COURT OF APPEALS, STATE OF COLORADO 101 West Colfax Avenue, Suite 800 Denver, Colorado 80202	
Appeal from the District Court, City and County of Denver Case No. 2010CV7731 Honorable Ann B. Frick, District Judge	
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	▲COURT USE ONLY▲
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/s/ Joseph J. Bronesky
Joseph J. Bronesky, Attorney for The Colorado Society of Anesthesiologists

TABLE OF CONTENTS

Certificate of Compliance i

Summary of Argument 1

Argument 2

I. UNDER COLORADO STATUTES, DELIVERY OF ANESTHESIA IS A DELEGATED MEDICAL FUNCTION THAT REQUIRES PHYSICIAN SUPERVISION. 2

A. Delivery of Anesthesia Is a Delegated Medical Function 2

1. The "Nothing Shall Limit" Provision of § 12-38-103(4) Does Not Recognize That CRNAs Perform Only Independent Nursing Functions Without Physician Supervision 3

2. Services That Are Delegated to Implement a Medical Plan *Are* Delegated Medical Functions 4

3. A Statute May Not Be Disregarded Because It Expresses the Intent of the General Assembly. 5

4. Conclusion. 6

B. No Provisions of the Nurse Practice Act Exempt CRNAs From Physician Supervision When Executing a Medical Plan. 6

1. CRNA's Don't Have "General" Authority to Always Practice Independently. 6

2. The Requirement of Consultation and Collaboration Does Not Create an Independent Practice. 9

C. Administrative Agencies Cannot Invalidate Statutes 10

D. The Legislative History of the Reenactment of the Nurse Practice Act in 2009 Is Controlling. 11

II. COLORADO COMMON LAW REQUIRES SUPERVISION OF CRNAs BY PHYSICIANS. 13

III. THE TRIAL COURT CORRECTLY CONCLUDED THAT IT HAD JURISDICTION TO ADJUDICATE APPELLANTS' CLAIMS. 17

A. Appellants Have an Actual Controversy With the Governor, and Standing to Challenge His Opt-Out Decision. 17

1. The Societies have standing because their members are suffering both tangible and intangible injuries. 18

2. The Governor's opt-out results in tangible and intangible injuries to Appellants' members. 20

3. The Societies have standing to protect the rights of patients... 26

4. Appellants are not seeking relief under the federal regulations. 28

B. This Court Has the Power to Determine Issues of Colorado Law in This Matter. 28

IV. CONCLUSION..... 32

TABLE OF AUTHORITIES

Cases

Aid for Women v. Foulston,
441 F.3d 1101 (10th Cir. 2006) 26

Ainscough v. Owens,
90 P.3d 851 (Colo. 2004) ..... passim

Banner Advertising, Inc. v. People of City of Boulder,
868 P.2d 1077 (Colo. 1994) 31

Barber v. Ritter,
196 P.3d 238 (Colo. 2008) 19

Bd. of County Comm'rs of Adams v. Colo. Dep't of Pub. Health & Env't,
218 P.3d 336 (Colo. 2009) 20

Beadles v. Metayka,
135 Colo. 366, 311 P.2d 711 (1957) 14, 16

Biotechnology Indus. Org. v. Dist. of Columbia,
496 F.3d 1362 (Fed. Cir. 2007) 18

Brass Monkey v. Louisville City Council,
870 P.2d 636 (Colo. App. 1994) 24

Bullock v. McGerr,
14 Colo. 577, 23 P. 980 (1890) 29

Burden v. Hoover,
137 N.E.2d 59 (Ill. 1956)..... 24

California v. ARC America Corp.,
490 U.S. 93 (1989) 31

Cipollone v. Liggett Group, Inc.,
505 U.S. 504 (1992) 31

City of Greenwood Village v. Petitioners for the Proposed City of Centennial,
3 P.3d 427 (Colo. 2000) 26, 27

Cloverleaf Kennel Club, Inc. v. Colorado Racing Comm'n,
620 P.2d 1051 (Colo. 1980) 25

Coll v. First American Title Ins. Co.,
642 F.3d 876 (10th Cir. 2011) 17

Colorado Chiropractic Ass'n v. State,
467 P.2d 795 (1970) 23

Conestoga Pines Homeowners' Ass'n v. Black,
689 P.2d 1176 (Colo. App. 1984) 18

Connecticut State Medical Society v. Connecticut Board of Examiners in Podiatry,
524 A.2d 636 (Conn. 1987) 23

Ezell v. Ritholz,
198 S.E. 419 (S.C. 1938) 24

Florida Medical Association, Inc. v. Department of Professional Regulation,
426 So.2d 1112 (Fla. App. 1983) 23

GF Gaming Corp. v. Hyatt Gaming Mgm't,
77 P. 3d 894 (Colo. App. 2003) 24

Gleason v. Becker-Johnson Associates, Inc.,
916 P.2d 662 (Colo. App. 1996) 12

GLN Compliance Group, Inc. v. Aviation Manual Solutions, LLC,
203 P.3d 595 (Colo. App. 2008) 9

Griswold v. Connecticut,
381 U.S. 479 (1965) 26

Hotaling v. Hickenlooper,
--- P.3d ---, 2011 WL 2474302 (June 23, 2011) 19

J.S. Dillon & Sons Stores Co. v. Carrington,
169 Colo. 242, 455 P.2d 201 (1969) 8

Jenkins v. Panama Canal Railway Co.,
208 P.3d 238 (Colo. 2009) 7

Kendall v. Russell,
49 V.I. 602 (D.V.I. 2008) 21

Kitto v. Gilbert,
39 Colo. App. 374, 570 P.2d 544 (Colo. App. 1977)..... 14, 16

Kort v. Hufnagel,
729 P.2d 370 (Colo. 1986) 30

Kowalski v. Tesmer,
543 U.S. 125 (2004) 26

Krane v. Saint Anthony Hospital Systems,
738 P.2d 75 (Colo. App. 1987) 14

Marbury v. Madison,
1 Cranch 137 (1803)..... 29

McDonnell v. Juvenile Court,
864 P.2d 565 (Colo. 1993) 30

Meese v. Keene,
481 U.S. 465 (1987) 21

Mt. Emmons Mining Co. v. Crested Butte,
690 P.2d 231 (Colo. 1984) 23

Norton v. Colorado State Bd. of Medical Examiners,
821 P.2d 897 (Colo. App. 1991) 23

