

authority to regulate services provided in private physicians' offices. We conclude that plaintiff lacks standing to maintain this action and reach no other issue.

The Guidelines

In 1997, defendants created a Committee on Quality Assurance in Office-Based Surgery in order to establish standards of care for the burgeoning, but unregulated, practice of surgeries performed in physicians' offices. In December 2000 -- with defendants' endorsement -- the Committee issued the Guidelines that are the subject of this action.

The stated intent and goal of the Guidelines is to "ensure that the public is adequately protected when undergoing surgery/invasive procedures in private offices of health care practitioners." The Guidelines include a broad range of recommendations for the qualification of practitioners and staff, equipment, facilities, ancillary services, and policies and procedures for patient admission, monitoring, discharge and emergency care. Most directly relevant to the present litigation, the Guidelines contain specifications regarding anesthesia administered in private offices -- from conscious to unconscious/deep sedation and general anesthesia. Among other things, the Guidelines suggest that CRNAs administering anesthesia to patients in doctors' offices be supervised by a physician, dentist or podiatrist who is "physically present, [and] qualified by law, regulation or hospital appointment to perform and supervise the administration of the anesthesia and

who has accepted responsibility for supervision." The Guidelines also recommend that the supervising physician perform a pre-anesthetic examination, prescribe the anesthesia, remain physically present during the surgery and be "available for diagnosis, treatment and management of anesthesia-related complications or emergencies."

Shortly before issuance of the Guidelines, plaintiff initiated this action seeking a declaration that the Guidelines are null and void because defendants' authority to regulate surgery is limited under Public Health Law § 2801 to hospital settings. In their motion to dismiss, defendants urged both that the case was not ripe for review and that plaintiff lacked standing to mount this challenge. Assuming standing, Supreme Court denied defendants' motion to dismiss, granted plaintiff summary judgment, and declared the Guidelines null and void as exceeding defendants' authority. The Appellate Division correctly recognized that a grant of relief to plaintiff first requires resolution of the standing issue; explicitly found that plaintiff had standing; and agreed with Supreme Court that the Guidelines are regulations beyond defendants' purview and thus illegal. In opposition to defendants' appeal to this Court as of right under CPLR 5601(b)(1), plaintiff argued that "[i]t is the statutory issue, i.e., whether the Department of Health exceeded the clear limits of its statutory authority, that is dispositive." We dismissed defendants' appeal as of right (100

NY2d 534 [2003]), granted their motion for leave to determine this issue (100 NY2d 510 [2003]) and now reverse.

Analysis

Standing is, of course, a threshold requirement for a plaintiff seeking to challenge governmental action. The two-part test for determining standing is a familiar one. First, a plaintiff must show "injury in fact," meaning that plaintiff will actually be harmed by the challenged administrative action. As the term itself implies, the injury must be more than conjectural. Second, the injury a plaintiff asserts must fall within the zone of interests or concerns sought to be promoted or protected by the statutory provision under which the agency has acted (see Socy. of Plastics Indus. v County of Suffolk, 77 NY2d 761, 773 [1991]; Colella v Bd. of Assessors, 95 NY2d 401, 409-410 [2000]). To establish standing, an organizational plaintiff -- such as plaintiff here -- must show that at least one of its members would have standing to sue, that it is representative of the organizational purposes it asserts and that the case would not require the participation of individual members. (See e.g. Rudder v Pataki, 93 NY2d 273, 278 [1999]; Matter of Dental Socy. of the State of New York v Carey, 61 NY2d 330, 333-334 [1984]; Matter of Dairylea Coop. v Walkley, 38 NY2d 6, 9 [1975].)

Although the Appellate Division determined standing by first looking to "zone of interests," concluding that plaintiff's members fall within the class of individuals protected by the constitutional and statutory provisions that are the basis for

suit, we begin our analysis with the critical element of in-fact injury -- the requirement that plaintiff have an actual legal stake in the matter in dispute. Because we conclude that plaintiff has not shown in-fact injury entitling it to challenge defendants' authority to issue the Guidelines, we need not reach the other components of standing.

