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10

ELECTRONICALLY
FILED

*Superior Court of California,
County of San Francisco*

10/01/2026
Clerk of the Court
BY: MARIVIC VIRAY
Deputy Clerk

8 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**
9 **FOR THE COUNTY OF SAN FRANCISCO**

11 CALIFORNIA ASSOCIATION OF NURSE
12 ANESTHESIOLOGY,

13 Plaintiff,

14 v.

15 CALIFORNIA DEPARTMENT OF PUBLIC
16 HEALTH and CALIFORNIA OFFICE OF
17 ADMINISTRATIVE LAW,

18 Defendants.

Case No.

**COMPLAINT FOR DECLARATORY
RELIEF**

CGC-26-641536

Comes now, Plaintiff California Association of Nurse Anesthesiology (CANA) files this Complaint for Declaratory Relief, as follows:

INTRODUCTION

1. CANA is a statewide nonprofit representing over 3,000 members licensed to administer anesthesia services as Certified Registered Nurse Anesthetists (CRNA). CANA's mission is to advance patient safety, foster access to the highest quality anesthesia, and support the nurse anesthesia profession. CANA works with California policymakers to increase access to anesthesia for California residents, particularly in rural areas where CRNAs provide a majority of anesthetics. CANA supports comprehensive, patient-centered anesthesia services consistent with their scope of practice.

2. CRNAs are highly educated providers who are board-certified nationally. CRNAs are trained in the delivery of all types of anesthesia techniques (e.g., general anesthesia, regional anesthesia, and monitored anesthesia care) and specialty anesthesia services (e.g., obstetrics, cardiac, acute and chronic pain management, dental, trauma, and emergency). CRNAs provide anesthesia care to patients with health complexities across a patient's lifespan, in all settings (e.g., hospital, surgery center, dental office, and U.S. military).

3. Rural hospitals increasingly rely on CRNAs to deliver anesthesia care. The growing workforce of CRNAs are more likely to practice in rural, medically underserved areas. In fact, CRNAs constitute more than 80% of anesthesia providers in rural counties nationwide. Approximately half of all U.S. hospitals rely on a CRNA-only model for obstetrical anesthesia care.

4. In California, CRNAs are the sole anesthesia providers in four underserved counties. CRNAs are critical to the ability of rural hospitals in those counties to maintain adequate anesthesia coverage.

THE PARTIES

5. Plaintiff California Association of Nurse Anesthesiology (Plaintiff or CANA) is a nonprofit California corporation with its principal place of business in San Francisco, California.

6. Defendant California Department of Public Health (CDPH) is the state agency responsible for oversight and enforcement of the institutional aspects of licensed California hospitals

1 and is the successor entity to the California Department of Health Service (DHS). When DHS split
2 into CDPH and DHCS, a new enabling act endowed CDPH with the authority to regulate and oversee
3 hospitals as institutions. CDPH's principal office is located in Sacramento, California.

4 7. Defendant California Office of Administrative Law (OAL) is the state agency
5 responsible for ensuring state regulations are properly adopted, rulemaking procedures are followed,
6 and underground regulations are stopped. OAL's principal office is located in Sacramento, California.

7 **JURISDICTION AND VENUE**

8 8. Jurisdiction is proper because Government Code § 11350 allows "any interested
9 person" to "obtain a judicial declaration as to the validity of any regulation or order of repeal by
10 bringing an action for declaratory relief in the superior court in accordance with the Code of Civil
11 Procedure."

12 9. Venue is proper under Code of Civil Procedure §§ 395, 401 which authorize the
13 Plaintiff to commence and try an action in any city where the Attorney General maintains an office
14 and which includes the County of San Francisco.

15 **BACKGROUND FACTS**

16 **CDPH's Authority Over Hospitals As Institutions**

17 10. CDPH derives its hospital regulatory authority primarily from the California Health
18 and Safety Code. Under Health & Safety Code § 1250(a), a general acute care hospital is defined as
19 a health facility having a duly constituted governing body with overall administrative and
20 professional responsibility and an organized medical staff that provides 24-hour inpatient care,
21 including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology,
22 pharmacy, and dietary services.

23 11. CDPH is authorized by Health & Safety Code § 1275 to adopt, amend, or repeal rules
24 and regulations reasonably necessary to carry out the purposes of the hospital licensing chapter.