Ochoa v. Vered,
212 P.3d 963 (Colo. App. 2009) 14, 15

People v. Rosburg,
805 P.2d 432 (Colo. 1991) 22

Radack v. United States,
2006 U.S. Dist. LEXIS 48148 (D.D.C. July 17, 2006)..... 21

Rocky Mtn. Animal Def. v. Colo. Div. of Wildlife,
100 P.3d 508 (Colo. App. 2004) 22

Silicon Economics, Inc. v. Financial Accounting Foundation,
2011 WL 3742182 (D. Del. Aug. 18, 2011) 21

Sloan v. Mitchell,
168 S.E. 800 (W. Va. 1933) 24

State Bd. for Community Colleges and Occupational Educ. v. Olson,
687 P.2d 429 (Colo. 1984) 17, 21, 26

State Personnel Board v. District Court,
637 P.2d 333 (Colo. 1981) 30

Utah Ass'n of Counties v. Bush,
455 F.3d 1094 (10th Cir. 2006) 18

Vickery v. Evelyn V. Trumble Living Trust,
--- P.3d ---, 2011 WL 3612245 (Colo. App. Aug. 18, 2011) 19

Watso v. Dept. of Social Services
841 P.2d 299 (Colo. 1992) 22

Wimberly v. Ettenberg,
570 P.2d 535 (Colo. 1977) 24

Statutes

C.R.S. § 2-4-201(1)(c) 8

C.R.S. § 2-4-203(c) 12

C.R.S. § 2-4-205 7

C.R.S. § 2-4-212 9

C.R.S. § 12-36-102 22

C.R.S. § 12-36-102(1) 27

C.R.S. § 12-38-103 7

C.R.S. § 12-38-103(10) ..... passim
C.R.S. § 12-38-103(12) ..... passim
C.R.S. § 12-38-103(4) ..... passim
C.R.S. § 12-38-104 7
C.R.S. § 12-38-109 7
C.R.S. § 12-38-111 7
C.R.S. § 12-38-111.5 5
C.R.S. § 12-38-111.5(2) 2
C.R.S. § 12-38-111.5(5) 4, 8, 29
C.R.S. § 12-38-111.5(6) 9, 10
C.R.S. § 12-38-111.6 5
C.R.S. § 12-38-111.8 5
C.R.S. § 12-38-115 7
C.R.S. § 12-38-116 7
C.R.S. § 12-38-116.5 7
C.R.S. § 12-38-117(1)(c) 8
C.R.S. § 12-38-118 7
C.R.S. § 12-38-118.5 7
C.R.S. § 12-38-121 7
C.R.S. § 12-38-122 7
C.R.S. § 12-38-125 7
C.R.S. § 12-38-127 7

C.R.S. § 12-38-131 7

C.R.S. § 12-38-132 7

Other Authorities

Captain of the Ship doctrine ..... passim

Senate Bill 239 12

Rules

Colorado Rule of Civil Procedure 57(b) 13

Colorado Rule of Civil Procedure 57(e) 13

Medical Board Rule 800 10

Medical Board Rule 800(I)(A)(2) 11

Regulations

3 CCR 713-12, Rule 220(1) 6

3 CCR 713-30, Section II(C) and (D) 10

6 CCR 1011-1, Chapter IV, Part 17.101(2) 10

66 Fed. Reg. 56762 32

66 Fed. Reg. 56765 32

SUMMARY OF ARGUMENT

This Reply Brief addresses arguments made in separate answer briefs by Governor Hickenlooper ("Gov. Br."), the Colorado Hospital Association ("CHA Br."), and the Colorado Association of Nurse Anesthetists and Colorado Nurses Association ("Nurse Br.").

This case requires a determination of the intent of the Colorado General Assembly, as expressed in the Nurse Practice Act and described in the legislative history for the reenactment of the Act in 2009. The legislature concluded that certified registered nurse anesthetists should *not* always practice independently, without being subject to physician supervision. This conclusion is mutually supportive of the Captain of the Ship doctrine applied by Colorado courts. Because Colorado law supports the position taken by the Colorado Medical Society and The Colorado Society of Anesthesiologists ("Appellants" and the "Societies"), this Court should reverse the trial court's order of dismissal and remand this case for entry of summary judgment in Appellants' favor.

The trial court did, however, rule correctly on the standing issues raised by the Governor and CHA. Colorado's judiciary has full authority over the issues in this case, and Appellants have properly posed them for adjudication.

ARGUMENT

I. UNDER COLORADO STATUTES, DELIVERY OF ANESTHESIA IS A DELEGATED MEDICAL FUNCTION THAT REQUIRES PHYSICIAN SUPERVISION.

The Opening Brief demonstrates why the trial court erred when it concluded CRNAs always act independent of physician supervision.

A. Delivery of Anesthesia Is a Delegated Medical Function.

The Societies have emphasized that anesthesia is not a therapy unto itself. Rather, it is a component of a medical plan of treatment for an individual. A prime example is a surgeon's delegation of the delivery of anesthesia to facilitate surgery required by a medical plan for a patient. By its nature, the delivery of anesthesia is a collection of individual functions that collectively, and in nearly all circumstances, individually, comprise acts and decisions that must be performed or supervised by a physician.

The legislature determined that nursing care that implements a medical plan is a "delegated medical function" that may be performed by a professional nurse if done under physician supervision. C.R.S. §§ 12-38-103(4) (defining "delegated medical function) and 12-38-103(12) (requiring delegated medical function to be performed under physician supervision). A CRNA is a professional nurse. C.R.S. § 12-38-111.5(2).

Appellees recognize the need to focus upon the statutory definition of "medical plan" on appeal, and contend that its limitations are not applicable to CRNAs. They make a number of arguments that should be rejected.

1. The "Nothing Shall Limit" Provision of § 12-38-103(4) Does Not Recognize That CRNAs Perform Only Independent Nursing Functions Without Physician Supervision.

Both the Governor and Nurses rely upon this provision and contend that it means that CRNAs do not perform delegated medical functions when they provide services under a medical plan. (Gov. Br. at 43; Nurse Br. at 22) Both parties have misquoted the statute. Subsection 12-38-103(4) states that nothing in the subsection "shall limit the practice of nursing as defined in this article." The Governor's quotation of the statute substitutes the words "advanced practice nursing" for "nursing" without indicating any reason for the alteration. The Nurses' quotation substitutes "professional nursing" for "nursing."