The core of plaintiff's assertion of in-fact injury is that the Guidelines "effectively" require CRNAs to be supervised by anesthesiologists; that physicians would find it cost prohibitive to have both CRNAs and anesthesiologists during surgery; and that the Guidelines therefore "effectively" prohibit CRNAs from performing anesthesia services in an office-based setting. In short, according to plaintiff, the Guidelines "[o]bviously * * * restrict the scope of a CRNA's area of practice." Plaintiff's asserted injury rests on the following extract from the Guidelines:

"Anesthesia should be administered only by a licensed, qualified and competent practitioner. Registered professional nurses (RNs) who administer anesthesia as part of a medical, dental or podiatric procedure (including but not limited to CRNAs) should have training and experience appropriate to the level of anesthesia administered, and function in accordance with their scope of practice. Supervision of the anesthesia component of the medical, dental or podiatric procedure should be provided by a physician, dentist or podiatrist who is physically present, who is qualified by law, regulation or hospital appointment to perform and supervise the administration of the anesthesia and who has accepted responsibility for supervision. The physician, dentist or podiatrist providing supervision should:

- "1. perform a preanesthetic examination and evaluation;
- "2. prescribe the anesthesia;
- "3. assure that qualified practitioners participate;
- "4. remain physically present during the entire perioperative period and immediately available for

diagnosis, treatment and management of anesthesia-related complications or emergencies; and
"5. assure the provision of indicated postanesthesia care."

The Appellate Division accepted plaintiff's assumption that CRNAs will likely be injured as "reasonable and sufficient to demonstrate a likelihood of actual injury" (301 AD2d 895, 898 [3d Dept 2003]). We conclude, however, that plaintiff's assumption lacks the concreteness required for "injury in fact."

Plaintiff's argument that CRNAs will likely be injured is founded on two layers of speculation -- that the Guidelines will be rigorously enforced as regulations and that, as such, they will effectively harm CRNAs. At this juncture, it is not at all "obvious" that, even if enforced as regulations, the Guidelines would in fact injure any of plaintiff's members as claimed.

The Guidelines themselves do not explicitly restrict a CRNA's area of practice; nor do they express any intent to do so. Rather, they explicitly provide for the continued employment of CRNAs so long as they have "training and experience appropriate to the level of anesthesia administered." When executing a medical regimen, all nurses -- including CRNAs working in a physician's office -- already must be supervised "by a licensed physician, dentist or other licensed health care provider legally authorized under this title" (Education Law § 6902 [1]; see also 1948 Op. Atty. Gen. 203 ["a nurse working under a physician, is entitled to administer general anesthesia"]; 48 State Dept. Rep.

137, 138 [1934] [a nurse does not violate the law if the nurse administers anesthesia "under the direction of a physician"]).

The Guidelines do not require anesthesiologist supervision, and do not prohibit operating physicians from themselves supervising CRNAs as they administer anesthesia. On the contrary, the Guidelines specifically recommend that the minimum number of available personnel during administration of all types of anesthesia should be two: "the practitioner performing the surgery and the individual monitoring the patient." Since the Guidelines allow nurses to administer all types of anesthesia, it is clear that the operating doctor can also be the supervising doctor. Furthermore, as defendants point out, the Guidelines recommend that the supervising physician be qualified by law to perform and supervise the administration of anesthesia, and a license to practice medicine under Education Law Article 131 is the only credential required by law to perform a medical procedure, including the administration of anesthesia.¹ These physicians may, as the Guidelines explicitly suggest, elect to participate in continuing education training in order to maintain high standards of quality.

The recommended procedures might, or might not, actually affect the employment of CRNAs in physicians' offices. At this point, there is no certainty whatsoever that any CRNA

¹ Defendants do not suggest that the Guidelines are "meaningless" or "redundan[t]" (dissent, at pp 8-9), only that they would not operate as plaintiff projects, underscoring the abstract quality of plaintiff's complaint.

would in fact be injured. That some physicians do not routinely or ordinarily perform measures now recommended in the Guidelines (as plaintiff argues) does not mean that physicians could not and would not themselves choose to do so, as opposed to firing CRNAS and hiring anesthesiologists.

Plaintiff's speculation about the future course the Guidelines might take cannot, under our precedents, supply the missing ingredient of in-fact injury. In Dental Society, we recognized the standing of an organization of licensed dentists to challenge a Medicaid dental fee reimbursement schedule, where dentist-members receiving reimbursements necessarily suffered actual economic loss from defendants' failure over nearly 20 years to update the schedule. In Rudder, by contrast, there was no showing that any member of plaintiff organization would be deprived of opportunities or entitlements. As we noted in affirming the dismissal of plaintiff's declaratory judgment action, standing requires a showing of "cognizable harm," meaning that an individual member of plaintiff organization "has been or will be injured"; "'tenuous' and 'ephemeral' harm * * * is insufficient to trigger judicial intervention" (93 NY2d at 279).