25 12. Critically, CDPH's institutional authority does not extend to regulating the individual
26 scope of practice of healthcare providers and likewise does not extend to the professional work
27 performed within the hospital. CDPH's responsibilities are limited to ensuring that a particular health
28 facility has adequate equipment and licensed personnel and is providing the specified services of its

1 facility license in a satisfactory manner.

2 13. This principle reflects the broader rule that an administrative agency may not usurp
3 the legislative function by promulgating regulations that enlarge the terms of a legislative enactment.

4 **The Medical Staff as a Legally-Separate, Self-Governing Entity**

5 14. California law mandates that every licensed hospital have an organized medical staff,
6 and it expressly requires that medical staff be self-governing with respect to the professional work
7 performed in the hospital. California courts have consistently recognized the medical staff's status as
8 a legally separate entity. The medical staff derives its regulatory authority primarily from the
9 California Business and Professions Code.

10 15. Under Business & Professions Code §§ 2282(b) and 2283(a), "membership on the
11 medical staff shall be restricted to physicians and surgeons and other licensed practitioners competent
12 in their respective fields and worthy in professional ethics."

13 16. Business & Professions Code § 2282.5 codifies the medical staff's right of self-
14 governance, as follows: (1) establishing criteria and standards for medical staff membership and
15 privileges; (2) establishing clinical criteria and standards to oversee quality assurance, utilization
16 review, and other medical staff activities; (3) selecting and removing medical staff officers; (4)
17 assessing medical staff dues; (5) retaining and being represented by independent legal counsel at the
18 expense of the medical staff; and (6) initiating, developing, and adopting medical staff bylaws, rules,
19 and regulations, subject to governing body approval (which approval shall not be unreasonably
20 withheld).

21 **The Nursing Board's Role in Regulating Individual Practitioners**

22 17. Whereas CDPH regulates the hospital as an institution and the medical staff governs
23 professional practice within the hospital, the California Board of Registered Nursing (BRN) holds
24 primary authority to regulate individual Advanced Practice Registered Nursing (APRN) licensees.

25 18. According to Business & Professions Code § 2725(e), "No state agency other than the
26 board may define or interpret the practice of nursing for those licensed pursuant to the provisions of
27 this chapter. . . unless so authorized by this chapter, or specifically required under state or federal
28 statute.

1 19. The BRN has the authority to regulate the individual APRNs who provide professional
2 services within California:

3 (a) Certified Nurse-Midwives (CNM), as set forth in Article 2.5 of the Nursing Practice Act
4 (Business & Professions Code §§ 2746-2746.8);

5 (b) Certified Registered Nurse Anesthetists (CRNA), as set forth in Article 7 of the Nursing
6 Practice Act (Business & Professions Code §§ 2825-2833.6); and

7 (c) Nurse Practitioners (NPs) as set forth in Article 8.5 of the Nursing Practice Act (Business
8 & Professions Code §§ 2837.100-2837.105).

9 20. At various points in time over the past 30 years, CNMs, CRNAs, and NPs have all
10 achieved independent practice in California, meaning that they may provide professional services,
11 without supervision, as established by their respective scope of practice acts cited above.

12 **Historical Chronology of the Restrictive Regulations**

13 21. In 1980, the California Legislature repealed and reenacted Business & Professions
14 Code §§ 2282(b) and 2283(a), which authorize hospital medical staffs to include as members any
15 “licensed practitioners competent in their respective fields and worthy in professional ethics.”

16 22. Three years later, in February 1983, DHS (the predecessor entity to CDPH) introduced
17 two regulations governing which individual practitioners may serve as members of the hospital
18 medical staff. Those regulations restrict medical staff membership to physicians, dentists, podiatrists,
19 and clinical psychologists. *See* 22 C.C.R. §§ 70701(a)(1)(e), 70703(a)(1).

20 23. On July 14, 1988, CANA petitioned DHS to amend the Title 22 regulations prohibiting
21 CRNAs from performing pre- and post-anesthesia evaluations (§§ 70723, 70527) and from serving
22 on general acute care hospital medical staffs (§§ 70701, 70703) (the “Initial Petition”).

23 24. The Initial Petition argued that the regulations conflicted with Conditions of
24 Participation for hospitals, with The Joint Commission’s accreditation standards for hospitals, and
25 with BRN scope of practice rulings regarding CRNAs.

