Consequently, when executing provisions of a medical plan, CRNAs are subject to supervision.

II. COLORADO COMMON LAW REQUIRES SUPERVISION OF CRNAs BY PHYSICIANS.

Colorado courts have consistently recognized that a surgeon has a legal duty to direct and supervise all operating room personnel. These courts have imposed liability upon the operating surgeon for the negligence of such personnel under the vicarious liability principle known as the Captain of the Ship Doctrine. *Ochoa v. Vered*, 212 P.3d 963 (Colo. App. 2009), *cert. granted on other grounds* (March 16,

2009)[5]; *O'Connell v. Biomet, Inc*., 250 P.3d 1278 (Colo. App. 2010) The District Court's conclusion that Colorado law permits a CRNA to administer anesthesia without physician supervision is inconsistent with the Captain of the Ship Doctrine as it exists in Colorado.

The Captain of the Ship Doctrine is grounded in Colorado's public policy. It is intended to protect patients who may be injured by negligence in the complex operating-room environment. It was first recognized in *Beadles v. Metayka*, 135 Colo. 366, 311 P.2d 711 (1957), where a patient sustained injuries in a fall from an operating table. The patient brought an action against the surgeon, an anesthesiologist, and the hospital. The jury returned a verdict only against the surgeon. On appeal the surgeon contended that the patient was under the care of the anesthesiologist when the accident occurred, the anesthesiologist was an independent contractor, and an orderly who had placed the patient on his side was not under his control because he was an employee of the hospital. The Colorado Supreme Court affirmed the verdict. It held that the surgeon had the right and duty to direct and supervise all personnel in the operating room:

[5] In granting certiorari review, the Colorado Supreme Court refused to consider whether "Colorado should join a number of other states in rejecting or sharply limiting the 'captain of the ship' doctrine." (Colorado Supreme Court Announcements, March 16, 2009.)

> The patient is helpless under the influence of an anesthetic, and absolutely at the mercy of the surgeons performing the operation, and they are charged with the duty to see that no preventable injury results to their patient. Under the modern science of surgery a surgical operation, with modern hospital appointments, is a complex enterprise. Necessarily the various agencies that enter into it must be performed by different individuals, *under the active supervision and direction of the operating surgeons in charge*. If the operating surgeons were not made liable for the negligent performance of the duties of those working under them, the law in a large measure would fail in affording a means of redress for preventable injuries sustained from surgical operations.

135 Colo. at 370-71, 311 P.2d at 713, *quoting Aderhold v. Bishop*, 94 Okla. 203, 207, 221 P. 752, 755 (1955)(emphasis added).

Both *Beadles* and *Kitto v. Gilbert*, 570 P.2d 544, 550 (Colo. App. 1977), applied the doctrine to surgeons who were presumed, as a matter of law, to have control over persons charged with administering anesthesia. The District Court's conclusion that a surgeon has no right or duty to control and supervise a CRNA, when the law imposes such control and supervisory authority over an anesthesiologist, is logically inconsistent. Colorado's public policy requires that the surgeon control and supervise *all* personnel in the operating room.

The strength and breadth of Colorado's Captain of the Ship Doctrine may be appreciated by comparing it to the public policy of Washington under virtually identical facts. In *Ochoa*, 212 P.3d at 963, two nurses informed a surgeon that the sponges had been counted and the count was correct, but a sponge had been left

inside the patient. Although the hospital's written procedures specifically stated that the nurses were responsible for counting the sponges, the Colorado court held that the surgeon was liable because he had legal control over the nurses. *Id.* at 966. On the exact same facts, Washington reached the opposite conclusion. *Van Hook v. Anderson*, 824 P.2d 509, 515 (Wash. Ct. App. 1992). The Washington court held that the evidence was "insufficient to support the inference of control needed for the captain of the ship doctrine." *Id.* (Emphasis added.) Conversely, Colorado public policy, applied in *Ochoa,* determined that the surgeon could "not overcome the presumption that, as the surgeon in charge, he had the authority and responsibility to direct the nurses." *Ochoa*, 212 P.3d at 966 (emphasis added).

Even where an advanced practice nurse in an operating room has a specialized knowledge and particularized responsibility, Colorado law presumes that the surgeon retains supervisory control to promote the safety of the patient. The Governor's opt-out attestation and the District Court's Order ignored and contradicted Colorado common law.

III. CONCLUSION.

The Nurse Practice Act recognizes that advanced practice nurses can perform delegated medical functions that require greater expertise and experience than the services performed by other professional nurses. Advanced practice

nurses can also obtain prescriptive authority by fulfilling the regimen established by the Colorado Legislature. But when they are contributing to the execution of a medical plan promulgated by a physician, they are subject to the supervision of that physician. The legislative history of the Nurse Practice Act and the Captain of the Ship Doctrine confirm this fact. The District Court erred when it dismissed the Complaint. This Court should reverse the dismissal, and direct the entry of summary judgment in favor of the Medical Society and the Anesthesiologist Society.

Dated this 31st day of October, 2011.

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