While the record leads us to a different conclusion from the dissent, we are unanimous in our commitment to predictability in the law of standing, starting with the element of in-fact injury.² Consistent with our precedents, we conclude

²Addressing the dissent, we note that standing may indeed be a complicated subject, posing close and difficult issues that divide the Court. Our jurisprudence, however, represents not a

that, on this record, plaintiff has failed to demonstrate an in-fact injury sufficient to meet the first prong of the test for standing. That in the future the hypothesized harm might befall CRNAs does not at this time entitle plaintiff to maintain this action.

Accordingly, the order of the Appellate Division should be reversed, with costs, and the complaint dismissed.

black box from which we conjure a desired result, but an effort to articulate, and consistently apply, sound, logical principles that assure that courts' decisions will be neither abstract nor advisory. That may at times mean dismissing a well-intentioned plaintiff who prematurely commences suit, or agreeing with a defendant who, in its briefs, places greater emphasis on other issues.

R. Smith, J. (dissenting):

The Commissioner of Health has promulgated "Guidelines", which say that certified registered nurse anesthetists (CRNAs) should provide certain services in connection with office-based surgery only when they are subject to what the Commissioner considers appropriate supervision. Plaintiff, an association of New York CRNAs, challenges the Guidelines, asserting that they are regulations in disguise. I think it is clear that the Guidelines will injure CRNAs' opportunities for employment, and I therefore dissent from the majority's conclusion that CRNAs lack standing because they have not shown that the Guidelines will injure them.

The Facts

The pertinent portion of the Guidelines is quoted in full in the majority opinion (Majority at 5-6). The Guidelines say that, when a CRNA administers anesthesia in an office setting, "[s]upervision *** should be provided by a physician, dentist or podiatrist who is physically present, who is qualified by law, regulation or hospital appointment to perform and supervise the administration of the anesthesia and who has accepted responsibility for supervision." The Guidelines go on to itemize five things that the person providing supervision should do, including "perform a pre-anesthetic examination and

evaluation" and "remain physically present during the entire perioperative period ***." The majority opinion does not describe the evidence provided by plaintiff of the economic harm that these provisions of the Guidelines will do to its members. This is a striking omission, for plaintiff's showing of injury is powerful, detailed and virtually unrebutted.

The verified complaint alleges that the Guidelines change the status quo in several ways that limit what a CRNA can do. The complaint says that CRNAs now commonly work under the supervision of surgeons who are not "qualified *** to perform the administration of anesthesia," and that the Guidelines will change this by "effectively requir[ing] the presence of an anesthesiologist [i.e. a doctor specializing in anesthesia] at all office-based surgeries." The complaint also alleges that the "pre-anesthetic examination and evaluation" are now performed routinely by CRNAs, and that requiring a physician to be present during the "entire perioperative period" effectively "necessitates the presence of an anesthesiologist since the surgeon routinely does not directly monitor the patient during the periods before and after the operation." As a result, according to the complaint, "[b]ecause it is cost-prohibitive for both CRNAs and anesthesiologists to be present during surgery, the Guidelines effectively prohibit CRNAs from performing anesthesia services in an office-based setting."

The sworn allegations of harm in the complaint were amplified in affidavits submitted to Supreme Court.

Sandra Tunajek, a CRNA and the Director of Practice of the American Association of Nurse Anesthetists, testified: "I can state unequivocally that the effect of these Guidelines will be to require the presence of an anesthesiologist whenever regional or general anesthesia are administered in the office-based setting." Tunajek's affidavit did not merely state this conclusion, but explained the basis for it in detail, dealing first with the impact of the requirement that the CRNA's supervisor be a "physician, dentist or podiatrist *** qualified *** to perform the administration of anesthesia." The gist of her explanation is that most surgeons lack these qualifications, and must hire either an anesthesiologist or a CRNA to administer anesthetic; the Guidelines would effectively force them to choose an anesthesiologist. Tunajek's testimony on this point is extensive, and I quote it only in part:

" *** Guideline G (1)(a) specifically requires that the supervising physician must be 'qualified by law, regulation or hospital appointment to perform *** the administration of anesthesia.' Operating physicians who are qualified by law, regulation or appointment to actually *perform* the administration of anesthesia are extremely rare. Most physicians who perform surgery in the hospital, ambulatory surgery or office setting are not qualified to administer anesthesia. These physicians rely upon the expertise of a CRNA or an anesthesiologist, both of whom are trained to administer

anesthesia. While operating physicians are qualified to deal with surgical complications, and may have limited knowledge of anesthesia complications, they are not qualified to administer anesthesia."