26 25. The Initial Petition also argued that the regulations violated California Health and
27 Safety Code § 1275, whose language and legislative history confirm that CDPH’s authority to
28 regulate outpatient services does not extend to a healthcare professional’s individual practice.

1 26. The Initial Petition further noted that the medical staff restrictions created harmful
2 effects. They decreased the availability of anesthesia care and increased its costs. The regulations
3 deprived hospitals of input from CRNAs who often were the primary, if not the only, anesthesia
4 providers at rural and underserved hospitals. Thus, the regulations were not *reasonably necessary* to
5 carry out Business & Professions Code §§ 2282-2283.

6 27. Finally, the Initial Petition noted the threat posed by recent legislative proposals to
7 prevent providers from performance services, including anesthesia, in outpatient facilities, unless
8 they were members of the facility medical staff.

9 28. On August 19, 1988, DHS granted in part and denied in part CANA's petition. DHS
10 proposed to allow pre- and post-anesthesia evaluations be performed by licensed independent
11 practitioners and proposed to eliminate restrictions on medical staff membership. DHS proposed that
12 licensed independent practitioners on the medical staff may provide services in outpatient units of
13 general acute care hospitals.

14 29. On April 25, 1990, DHS issued its formal proposed rulemaking consistently with the
15 August 19, 1988 regulatory action. That same day, DHS issued a Legal Opinion, finding that nothing
16 in California law requires DHS to limit medical staff membership to specific types of providers.

17 30. On June 11, 1990, California Attorney General Van de Kamp issued a Legal Opinion
18 to DHS Director Kenneth Kizer, MD, MPH in response to DHS's request for legal opinions on the
19 following questions:

- 20 1. Is membership on the medical staff of a general acute care hospital
21 statutorily restricted to physicians and surgeons (including
22 osteopaths), podiatrists, dentists, and clinical psychologists?
23 2. Must the Department of Health Services maintain and enforce
24 regulations which limit membership on the medical staffs of general
25 acute care hospitals either to members of those professions listed in
26 question[] number one, or to any other categories of licensed
27 practitioners?

28 31. According to the California Attorney General: "The answer to both questions is,
29 'No.'"

30 32. The Legal Opinion notes the careful review of DHS's staff attorney opinion that
31 reached the same conclusions as well as review of "the very comprehensive opinion submitted by the

1 California Medical Association.”

2 33. The Attorney General Legal Opinion notes that the only applicable statutes restricting
3 the composition of the medical staff are Business & Professions Code §§ 2282(b) and 2283(a).
4 Critically, the Attorney General tells DHS Director Dr. Kizer:

5 [Y]our current regulation concerning the composition of the medical
6 staff restricts membership to those specific professions named in the
7 above code sections. (Title 22, CCR § 70703(a).) The law does not
8 require that restriction.

9 34. In other words, regulations restricting hospital medical staff to certain provider types
10 were not *reasonably necessary* to carry out the provisions of Business & Professions Code §§ 2282(b)
11 and 2283(a).

12 35. On December 5, 1990, DHS issued a notice of post-hearing changes to the proposed
13 regulations. DHS proposed to eliminate the LIP references, allow pre- and post-anesthesia services
14 by a “licensed practitioner whose scope of licensure permits” and allow medical staff membership by
15 “other licensed practitioners competent in their restrictive fields and worthy in character and
16 professional ethics.”

17 36. On April 11, 1991, DHS sent a final regulation package to Office of Administrative
18 Law (OAL) for final review and approval.

19 37. A few weeks later, DHS withdrew the proposal to conform medical staff regulations
20 with Business & Professions Code §§ 2282(b) and 2283(a).

21 38. Two years went by.

22 39. Then, on April 15, 1993, with full knowledge of the DHS issued a Legal Opinion and
23 California Attorney General Legal Opinion, OAL adopted and filed Title 22 § 70529 “Outpatient
24 Service Staff” which limits medical staff membership to “physicians, dentists and podiatrists
25 providing services in the outpatient unit...” The regulation became operative a month later.