These misquotes underscore the fact that the legislature did not insert this provision to address advanced practice nursing, as it refers to all nurses. In fact, this sentence was added by Ch. 93, L. 1990, well before the Nurse Practice Act was amended in 1994 to include provisions for advanced practice nurses.

The Opening Brief noted that this sentence could assist Appellees if any provisions of the Act called for CRNAs to perform only independent nursing

functions. Yet, just the opposite is true. The Act specifies that CRNAs, as advanced practice nurses, perform *both* delegated medical functions and independent nursing functions. C.R.S. § 12-38-111.5(5) (advanced practice nurses shall perform both independent nursing functions and delegated medical functions as specified in § 12-38-103(10)).

2. Services That Are Delegated to Implement a Medical Plan *Are* Delegated Medical Functions.

The Nurses contend that services performed under a medical plan can also include independent nursing functions. (Nurse Br. at 22) They make this argument to support their contention that a CRNA who delivers anesthesia when the task is delegated by a surgeon is performing an independent nursing function that is not subject to the surgeon's supervision. This contention is not supported by the example they provide, where a nurse performs a physical assessment before a physician formulates a medical plan for that patient. If the physician directs the assessment as part of a plan for treating a patient, the assessment is a delegated medical function. Similarly, a CRNA delivering anesthesia will perform a delegated medical function because the delivery has been delegated as part of a surgeon's medical plan.

3. A Statute May Not Be Disregarded Because It Expresses the Intent of the General Assembly.

The final attack on the definition of "medical plan" mimics the conclusion of the trial court. The Governor contends that applying the definition the way the legislature wrote it would "eviscerate" the expanded scope of professional nursing (Gov. Br. at 45) and render three sections of the Nurse Practice Act superfluous.

The record, however, does not support any assertion that other advanced practice nurses—certified nurse midwifes, clinical nurse specialists, and nurse practitioners—always perform services as part of a "medical plan." On the other hand, the legislature has recognized that CRNAs who are delivering anesthesia as part of a medical plan calling for surgery will be subject to the supervision of the surgeon who is responsible for the implementation of the plan. Under such supervision, however, a CRNA with prescriptive authority and an articulated plan may perform a full range of services that befit the CRNA's education and experience, and are consistent with the surgeon's knowledge of and confidence in the CRNA's abilities. Such a relationship is faithful to the intent of the legislature, and fully implements the provisions of C.R.S. §§ 12-38-111.5 and 12-38-111.6. It is also consistent with the insurance requirements imposed upon CRNAs by § 12-38-111.8, which are only half of the $1,000,000 per incident/$3,000,000 annual aggregate coverage required of physicians by the Colorado Medical Board.

3 CCR 713-12, Rule 220(1). If CRNAs had an independent scope of practice for the delivery of anesthesia that was similar to that of a physician, the General Assembly would have imposed the same insurance requirements.

4. Conclusion.

The intent of the Colorado General Assembly is clear, and it is contrary to the opt-out determination by Governor Ritter. CRNAs, as advanced practice nurses, are expected to perform both delegated medical functions and independent nursing functions. While performing services to implement a medical plan promulgated by a physician, they are subject to physician supervision.

B. No Provisions of the Nurse Practice Act Exempt CRNAs From Physician Supervision When Executing a Medical Plan.

1. CRNA's Don't Have "General" Authority to Always Practice Independently.

To avoid the implications of the specific statutes and the 2009 legislative history, Appellees contend that the Nurse Practice Act is a "general" statute that abdicates all scope of practice determinations to the Board of Nursing. (Gov. Br. at 35, CHA Br. at 12, Nurse Br. at 18) Appellees assert that the Act allows CRNAs to practice to the "full extent" of their training and experience and, consequently, without physician supervision at any time.

Several reasons compel rejection of Appellees' interpretation of the Act.

Appellees are incorrect in their assertion that the Act is "general" without guidance from the legislature. The Act is quite detailed. It contains detailed definitions of terms (§ 12-38-103), provisions relating to the operations of the Board of Nursing (§ 12-38-104 through -109), requirements for licenses and prescriptive authority (-111 through -115, -118.5), educational programs (-116, -127), procedures for disciplinary proceedings and professional review (-116.5 through -118, -121, -122 through -125, -131), and the delegation of nursing tasks (-132). Moreover, the provisions regarding medical plans and delegated medical functions and the fact that CRNAs perform delegated medical functions under physician supervision (*e.g.*, C.R.S. §§ 12-38-103(4), -103(10), -103(12)) apply to specific aspects of medical care. These specific provisions defeat Appellees' contention that generalized terms of the Act take precedence, C.R.S. § 2-4-205 (specific terms of statute prevail over general), *Jenkins v. Panama Canal Railway Co.*, 208 P.3d 238, 241-42 (Colo. 2009), particularly in the absence of a legislative declaration that these specific provisions no longer apply to CRNAs.

Additionally, the implications of Appellees' argument are problematic. In defining "delegated medical function" and "medical plan" in C.R.S. § 12-38-103(4), the legislature expressed its intent that a physician who develops a medical plan for a surgical procedure is responsible for ensuring that the plan is

faithfully executed. A necessary component of the physician's responsibility is the ability to supervise those who take part in the 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. By contrast, Appellees contend that under the Act, any CRNA can independently determine what anesthesia procedures to perform, no matter how complicated or how unfamiliar, and the surgeon has no authority to supervise. Yet, the Board of Nursing can impose discipline only after the fact under C.R.S. § 12-38-117(1)(c), while a surgeon, with proper authority, can address a concern before harm occurs. Consequently, Appellees' interpretation of the Act should be rejected because it is unreasonable and inconsistent with the legislature's intent. C.R.S. § 2-4-201(1)(c) (presumption that legislature intended a just and reasonable result); *J.S. Dillon & Sons Stores Co. v. Carrington*, 169 Colo. 242, 247, 455 P.2d 201, 203 (1969) (statutes should be interpreted to achieve reasonable meaning, consistent with the legislative intent behind it).