In addition, Tunajek testified that, of the five steps which the Guidelines require a physician to perform, "four *** are routinely performed by CRNAs or anesthesiologists." Again, she set forth the basis for her conclusion in clear and persuasive detail, and again I quote only an excerpt, relating to one of the requirements -- that of the supervisor's physical presence:

"[T]he Guidelines require the physician to remain physically present during the entire 'perioperative period' and immediately available for management of 'anesthesia-related complications or emergencies.' In virtually all surgeries, the operating surgeon does not remain present with the patient during the entire perioperative period. It is the job of the CRNA or the anesthesiologist to remain with the patient to assure that the patient is recovering properly from the effects of the anesthesia. Further, the CRNA or the anesthesiologist is specifically trained to deal with complications or emergencies arising from the administration of anesthesia."

Again, Tunajek explained, the effect of the Guidelines is to require the presence of an anesthesiologist at office-based surgeries. Tunajek concluded:

"If an anesthesiologist's presence is

compulsory, the CRNA would have no role in the office-based setting. It is simply not economically feasible to have both an anesthesiologist and a CRNA involved in an office-based surgery. Virtually all office-based surgeries conducted throughout the United States involve the presence of a CRNA or an anesthesiologist, not both."

Plaintiff also submitted the affidavit of an eye surgeon, Kenneth Anthone. Dr. Anthone testified that he and his partner "have routinely used CRNAs since 1994;" that "[n]either I nor my partner consider ourselves to be able to 'perform' anesthesia;" and that "[w]e do not remain physically present with the patient during the post-operative period." Dr. Anthone concluded: "Since there would be no reason to have both a CRNA and an anesthesiologist present during the procedure, and the cost of such duplication of services would be prohibitive, the net effect of the application of the Guidelines to our practice would be the elimination of all positions for CRNAs."

In defendants' factual submissions to Supreme Court, their response to all this evidence of harm was virtual silence. Defendants' answer denied plaintiff's allegation that the Guidelines "effectively require [CRNAs] to be supervised by anesthesiologists," but the more specific allegations of the verified complaint that I quoted or summarized above were met either with a reference "to the guidelines themselves as the best evidence of their contents" or with a denial of "sufficient

knowledge or information to form a basis for responding."¹ In the affidavits submitted below, defendants presented no evidence on the "injury in fact" issue except one conclusory and ambiguous sentence in the affidavit of Wayne Osten, Director of the Office of Health Assistance Management. Osten testified: "The Guidelines do not require anesthesiologist supervision as alleged by the plaintiff, and I am aware of no objective information to substantiate plaintiff's economic concerns."² Osten added that the Guidelines served worthy goals which "far outweigh potential economic impacts on CRNAs" -- thus virtually admitting that such "potential economic impacts" exist.

On this record, the majority concludes that plaintiff has failed to show that CRNAs will be injured by the Guidelines.

Discussion

The majority opinion correctly states the two-part test for determining standing -- plaintiff must show "injury in fact"

¹As to one paragraph of the complaint (¶ 30), defendants' answer first admitted it in part, and referred the Court to the Guidelines as to the remainder; then, later, denied the entire paragraph. The reason for this inconsistency is not apparent.

²This statement is even less impressive than it appears on its face because of the use of the word "require." It is defendants' position that the Guidelines are only recommendations and do not "require" anything. Thus Osten's statement could be literally true, in his own opinion, even if the Guidelines' "recommendations" include anesthesiologist supervision.

and must also show that the injury is within the "zone of interest" appropriate to confer standing. The first part of the test is of course the easier to satisfy, and common sense suggests that it will be satisfied in most cases. People do not usually spend the time and money to bring lawsuits challenging actions that do not in fact injure them.

Here, as I pointed out above, plaintiff made a powerful factual showing of injury in Supreme Court, and defendants submitted no contrary evidence of substance. But defendants now argue that "injury in fact" is lacking. The gist of their argument is that the Guidelines could not possibly injure CRNAs because the Guidelines, to the extent plaintiff complains of them, are meaningless.