26 **Recent Petitions Challenging Title 22 Restrictions on Medical Staff Membership**

27 40. In 2018, Mercy Medical Center of Mount Shasta medical staff submitted a petition to
28 CDPH under Government Code § 11340.6 seeking to amend 22 C.C.R. § 70703 to include CRNAs
as members of the medical staff (the “Mercy Petition”). Copied on the Mercy Petition was J.W., a

1 CRNA who hoped to serve on the hospital medical staff of this hospital located in Mount Shasta,
2 California.

3 41. In response, on July 27, 2018, CDPH denied the Mercy Petition on the basis that
4 “CDPH is currently drafting comprehensive updates to the GACH administration regulations in title
5 22, division 5, chapter 1, article 7 of the California Code of Regulations.” According to CDPH’s
6 denial letter, “[t]he rulemaking is still in the development phase and has not yet been finalized and
7 published for public comment.”

8 42. In the same denial letter, CDPH provided the hospital with a program flex allowing
9 CRNAs to serve as members of the medical staff. J.W. served as both a member of the medical staff
10 and Chief of Nurse Anesthesia at the hospital. Further, the Vice Chair of the medical staff is now a
11 CRNA, and the CRNA medical staff members attend medical staff meetings regularly, playing a
12 valuable role in managing hospital affairs and regulations.

13 43. Notwithstanding CDPH’s claim that it was in the process of comprehensively updating
14 the Title 22 regulations, five years went by with no proposed change to the medical staff regulations.

15 44. On December 8, 2023, CANA submitted a petition to CDPH which challenged the
16 restrictive list of healthcare providers who may serve as medical staff members in the regulations set
17 forth at 22 C.C.R. §§ 70701(a)(1)(e), 70703(a), and 70529(b) and proposed that the regulations be
18 updated to include CNMs, CRNAs, and NPs (the “2023 Petition”).

19 45. The 2023 Petition was made upon the authority of Government Code § 1132.42, which
20 states: “No regulation adopted is valid or effective unless consistent and not in conflict with the statute
21 and *reasonably necessary* to effectuate the purpose of the statute.”

22 46. The 2023 Petition raised violations of Government Code § 11342.2 on the bases that:

- 23 a. California had enacted new legislation providing a pathway for nurse practitioners to
24 become independent practitioners and members of the hospital medical staff. *See*
25 Business & Professions Code § 2837.104(a)(2), a.k.a. Assembly Bill 890.
- 26 b. The Centers for Medicare and Medicaid (CMS) had authorized inclusion of non-
27 physician practitioners in medical staff membership, which, according to the Federal
28 Register, was “written to allow a hospital’s governing body the greatest flexibility in

determining which categories of non-physician practitioners that it chooses to be eligible for appointment to the medical staff.” *See* Vol. 77, No. 95, at 29047.

c. The California Attorney General and DHS Legal Opinions both had confirmed that the Title 22 regulations restricting medical staff membership to specifically-listed professions are not *reasonably necessary* to effectuate Business & Professions Code §§ 2282(b) and 2283(a).

47. CDPH accepted the 2023 Petition and set a public hearing in or about May 7, 2024.

48. At the hearing and during the 30-day notice and comment period that followed, the California Hospital Association, California Association of Nurse Midwives, California Society of Health-System Pharmacists, and California Association for Nurse Practitioners expressed support for the 2023 Petition with only minor distinctions among them. For instance, the California Association for Nurse Practitioners also raised the need to update 22 CCR § 71503, which limits the medical staff of psychiatric hospitals to physicians, dentists, podiatrists, and clinical psychologists.

49. These trade associations were joined in support by individual healthcare providers, including at least one CRNA who served as the only anesthesia provider in one of four rural counties in California and expressed that the medical staff at the hospital recognized the value of being able to include him as a member of the medical staff. He specifically described medical staff meetings where a quorum of members was lacking and which led to delays from matters not being able to be heard or decided upon.

50. During the 30-day notice and public comment period that followed the hearing, the American Nurses Association\California (ANA\C) submitted a similar petition to CDPH (the “ANA Petition”). Nearly a year later, on January 28, 2025, CDPH set a public hearing on the ANA Petition and accepted comments through February 28, 2025. Most, if not all, of the above trade groups along with many individual healthcare professionals expressed support for the ANA Petition.

51. CANA submitted a comment supporting the ANA Petition and requesting that CDPH simply delete the regulations at issue to allow the hospitals the greatest flexibility to determine the “other licensed practitioners competent in their respective fields and worthy in professional ethics” consistent with Business & Professions Code §§ 2282(b) and 2283(a).