Finally, the legislative history of reenactment of the Act in 2009 discussed at pages 25-30 of the Opening Brief refutes Appellees' arguments. This legislative history is relevant because Appellees' construction of the Act conflicts with C.R.S. §§ 12-38-103(4), -103(10), -103(12), and 12-38-111.5(5). Appellees' contention

that the Act allows a completely independent practice for CRNAs is contrary to the intent of the General Assembly and must be rejected. C.R.S. § 2-4-212 (statutes must be construed in order that the true intent and meaning of the General Assembly may be fully carried out); *GLN Compliance Group, Inc. v. Aviation Manual Solutions, LLC*, 203 P.3d 595, 598 (Colo. App. 2008).

2. The Requirement of Consultation and Collaboration Does Not Create an Independent Practice.

The requirement that a CRNA establish a "safe mechanism for consultation or collaboration with a physician" under C.R.S. § 12-38-111.5(6) does not eliminate the requirement of physician supervision of delegated medical functions. (*See* Gov. Br. at 44, CHA Br. at 17, Nurse Br. at 17) Nor does it make every act of a CRNA an independent nursing function. This statute must be construed in a manner to give full effect to legislative purpose underlying the physician supervision requirements in C.R.S. § 12-38-103(4), -103(10), and -103(12). This statute requires all advanced practice nurses to consult or collaborate with a physician when circumstances call for such communication.

Review of the Act demonstrates that the legislature understood that there are instances when a CRNA, not an anesthesiologist, will deliver anesthesia, including areas where anesthesiologists may not be available. For this reason it imposed a collaboration and consultation requirement to ensure that CRNAs reached out to a

physician, including anesthesiologists, when they need help or have questions. Establishment of this mechanism does not eliminate the surgeon's responsibility to supervise delivery of anesthesia as a delegated medical function. In imposing the collaboration requirement of C.R.S. § 12-38-111.5(6), the legislature did not express any intent to make C.R.S. § 12-38-103(4), -103(10), and -103(12) inapplicable.

C. Administrative Agencies Cannot Invalidate Statutes.

Appellees rely upon two administrative-promulgated rules, but do not contend that an administrative agency can effectively repeal or invalidate statutes enacted by the General Assembly. (Gov. Br. at 50, CHA Br. at 13, Nurse Br. at 16) The first of these—6 CCR 1011-1, Chapter IV, Part 17.101(2)—was cited by the trial court. Pages 23-24 of the Opening Brief demonstrate why this regulation cannot support the Governor's opt-out determination, principally because regulations must conform to statutes.

The Governor's reliance on a second rule is curious. He cites Medical Board Rule 800, specifically 3 CCR 713-30, Section II(C) and (D), for the proposition that a physician can delegate to an unlicensed provider only those services that the physician is qualified to perform because of education, training, and experience. But he then admits that Rule 800 does not even apply to the

delegation of anesthesia services to professional nurses. (Gov. Br. at 49) He is right. Subsection 800(I)(A)(2) states: "[T]hese Rules do not apply to a registered nurse (also known as a professional nurse or an RN)." The best way to look at the Governor's argument is that the Medical Board has *not* adopted the kind of rule that the Governor now implicitly asks this Court to write and apply.

D. The Legislative History of the Reenactment of the Nurse Practice Act in 2009 Is Controlling.

The trial court stated that the key to this case was the determination of the intent of the General Assembly: Did it intend that CRNAs would always perform independent nursing functions and never be subject to physician supervision? But the court ignored the compelling expressions of this intent in the legislative history of the reenactment of the Nurse Practice Act in 2009, as described in the Opening Brief, when it declined to consider Appellants' motion for summary judgment.

The Governor does not address this legislative history. Presumably he assumes that the Nurse Practice Act clearly provides for unfettered independent practice. (*See* Gov. Br. at 42)

CHA relies upon the remarks of Senator Tochtrop to support its argument that the legislature intended that CRNAs should practice independently. (CHA Br. at 18-20) Senator Tochtrop noted that CRNAs deliver surgical anesthesia in places where anesthesiologists are unavailable, and she believes that some surgeons may

not have specialized knowledge of anesthesia. Accordingly, she supported Amendment L006 to Senate Bill 239, which stated that advanced practice nurses would practice independently, and, opposing any modification of L006, stated: "That's the concern that I have if we pass, you know, the delegated practice." Shortly after her testimony the committee amended L006 to state that the scope of practice of APNs *did* include delegated medical functions. (CD #350046603, pp. 2-5) The Colorado Senate later removed another provision in Amendment 006 that called for complete independent practice. In short, Senator Tochtrop's position was rejected, and the General Assembly confirmed that operating physicians are responsible for supervising rural CRNAs.

The Nurses concede that CRNAs perform *both* delegated medical functions and independent nursing functions—a concession at odds with the Governor's opt-out determination. They contend that legislative history is unimportant because it has not been "accepted" by the Board of Nursing or the Colorado Medical Board, who have made their own interpretations of the legislative intent. (Nurse Br. at 25-26) Their position is undermined by the fact that legislative history is far more important than administrative construction in determining the intent of the General Assembly. C.R.S. § 2-4-203(c); *Gleason v. Becker-Johnson Associates, Inc.*, 916 P.2d 662, 664-65 (Colo. App. 1996). In addition, there is no

evidence that either board reviewed the legislative history. In fact, the Medical Board debated whether to even provide a position on Colorado law, since it had not undertaken a legal assessment. (CD 33285742 at 3, ¶ 11)

The General Assembly reaffirmed its determination that CRNAs do not always practice independently when it reenacted the Nurse Practice Act in 2009. The Governor contradicted this legislative intent with his opt-out, as did the district court. This case should be reversed for this reason.

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

The Opening Brief demonstrates that Colorado courts consistently recognize that, under the Captain of the Ship doctrine of Colorado common law, a surgeon has a legal duty to direct and supervise all operating room personnel, including CRNAs.[1] The Captain of the Ship doctrine is grounded in Colorado's public policy and is intended to protect patients who may be injured by negligence—while they are unconscious—in the complex operating room environment.

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[1] The Governor erroneously argues that because C.R.C.P. 57(b) provides for the right to seek declaratory relief under a statute, the Court may not consider Colorado's common law. (Gov. Br. at 52) This ignores the plain reading of C.R.C.P. 57(e), which provides that the enumeration of grounds for declaratory relief in Rule 57(b) "does not limit or restrict the exercise of the general powers" for declaring rights. Moreover, Colorado's common law Captain of the Ship doctrine is relevant to determining rights under statutes and the lawfulness of executive action in this case.