Defendants claim that the requirement for supervision of anesthesia by "a physician *** who is qualified by law, regulation or hospital appointment to perform and supervise the administration of anesthesia" requires only supervision by "a physician" and that the "who is qualified" clause is tautological. Defendants point out that there is no separate legal requirement for the credentialing of an anesthesiologist, and they conclude from this that "all M.D.s are qualified by law to perform anesthesia and therefore qualify under the Guidelines to supervise CRNAs." Thus, defendants say that "[w]ith respect to physicians, this guideline adds nothing to the parameters of

medical practice." Why the Commissioner would write a Guideline that "adds nothing" remains a mystery.³

I find defendants' reading of this portion of the Guidelines completely unpersuasive. Plaintiff's evidence shows, and defendants do not dispute, that there are physicians who are not in fact qualified to administer anesthesia. Indeed, one such physician submitted an affidavit to that effect below. To say that all physicians -- even those who could not administer anesthesia without endangering a patient's life -- are "qualified by law" within the meaning of the Guidelines because there is no law that prohibits them from administering anesthesia strikes me as a bit of verbal cleverness devised by lawyers for litigation purposes.

There is not a hint in the Guidelines themselves, or in the extensive materials submitted to Supreme Court concerning the development of the Guidelines, to the effect that the words "physician *** who is qualified *** " were intended as a mere redundancy. On the contrary, an e-mail generated during the drafting of the Guidelines shows that the author of the clause

³Defendants say that the clause requiring a "physician, dentist or podiatrist *** who is qualified *** " was included "because the Guidelines also applied to dentists and podiatrists." This leaves unanswered the question of why the clause was made applicable to physicians. If defendants are correct, the Guidelines should read "by a physician, or by a dentist or podiatrist who is qualified *** ."

thought it did have meaning: the head of the relevant subcommittee said in the e-mail that, while the words of the Guidelines did not "specify *** an anesthesiologist," they implied that "only someone with qualifications as outlined" should supervise CRNAs. If, as defendants now claim, all physicians have these qualifications, this e-mail does not make sense.⁴

Thus the essential meaninglessness of the "who is qualified" language, as applied to doctors, was apparently first discovered by the lawyers defending this lawsuit.⁵ But it does not really matter whether defendants are right or wrong about the "who is qualified" clause, for defendants do not even attempt to answer plaintiff's demonstration that CRNAs will be injured by other provisions of the Guidelines. For example, there is uncontradicted proof in the record, quoted above, that a supervising physician does not ordinarily perform "pre-anesthetic

⁴I assume that -- as the author's e-mail seems to suggest -- some non-anesthesiologists could meet the criteria specified for supervisors in the Guidelines, and that plaintiff's claim that the Guidelines would require an anesthesiologist at all office-based surgeries is therefore overstated. But this does not affect the thrust of plaintiff's "injury in fact" argument -- that the Guidelines will compel many physicians to hire anesthesiologists instead of CRNAs.

⁵ It will be interesting to see whether, having prevailed on their argument that the language is meaningless, defendants will now interpret it that way in practice.

examination and evaluation" and is not present during the "entire perioperative period", as the Guidelines require. If the Guidelines are implemented, supervising physicians who are not able, or do not choose, to take on these added responsibilities will have to hire anesthesiologists to perform them -- making CRNAs superfluous. Defendants nowhere even assert that this is not so.

In short, defendants' response to plaintiff's position on the "injury in fact" issue is partly unpersuasive and partly non-existent. The majority opinion does not remedy any of the deficiencies in defendants' argument.

The majority says that plaintiff's claim of injury is founded on "two layers of speculation." The first "layer" is "that the Guidelines will be rigorously enforced as regulations"⁶ (Majority at 6). But the question of whether the Guidelines are recommendations or regulations is the question presented by this case on the merits - the question that plaintiff is asking us to decide, and that we are refusing to decide on standing grounds. Plaintiff need not show it would win on the merits in order to establish its standing (see e.g. Socy. of Plastics v. County of Suffolk, 77 NY2d 761, 780 [1991] [inappropriate to consider the

⁶The majority's reference to "rigorous" enforcement is pure surplusage. CRNAs will be injured if the Guidelines are enforced at all - the "rigor" of the enforcement would affect only the extent, not the fact, of their injury.

merits in determining standing]; Matter of Dairylea Coop. v. Walkley, 38 NY2d 6, 9 [1975][same]).

The majority's second "layer of speculation" is that the Guidelines, if enforced, "will effectively harm CRNAs" (Majority at 6). But to label plaintiff's expectation of harm as "speculation" is simply to ignore the extensive evidence I described above. The majority does ignore this evidence; and it does not analyze either side's argument on the "injury in fact" issue in any detail.