1 52. On September 29, 2025, CDPH denied both the 2023 Petition and the ANA Petition
2 using what appears to be the same template letter, which contained three discussion points.

3 a. In the “Authority” section, the letter claims that Health & Safety Code § 1275 provides
4 CDPH with authority to regulate general acute care hospitals – even though, as noted
5 above, this statute and its legislative history prohibit CDPH from interfering with the
6 practice of individual providers.

7 b. In the second “Petitioner’s Request” section, the letters briefly summarized the request
8 being made to change the regulations regarding medical staff.

9 c. In the third and final “Bases for Denial” section, CDPH “acknowledge[d] that it may
10 need to revise certain title 22 medical staffing regulations to align with AB 890” but
11 argued that the proposed changes made by CANA and ANA\C are too broad to be
12 consistent with AB 890.

13 53. Notably absent from the CDPH petition denial letters was any acknowledgement that
14 the regulations are not reasonably necessary to effectuate Business & Professions Code §§ 2282(b)
15 and 2283(a). In fact, the letters seem to be based on the false assumption that only a specific statute
16 adding a specific type of provider to medical staff membership would be sufficient to warrant
17 amendment of the medical staff regulations.

18 **Unlawful Restriction of the Medical Staff and CRNA Scope of Practice**

19 54. At present, CRNAs are required by law to be credentialed by the hospital medical staff
20 and granted privileges to provide anesthesia services. Yet, except in the one case involving the single
21 program flex, CRNAs are excluded from membership on the medical staff due to the restrictive
22 regulations.

23 55. Without a seat at the table, CRNAs are denied the ability to engage in critical self-
24 governance including clinical quality, peer review, credentialing, privileging, availability of
25 providers for emergencies, professional education programs, medical records, tissue review,
26 utilization review, infection control, pharmacy and therapeutics. *See* 22 C.C.R. § 70703(b)-(h).

27 56. For example, in excluding CRNAs from the medical staff, hospitals are deprived of
28 the authority to comprehensively assess the quality of care as it relates to the practice of anesthesia,

1 or, on the flip side, to take into account the clinical experience and expertise of the anesthesia
2 providers at their own hospital when designing policies that directly relate to anesthesia care of
3 patients.

4 57. Some hospitals have proceeded in the face of regulatory uncertainty by placing
5 CRNAs on the medical staff and authorizing them to practice within the full scope of their practice
6 under California law.

7 58. However, beginning in January 2024 and continuing into 2025, CDPH used its survey
8 authority over hospital institutions to issue citations and fines to several rural and critical access
9 hospitals for including CRNAs as independent practitioners on hospital medical staffs.

10 59. At least two of these CDPH surveys resulted in hospitals removing, without notice, all
11 CRNAs from the medical staff.

12 60. The removal of CRNAs from these two hospitals resulted in cancellation of thousands
13 of surgeries for a rural and underserved populations of patients.

14 61. On information and belief, several hospitals were forced under threat of continuing
15 CDPH fines and penalties, to enact restrictive language prohibiting the medical staff's credentialing
16 of CRNAs within their full scope of practice under Article 7 of the Nursing Practice Act.

17 62. For example, Doctor's Medical Center of Modesto (DMC) ultimately agreed to the
18 following "requirements for CRNAs" in response to the immediate jeopardy citation that CDPH
19 issued to the hospital for using CRNAs within the full scope of their practice:

- 20 • A supervising physician will co-sign all orders effective immediately (5/23/24)
- 21 • All outpatient pre-op assessments and testing will be screened and flagged per
22 protocol to be reviewed by a[] [physician] Anesthesiologist.
- 23 • The primary Anesthesia provider will review the chart and discuss any concerns with
24 the [physician] Anesthesiologist or Surgeon.
- 25 • All inpatient procedures will be screened by the [physician] Anesthesiologist.
- 26 • The [physician] Anesthesiologist will be present on induction, intubation, and
27 extubation.

28 63. As such, CDPH has demonstrated a willingness to overstep its legislative authority by
restricting the medical staff's professional practice authority and the scope of CRNA practice.