The Nurses and the Governor contend that the Captain of the Ship doctrine does not impose a legal duty upon a surgeon to direct and supervise all operating room personnel. (Gov. Br. at 52, Nurse Br. at 27) Their contentions are unsupported by the controlling decisions.

Beadles v. Metayka, 135 Colo. 366, 311 P.2d 711 (1957), first applied the doctrine in Colorado to protect patients who were helpless under the influence of an anesthetic. It approved an instruction of law that explained the doctrine:

> You are instructed that in the operating room the surgeon is master, and has exclusive control over the acts of the orderly and nurse, and is responsible for the negligence, if any, of the orderly or nurse, during the time the patient is being prepared for the operation in the operating room in accordance with the instructions of the surgeon, and in the presence of the surgeon.

135 Colo. at 371, 311 P.2d at 714. The only issue of fact in the case was the "exact moment" at which the surgeon took control over the operating room. Once he did, he had the duty to control and supervise. *Krane v. Saint Anthony Hospital Systems*, 738 P.2d 75, 76-77 (Colo. App. 1987) (no factual issue existed—the operating surgeon had assumed control once surgery began).

The jury instruction approved in *Ochoa v. Vered*, 212 P.3d 963 (Colo. App. 2009), was similar to the instruction given in *Kitto v. Gilbert*, 570 P.2d 544, 550 (Colo. App. 1977), which held that a surgeon was responsible for the negligence of a nurse who was employed by the hospital. The trial court instructed the jury:

> The operating room staff, including [nurses] were under the control of the defendant Eldad Vered, M.D., at the time of this occurrence. Therefore, any act or omission or any member of the operating room staff, including [nurses] was in law the act or omission of the defendant Eldad Vered, M.D.

Ochoa v. Vered, 212 P.3d at 963, 966 (Colo. App. 2009). The case applied a legal "presumption that, as the surgeon in charge, he had the authority and responsibility to direct the nurses. *Id.*

CHA does not argue the same fallacious position. Rather, it expresses the expectation that Colorado common law will "evolve" so that surgeons will not be required to direct and supervise CRNAs. (CHA Br. at 21) It cites the fact that CRNAs are now required to carry insurance. (*Id.*)

CHA's expectation that the Captain of the Ship doctrine might evolve in the future has nothing to do with the Governor's erroneous certification in September 2010 that Colorado common law, as it exists *now*, does not require or allow a surgeon to supervise a CRNA. Moreover, CHA's predicted evolution is questionable, given the Colorado Supreme Court's recent refusal to revisit the Captain of the Ship doctrine by *certiorari* in *Ochoa v. Vered*, 08SC498. Finally, the Captain of the Ship doctrine was formulated to assist a patient who is under the influence of an anesthetic and is helpless. It was not fashioned to address the

existence of insurance, which, in the case of a CRNA, may be only half the amount carried by a physician.

The Captain of the Ship doctrine was employed to assert liability against a surgeon for the alleged negligent conduct of an anesthesiologist in *Beadles* (fall from operating table) and *Kitto v. Gilbert*, 39 Colo. App. 374, 570 P.2d 544 (Colo. App. 1977) (anesthetic tubing improperly inserted or dislodged; case remanded for determination of whether surgeon had assumed control of operating room). It is equally applicable to the conduct of a CRNA. The Governor erred in concluding otherwise in his opt-out letter. Stated differently, Colorado's common law requires a surgeon to supervise a nurse anesthetist in the operating room and imposes liability on the surgeon for the nurse's errors, regardless of what the Governor has certified to the federal government. The law and public policy of Colorado concerning physician supervision, as decided and defined by Colorado's courts, is certainly relevant to the determination of whether Colorado law imposes a physician-supervision requirement on the administration of anesthesia by nurses.

III. THE TRIAL COURT CORRECTLY CONCLUDED THAT IT HAD JURISDICTION TO ADJUDICATE APPELLANTS' CLAIMS.

A. Appellants Have an Actual Controversy With the Governor, and Standing to Challenge His Opt-Out Decision.

"In determining whether standing has been established, all averments of material fact in a complaint must be accepted as true." *State Bd. for Community Colleges and Occupational Educ. v. Olson*, 687 P.2d 429, 434 (Colo. 1984); *see also Coll v. First American Title Ins. Co.*, 642 F.3d 876, 892 (10th Cir. 2011) ("In addressing standing at the motion-to-dismiss stage of these proceedings, we must accept as true all material allegations of the complaint, and must construe the complaint in favor of the Plaintiffs, as complaining parties.") (quotation omitted). Plaintiffs may also provide an affidavit "to supply further particularized allegations of fact supportive of standing." *State Bd. for Community Colleges*, 687 P.2d at 434-35. The Complaint and the Affidavit of Dr. Clark establish that Appellants have standing based on the tangible and intangible injuries suffered by their members and the injuries suffered by their patients. This Court should exercise jurisdiction over the claim because these members are suffering tangible and intangible injuries, the special nature of the doctor-patient relationship allows Appellants to protect the rights of their patients, and Appellants are seeking relief under Colorado law, not the federal regulations.

1. The Societies have standing because their members are suffering both tangible and intangible injuries.

An association can bring a claim if its members would have standing to sue in their own right, the issue is germane to the association's purpose, and the participation of individual members is unnecessary. *Conestoga Pines Homeowners' Ass'n v. Black*, 689 P.2d 1176, 1177 (Colo. App. 1984). It is undisputed that the issues of who may deliver anesthesia and who may supervise CRNAs are germane to the Societies' purpose. The participation of individual physicians is unnecessary at this stage. An association has standing even if only one of its members would have standing.[2] *Utah Ass'n of Counties v. Bush*, 455 F.3d 1094, 1099 (10th Cir. 2006) ("if even one member of the association would have had standing to sue in his or her own right, that is sufficient."); *Biotechnology Indus. Org. v. Dist. of Columbia*, 496 F.3d 1362, 1370 (Fed. Cir. 2007) ("One such member will suffice.").