The majority says that it is "not at all 'obvious' that the Guidelines would in fact injure any of plaintiff's members as claimed." (Id.). It bolsters this remark with a very brief review of the Guidelines, largely ignoring plaintiff's explanations of why the Guidelines are harmful, and swallowing whole, without noting its flaws, defendants' interpretation of the "who is qualified" phrase. The majority also says that physicians who "do not routinely or ordinarily perform measures now recommended in the Guidelines" might "themselves choose to do so, as opposed to firing CRNAs and hiring anesthesiologists" (Majority at 8). There are two answers to this: First, the record shows that the reason most physicians do not themselves perform these "measures" is that most of them are not qualified to perform them; secondly, even if some do choose to perform the tasks themselves, it is most unlikely, based on the evidence in this record, that so few

will turn to anesthesiologists that CRNAs will suffer no injury.

The majority's conclusion is agnostic: "The recommended procedures might, or might not, actually affect the employment of CRNAs in physicians' offices." (Id. at 9). The majority's reasoning seems to suggest that any doubt about the existence of plaintiff's injury is a sufficient reason to deny standing. I do not think this is, or ever has been, the law -- and in any event, for the reasons I have stated, I do not think there is any doubt about the injury to the CRNAs here.

The injury in fact issue here is controlled by Dental Soc'y of State of N.Y. v Carey (61 NY2d 330 [1984]), in which an organization of licensed dentists was held to have standing to challenge a Medicaid dental fee reimbursement schedule. The plaintiff alleged, and the record demonstrated, that among its members were some who would receive less compensation because of the inadequate fee schedule; this was enough to show injury in fact. The present case differs only in that the facts relevant to the injury to plaintiff's members are more complicated; the record, as described above, overwhelmingly demonstrates that at least some CRNAs will lose the opportunity for work if the Guidelines are implemented.

The only case cited by the majority as supporting its holding is Rudder v Pataki (93 NY2d 273 [1999]). In Rudder, an association of social workers and a union of health and human

services workers were among the plaintiffs who challenged an Executive Order of the Governor. That order had prevented the Department of Health from instituting a requirement that certain hospital positions be held only by people having a Masters Degree in Social Work (MSW). Some members of the organizational plaintiffs held MSWs, and the Court acknowledged that those members "will not have the benefit of increased job prospects" because of the Executive Order in issue. But, the Court said, "this does not mean that any one individual with an MSW has been or will be injured." The Court concluded that the anticipated injury to the association members was "[a]t best only 'tenuous' and 'ephemeral'" (92 NY2d at 279).

I admit I find this portion of the Rudder opinion difficult to explain; I can no more understand why people holding MSWs were not injured in Rudder than I can understand how the CRNAs are not injured here. I believe that Rudder was more soundly based on its second alternative holding - that since the organizational plaintiffs represented both social workers with MSWs and social workers without them, "the interests of the organizations... are not entirely germane to the relief they seek *** " (Id). In any event, even if it could be shown that Rudder rests on a logical error, I would not regard that as justification for being equally illogical in the present case.

I find decisions like the present one, and like the

first alternative holding in Rudder, to be troubling because they render the law of standing unpredictable. Indeed, I am convinced from a reading of the briefs that no party expected this case to be dismissed on "injury in fact" grounds.⁷ Standing is a complicated subject at best, and there is always the danger that it will become a black box, from which a judicial conjurer can extract the desired result at will. I do not say that any such thing has happened in this case; but I do say that such things have happened before, and will probably happen again. Today's decision can only increase that unfortunate likelihood.

Because I am convinced that injury in fact is present and because I believe that CRNAs are within the "zone of interests" protected by the statutes and legal doctrines plaintiff is seeking to enforce (see Dental Soc'y, 61 NY2d 330), I would hold that plaintiff has standing to maintain this action. Since the majority concludes otherwise, the merits of the action are moot, and I do not address them.

⁷ Defendants' "injury in fact" argument is not only extremely weak, as I pointed out above; it is presented in perfunctory and unenthusiastic fashion. Though "injury in fact" is logically a threshold issue, defendants do not discuss it until after a lengthy argument on the "zone of interests" issue. They then devote three pages of their 46-page brief to "injury in fact."

* * * * *

Order reversed, with costs, and complaint dismissed. Opinion by Chief Judge Kaye. Judges George Smith, Ciparick, Rosenblatt, Graffeo and Read concur. Judge Robert Smith dissents in an opinion.

Decided March 30, 2004