64. CANA attempted to address CDPH's actions through a petition and amended petition
to OAL sent in March and May 2025, respectively, both of which were summarily denied in May and

1 July 2025, respectively.

2 65. Based on the examples below, the regulatory restrictions actually were applied or were
3 threatened to be applied against individual CANA members, such that CANA has associational
4 standing to bring this action on behalf of its members.

5 66. Beginning in February 2023, D.V. (a CANA member) worked as a CRNA for an
6 anesthesia practice serving rural and critical access facilities in Manteca and Modesto in which
7 CRNAs practiced independently. A May 2024 CDPH inspection prompted hospital DMC, under
8 threat of an Immediate Jeopardy finding, to remove all CRNAs for approximately six weeks. This
9 abrupt removal disrupted more than 1,000 surgical cases, deprived CRNAs and other surgical staff
10 of scheduled work and compensation, and caused D.V. personally to lose approximately \$4,000 to
11 \$6,000 weekly for several weeks. D.V. also suffered resulting professional reputational harm as the
12 publicity caused by the event led the public to question D.V.'s competence for the first time in a
13 career spanning more than 30 years.

14 67. According to D.V., the consequences remain ongoing because DMC requires
15 physician signatures on CRNA preoperative evaluations, postoperative orders, and recovery-room
16 discharges even when the physician has neither seen the patient nor participated in the anesthetic,
17 thereby delaying and potentially harming patient care. According to D.V., DMC's medical staff has
18 refused to modernize the bylaws or permit CRNA participation in medical-staff governance, on
19 information and belief, because of CDPH's harmful and costly surveys. This ongoing pressure has
20 rendered it difficult for D.V.'s anesthesia practice to recruit new anesthesia providers to serve this
21 and several other local hospitals.

22 68. CANA member J.W. is a CRNA currently serving on the medical staff at Mercy
23 Mount Shasta, pursuant to the program flex. Recently, J.W. began providing anesthesia and pain
24 management at a rural hospital where CRNAs do not have membership privileges. Although J.W.
25 strived to change the bylaws at this hospital to permit CRNAs to provide a full range of services, the
26 hospital's legal department advised against it citing, on information and belief, the restrictive medical
27 staff regulations. According to J.W., his anesthesia practice has been financially harmed as a direct
28 and proximate result.

69. CANA also has direct standing to pursue this action because the restrictive medical staff regulations have actually and proximately led to increased associational costs to pursue the 2023 Petition and to support the ANA Petition (both rejected in September 2025); lost monies spent on legislative advocacy to update the Business and Professions Code through proposed Assembly Bill 1215 (which failed in committee in February 2026); and waste of CANA staff time and resources spent to address CDPH's hospital surveys and citations impacting individual CANA members from 2024 to 2025. These expenses have reached approximately \$1.2 million.

SPECIFIC ALLEGATIONS

70. California law establishes the medical staff as an independent, self-governing legal entity that is a separate from the hospital and that operates under a distinct regulatory framework. CDPH's authority over hospital facilities does not grant it authority over the determination of which individual licensed practitioners the medical staff has deemed "competent in their respective fields and worthy in professional ethics" under Business & Professions Code §§ 2282(b) or 2283(a). That power lies entirely with the medical staff under Section 2282.5(a)(1), which specifically grants to the medical staff the right to establish and enforce criteria and standards for medical staff membership and privileges.

71. Notably, CDPH directly avoids citing Business & Professions Code §§ 2282 and 2283 as authority for enacting the medical staff regulations set forth in Title 22. The September 2025 petition denial letters further acknowledge that the only enabling statute on point is Health & Safety Code § 1275. As such, CDPH and OAL have acted outside the scope of delegated authority.

72. CDPH's rulemaking and OAL's adoption of the regulations are not reasonably necessary to effectuate the purpose of the statutes, and are arbitrary, capricious, and without rational basis, as exemplified by the following:

- a. CRNAs must be granted privileges to perform anesthesia and pain management procedures, but they are prohibited – by CDPH – from serving as members of the organization that regulates them.
- b. CRNAs are authorized to serve as members of the medical staff in outpatient health clinics, but are not authorized to serve as members of the medical staff in inpatient or

1 outpatient departments of hospitals. Yet, the same CRNA providers often work in all
2 of the above practice settings. In fact, many CRNAs move between hospital and
3 outpatient anesthesia coverage in the same week or month.