In Colorado, parties to lawsuits benefit from a relatively broad definition of standing. *Ainscough v. Owens*, 90 P.3d 851, 856 (Colo. 2004). An injury-in-fact

[2] The Governor has argued that Plaintiffs allegations only implicate anesthesiologists and not other types of physicians. Even if this were the case, it would still provide CMS standing to raise the rights of its anesthesiologist members. The Governor's argument, however, ignores the impact on operating surgeons impacted by the Captain of the Ship doctrine and the ability of CMS's members to raise the safety rights of their patients.

or legally protected interest "may rest in property, arise out of contract, lie in tort, or be conferred by statute." *Barber v. Ritter*, 196 P.3d 238, 246 (Colo. 2008). A standing-conferring injury may be "tangible," which includes economic harm, or "intangible," which can include even an aesthetic harm. *Id.* at 245-46. "Generally speaking, this prong of the standing test requires a concrete adverseness which sharpens the presentation of issues that parties argue to the courts." *Hotaling v. Hickenlooper*, --- P.3d ---, 2011 WL 2474302, at *2 (June 23, 2011). A legally protected interest may arise under the constitution, the common law, a statute, or a regulation. *Hotaling v. Hickenlooper*, --- P.3d ----, 2011 WL 2474302 at *2 (June 23, 2011). "A civil plaintiff claiming to have been injured by a defendant's actions has standing to sue even if a court, upon reaching the merits, ultimately determines the defendant committed no wrong." *Vickery v. Evelyn V. Trumble Living Trust*, --- P.3d ---, 2011 WL 3612245 (Colo. App. Aug. 18, 2011) (quotation omitted).

The test for standing in Colorado "has traditionally been relatively easy to satisfy." *Ainscough*, 90 P.3d at 856. Colorado has a tradition of conferring standing to a wide class of plaintiffs, as its courts "frequently decide general complaints challenging the legality of government activities and other cases involving intangible harm." *Id.* at 853. The question of standing is ultimately

whether the injury "constitute[s] an actual controversy." *Bd. of County Comm'rs of Adams v. Colo. Dep't of Pub. Health & Env't*, 218 P.3d 336, 341 (Colo. 2009).

Appellants and the Governor have an actual controversy—the parties sharply disagree and, along with the intervenors and *amicus*, have presented every possible argument to this Court. If physicians do not have an actual controversy with the Governor over his attempt to change the ability of a physician to supervise the ordering and delivery of anesthesia for which they are ultimately liable, it is difficult to imagine who would have standing.

2. The Governor's opt-out results in tangible and intangible injuries to Appellants' members.

The Complaint alleged that the Governor's actions have created confusion and misunderstanding relating to anesthesia services, and whether or not the delivery of anesthesia is a medical function that requires the supervision of a physician. This confusion results in injuries to physicians who deliver or supervise anesthesia services—most notably, removal of the ability to supervise the conduct of CRNAs for whom the physician remains legally liable. Additional injuries include (1) reduced value of physicians' professional licenses, and (2) a negative effect upon the public's perception and appreciation that physicians have superior education and experience, and are better able to address exigencies that may arise in the administration of anesthesia. (Affidavit of Randall M. Clark, M.D., at ¶ 6)

These are real, practical consequences that create a direct, concrete injury to the Societies' members' property, income, and professional status.

By altering the perception of "the legal and practical scope of practice of physicians and nurses known as certified registered nurse anesthetists" and "the levels of education, skill, and training that are required to administer anesthesia safely to patients" in conflict with Colorado law, the Governor has diminished the value of the licenses held by physicians, and their professional stature and reputation. *See Kendall v. Russell*, 49 V.I. 602, 611 (D.V.I. 2008) ("The Supreme Court has long recognized that an injury to reputation may satisfy the injury element of standing.") (citing *Meese v. Keene*, 481 U.S. 465, 472-77 (1987); *Silicon Economics, Inc. v. Financial Accounting Foundation*, 2011 WL 3742182 at *6 (D. Del. Aug. 18, 2011) ("Injury to reputation, including commercial reputation, may constitute a cognizable injury-in-fact for Article III standing."); *see also Radack v. United States*, 2006 U.S. Dist. LEXIS 48148, at *7 n.3 (D.D.C. July 17, 2006) (standing exists where party "sustained injury in the form of a damaged reputation and reduced employment prospects"). Dr. Clark's Affidavit establishes the impact on anesthesiologists' reputations, which is a material fact that the trial court presumably accepted as true. *See State Bd. for Community Colleges*, 687 P.2d at 434. By contrast, the case cited by the Governor for the proposition that an

injury to reputation does not establish standing, *Watso v. Dept. of Social Services*, involved plaintiffs who could not show that the challenged action "interfered with their present occupations." 841 P.2d 299, 305 (Colo. 1992).

The Governor claims that the alleged "confusion" created by his opt-out is not a concrete injury. Injuries much less concrete than this have sustained standing. For example, this Court found standing where an association's members suffered a diminution in their ability to observe and enjoy the presence of wildlife. *Rocky Mtn. Animal Def. v. Colo. Div. of Wildlife*, 100 P.3d 508, 513 (Colo. App. 2004). The impact that Defendant's action has had on Plaintiffs is much more concrete and tangible, and it affects a legally protected interest.

"To be a 'legally protected interest' for purposes of standing, the interest the complainant seeks to protect must be arguably within the zone of interests to be protected." *See Rocky Mtn. Animal Def.*, 100 P.3d at 513 (Colo. App. 2004). The purpose of the Medical Practice Act is to protect against "unauthorized, unqualified, and improper practice of the healing arts in this state." C.R.S. § 12-36-102; *see also People v. Rosburg*, 805 P.2d 432 (Colo. 1991) (act's purpose is "prohibiting unlicensed persons from providing medical treatment"). The physicians who are affected by improper practice of medicine are within the zone of interest protected by that Act. Further, Colorado law recognizes that a license to

practice medicine is a unique and valuable property right which is entitled to protection from harm caused by illegal conduct. *Norton v. Colorado State Bd. of Medical Examiners*, 821 P.2d 897, 901 (Colo. App. 1991) (recognizing right to procedural due process in actions to affect medical license).