4 73. As of the filing of this Complaint, Defendants have failed to withdraw the regulations
5 in response to petitions submitted in 2023, 2024, and 2025, and CDPH has sought to enforce the Title
6 22 regulations by engaging in actions resulting in the removal of CRNAs from hospital medical staffs
7 and restricting individual practitioners' ability to practice within their scope in California hospitals.

8 74. Although CANA is not required to exhaust administrative remedies, CANA believes
9 that any further administrative action would be futile.

10 75. As set forth above, CANA has established associational standing because at least one
11 CANA member has standing to sue in his or her own right based on Defendants' recent actions; the
12 interests CANA seeks to protect are germane to its organizational purpose; and neither the claim
13 asserted nor the relief requested require individual members to participate in the litigation.

14 76. CANA also has a direct, present, and legally cognizable interest in this action—not
15 merely a general concern that the Defendants acted unlawfully.

16 77. CANA now pursues a declaratory relief action pursuant Government Code § 11350.

17 **CAUSE OF ACTION FOR DECLARATORY RELIEF**

18 **By Plaintiff against Defendants**

19 78. CANA repeats, realleges and incorporates by reference each allegation contained in
20 the proceeding paragraphs of this Complaint as though fully set forth herein.

21 79. An actual and justiciable controversy exists as to whether there is substantial evidence
22 to support Defendants' determination that the regulations, and each of them, were *reasonably*
23 *necessary* to effectuate the purpose of the statute.

24 80. A second actual and justiciable controversy exists as to whether the regulations, and
25 each of them, are arbitrary, capricious, or without rational basis, and whether substantial evidence
26 supports the agency's determination that only "physicians, dentists, podiatrists, and clinical
27 psychologists" may serve on the hospital inpatient and outpatient medical staff.

28 81. A third actual and justiciable controversy exists as to whether the Title 22 medical

1 staff regulations conflict with a state statute mandating inclusion of NPs as authorized members of
2 the medical staff.

3 82. A fourth actual and justiciable controversy exists as to whether Defendants have
4 exceeded their enabling authority, by enforcing regulations outside of their authority to regulate
5 hospitals as institutions and by usurping the authority of the legally separate and self-governing
6 medical staff.

7 83. A fifth actual and justiciable controversy exists as to whether CDPH has exceeded its
8 enabling authority through its recent efforts to restrict the scope of practice of individual practitioners
9 though hospital surveys and citations and by usurping the BRN's authority over CRNA scope of
10 practice.

11 84. CANA seeks a judicial determination that the regulations, and each of them, are
12 void and stricken because they are not reasonably necessary to effectuate the purpose of
13 Business & Professions Code §§ 2282(b) and 2283(a).

14 85. CANA seeks a judicial determination that the regulations, and each of them, are
15 void and stricken because they are arbitrary, capricious, without rational basis, and/or lack
16 substantial evidence to support the agency's determination of who may serve as members of
17 the medical staff of California hospitals.

18 86. CANA seeks a judicial determination that the regulations, and each of them, are
19 void and stricken due to a conflict with state statutes, including but not limited to Business &
20 Professions Code § 2837.104.

21 87. CANA seeks a judicial determination that the regulations, and each of them, are void
22 and stricken because Defendant CDPH has exceeded its enabling act authority by promulgating
23 regulations that appear to legislate in an area reserved to the medical staff.

24 88. CANA seeks a judicial determination that the regulations, and each of them, are void
25 and stricken because Defendant CDPH has exceeded its enabling act authority by enforcing, though
26 hospital surveys and citations, restrictions on CRNA scope of practice.

27 **PRAYER FOR RELIEF**

28 WHEREFORE, CANA prays for judgment against Defendants, and each of them, as

1 follows:

- 2 1. For judicial declaration invalidating 22 C.C.R. §§ 70701(a)(1)(e), 70703(a), 71503,
3 71529(b);
- 4 2. For CANA's costs of suit and attorneys' fees incurred pursuant to California Code
5 of Civil Procedure § 1021.5; and
- 6 3. For such other and further relief as the Court deems just and proper.

7

8 Dated: October 1, 2026

FENNEMORE LLP

9 By: Kate Bowles
10 Katherine A. Bowles
11 Attorneys for Plaintiff
12 CALIFORNIA ASSOCIATION OF
13 NURSE ANESTHESIOLOGY
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