Colorado recognizes the right of an association of medical practitioners to seek declaratory relief regarding regulations affecting their practice. *Colorado Chiropractic Ass'n v. State*, 467 P.2d 795 (1970) (determining whether chiropractics were medical practitioners); *see also Mt. Emmons Mining Co. v. Crested Butte*, 690 P.2d 231, 240 (Colo. 1984) ("the required showing of demonstrable injury is somewhat relaxed in declaratory judgment actions"). Similarly, standing is recognized in many states that have looked to the professional license held by a plaintiff to determine that sufficient injury exists to confer standing. *See*, *e.g.*, *Connecticut State Medical Society v. Connecticut Board of Examiners in Podiatry*, 524 A.2d 636, 640 (Conn. 1987) (physicians and their society have standing to challenge decisions that would affect the scope of medical practice in cases involving expansion of podiatrists' scope of practice); *Florida Medical Association, Inc. v. Department of Professional Regulation*, 426 So.2d 1112, 1116 (Fla. App. 1983) ("the right of physicians or other healthcare professionals to practice their respective professions has been specifically

determined to confer standing to challenge and enjoin encroachments upon their professional interests"); *Burden v. Hoover*, 137 N.E.2d 59, 62 (Ill. 1956) (property rights created in chiropractic license provide right to secure relief against unlawful practitioners); *Ezell v. Ritholz*, 198 S.E. 419 (S.C. 1938) (optometrists have standing to bring an action in equity to prohibit unlawful practice by others); *Sloan v. Mitchell*, 168 S.E. 800 (W. Va. 1933) (same). Appellants, therefore, have standing because they are protecting the interests of their members in their professional licenses against unlawful practice.

The Governor has cited several cases where the court held that lawful competition, on its own, does not create standing. These cases are not applicable. *Wimberly v. Ettenberg*, 570 P.2d 535, 539 (Colo. 1977), involved *lawful* competition against bail bondsmen. Similarly, *Brass Monkey v. Louisville City Council*, 870 P.2d 636, 639 (Colo. App. 1994), and *GF Gaming Corp. v. Hyatt Gaming Mgm't*, 77 P. 3d 894, 897 (Colo. App. 2003), involved disputes with another *licensee.* This case involves a challenge against the Governor's decision and whether it would permit *unlawful* practice of medicine without physician supervision. Moreover, the law is clear that a competitor is not disqualified from bringing a challenge merely because it is a competitor. *Brass Monkey*, 870 P.2d at 639. All of the cases cited involve purely economic injuries. In addition to a

direct economic injury in the form of maintaining liability for nurses over whom they have no control, decreased income, and decreased value of the professional license, Appellants are suffering intangible injuries related to public perception and reputation. The Governor's legal authority does not address these issues, nor does it properly recognize the importance of medical licenses and professional standing. Colorado law recognizes that an injury-in-fact that confers standing may be intangible, and that it may exist solely by virtue of statutes and licensing provisions that create legal rights. *Cloverleaf Kennel Club, Inc. v. Colorado Racing Comm'n*, 620 P.2d 1051, 1058 (Colo. 1980). These decisions have recognized that a party may have standing to prevent improper competition.

Further, Colorado common law recognizes and imposes a supervision requirement and potential liability on a physician's role as "captain of the ship" for the provision of surgical care. The Governor's opt-out decision sets up a situation where there is supervisory liability without corresponding authority and control. Because the Defendant's actions are causing actual injuries to the Societies' members, they have standing under Colorado law, which "has traditionally been relatively easy to satisfy." *Ainscough*, 90 P.3d at 856.

3. The Societies have standing to protect the rights of patients.

Appellants also seek to protect the right of their members' patients. The Complaint alleges that: "The 'opt-out' decision will diminish patient safety in the state of Colorado." (Compl. at ¶ 5) This is a factual allegation that must be accepted by the Court as true. *See State Bd. for Community Colleges*, 687 P.2d at 434. To establish third-party standing, the Societies must meet any one of the following tests:

> (1) the existence of a substantial relationship between the party before the court and the third party; (2) the difficulty or improbability of the third party in asserting an alleged deprivation of his or her rights; or (3) the need to avoid dilution of third-party rights in the event that standing is not permitted.

City of Greenwood Village v. Petitioners for the Proposed City of Centennial, 3 P.3d 427, 439 (Colo. 2000).

The physician-patient relationship is exactly the kind of substantial relationship that permits third-party standing, thus "[m]any courts have found the physician-patient relationship to be sufficiently close for third-party standing." *Aid for Women v. Foulston*, 441 F.3d 1101, 1112-13 (10th Cir. 2006) (collecting cases); *see also Kowalski v. Tesmer*, 543 U.S. 125, 139 (2004) ("the significant bond between physician and patient" can form the basis for third-party standing); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (doctor-patient relationship

sufficiently close to justify third-party standing). The Governor's argument that "[n]o patients or patient advocacy groups are parties to this lawsuit" (Gov. Br. at 32) ignores the special relationship between doctors and patients—the physicians themselves are the patient advocacy group in this lawsuit. The concept of third-party standing involves raising the rights of *others*. *See Greenwood Village*, 3 P.3d at 439. Patient safety is among the interests protected by the Medical Practice Act. *See* Gov. Br. at 26 (citing C.R.S. § 12-36-102(1)). Because the members of the Societies have a doctor-patient relationship with their patients, and because the Societies allege that the safety of these patients was diminished by the opt-out, the Societies have third-party standing to protect the rights of patients.

To the extent that this Court may require allegations regarding a diminution of patient safety causing subsequent injury to the members of the Societies, reduced patient safety also impairs the personal and professional relationship between physicians and their patients, which results in economic losses and reduced professional standing. Moreover, decreased patient safety exposes physicians to additional tort liability and correspondingly higher insurance costs. For all these reasons, the Societies have standing to challenge the Governor's opt-out.

4. Appellants are not seeking relief under the federal regulations.

The Governor also argues that Appellants do not have standing because the federal opt-out regulations do not provide a right of action. The Societies are not, however, seeking relief under, or any interpretation of, the federal regulations. This action is explicitly based on state law "because of the existence of a controversy between the Societies and Defendant about the construction and application of various statutes and precepts of common law pertaining to the practice of medicine and delivery of anesthesia care." (Compl. ¶ 5) The Governor's certification regarding the nonexistence of a requirement of physician supervision goes far beyond the application of federal regulations. His determination affects the practice of medicine and the delivery of anesthesia care generally in Colorado, not just those situations where Medicare and Medicaid reimbursement is involved. Even if the Governor had unreviewable discretion under the federal regulations, this would not defeat the Societies' standing or deprive this Court of the ability to determine Colorado law. *See Ainscough*, 90 P.3d at 857 (finding standing in a right to a non-arbitrary exercise of discretion).

B. This Court Has the Power to Determine Issues of Colorado Law in This Matter.

CHA contends that the Governor's opt-out decision is "simply not subject to judicial review." (CHA Br. at 23) The wisdom of the Governor's determination

that opt-out is in the best interest of the citizens of Colorado could be an unreviewable political question. But the issue before this Court is whether the opt-out is consistent with Colorado law. The words of Chief Justice Marshall still ring true today: "It is emphatically the province and duty of the judicial department to say what the law is." *Marbury v. Madison*, 1 Cranch 137, 177 (1803). Colorado also looks to its judiciary to determine—definitively—what the law of the state is. *Bullock v. McGerr*, 14 Colo. 577, 583-84, 23 P. 980, 983 (1890).

CHA also asserts that only the General Assembly can require physician supervision of nurse anesthetists. But this is exactly what the legislature did in enacting C.R.S. §§ 12-38-103(4), -103(10), -103(12), and -111.5(5), and rejecting provisions calling for independent practice of CRNAs in 2009. Appellants have asked the Court to declare what the law is, not to make the law.

CHA's claim that the federal regulations delegated exclusive, unreviewable authority to the Governor to determine opt-out issues is also misplaced because this case transcends the federal regulations. Governor Ritter's determination that Colorado law does not require physician supervision of CRNAs does not apply solely to reimbursement under regulations promulgated by Health & Human Services ("HHS"). Rather, his determination affects the practice of medicine and

the delivery of anesthesia care generally in Colorado. (*See* Compl. ¶ 5) Regardless of whether the federal opt-out regulations do or do not recognize a private right of action, the Societies have based this action on state law and they are not seeking relief under, or any interpretation of, the federal regulations.

The case law cited by CHA does not support its assertion that the Governor—not the courts—has the final say in interpreting Colorado law. *McDonnell v. Juvenile Court*, 864 P.2d 565, 567 (Colo. 1993), and *Kort v. Hufnagel*, 729 P.2d 370, 372-73 (Colo. 1986), both involved situations where a juvenile court acted in excess of its jurisdiction by interfering with the discretion that the legislature had conferred upon the executive branch to place juvenile offenders in specific institutions. *State Personnel Board v. District Court*, 637 P.2d 333, 335 (Colo. 1981), determined that the legislature conferred jurisdiction upon a trial court to issue a stay of a personnel decision until it was final. Contrary to the holdings of those three cases, the Colorado Legislature has unmistakably conferred power upon this Court to issue a declaratory ruling regarding Plaintiffs' dispute with the Governor.

Nor does the deference ostensibly given to the Governor under the HHS regulations eliminate or preempt any right to seek relief under state law. The "court must presume that" a federal law does not preempt state law unless it "is the

clear and manifest purpose of congress." *Banner Advertising, Inc. v. People of City of Boulder*, 868 P.2d 1077, 1080 (Colo. 1994) (quoting *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 517 (1992)). This presumption against preemption "is especially strong in matters related to health and safety, traditionally within the province of state and local governments." *Id.* at 1081 (citing *California v. ARC America Corp.*, 490 U.S. 93 (1989)). As such, even if the Governor were conferred some discretion under the federal regulations, this does not defeat standing or preempt the authority of a Colorado court to determine Colorado law and enjoin the Governor's actions pursuant to Colorado law. *See Ainscough v. Owens*, 90 P.3d 851, 857 (Colo. 2004) (plaintiffs had a right to challenge an executive action because of their right to a non-arbitrary exercise of discretion).

The commentary to the HHS regulations makes clear that HHS did not intend to interfere with the power of states to interpret their laws in the manner established by those states. Persons who offered comments on the proposed rules proposed that HHS require that the attorney general of a state support any opt-out decision. In response, HHS concluded that imposing an attorney general requirement would be burdensome, and it recognized that each state would follow its own procedures for clarifying their laws and seeking opinions on opt-out issues:

> *Comment:* Commentators suggested that we strengthen the requirement by mandating a written opinion of a State attorney

> general to support any opt-out decision, arguing that determination of the issue of "consistent with State law" will require examination of the nursing code, medical code, various institutional codes, codes for controlled substances, and reconciliation of the terms of each code to the others. These commentators concluded that this is a task "normally" performed by the State attorney general.
>
> *Response:* States have their own regulatory and administrative structures and rules in place, and we respect the authority of States to meet regional/local needs. State authorities are experienced at regulating the licensing, education, training, and skills of the professionals practicing under their purview, without the burden of prescriptive Federal regulations. The Congress has left this licensure function to States, and Medicare recognizes the scope of practice for which health professionals are licensed by States. *Given this, we believe States have the responsibility for clarifying their laws and seeking opinions, if needed, on definition of terms such as collaboration, direction or the allowance of CRNAs to practice without physician supervision.* This one exception to Medicare's standard for deferring to States on health professionals licensure matters does not require further unnecessary burdensome restrictions such as mandatory solicitation of the attorney general's opinion.

66 Fed. Reg. 56762, 56765 (emphasis added). In Colorado, responsibility for issuing binding rulings that clarify laws and provide opinions regarding their meaning rests with the judiciary, not the executive branch.

If this case involves a determination of "a straightforward point of law" as the CHA argues (CHA Br. at 26), this Court is certainly up to the task.

IV. CONCLUSION.

Under the Nurse Practice Act, a CRNA can perform delegated medical functions that require greater expertise and experience than the services performed

by other professional nurses. They can also obtain prescriptive authority by meeting the requirements set out in the Act. 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 trial court erred when it dismissed the Complaint. This Court should reverse the dismissal, and direct the entry of summary judgment in favor of Appellants.

Dated this 23rd day of January, 2012.

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Colorado Medical Society	Appellant	Hershey, Kari MacKercher	Hershey Skinner LLC	Privately Retained Attorney
Colorado Nurses Assoc	Appellee	Stuller, William Stuart	Caplan & Earnest LLC-Boulder	Privately Retained Attorney
Colorado Nurses Assoc	Appellee	Siderius, Linda L	Caplan & Earnest LLC-Boulder	Privately Retained Attorney
Colorado Society of Anesthesiologists	Appellant	Bronesky, Joseph J	Sherman & Howard LLC-Denver	Privately Retained Attorney
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Ritter, Bill Jr	Appellee	Grove, Matt	CO Attorney General	Attorney General

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