
Legal Briefs

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Captain of the Ship

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Recently, I was asked to review some material prepared by a lawyer commenting on the application of "Captain of the Ship." I realized how loosely the phrase was being used. Because Captain of the Ship has many disturbing connotations in the healthcare area, it is important to have an understanding of exactly what it refers to and, just as importantly, what it does *not* refer to.

In the anesthesia field, Captain of the Ship is sometimes used, inappropriately, to refer to any liability that a surgeon or obstetrician may have for an anesthetic mishap. One problem that has resulted from the confusion is that when surgeons are unable to obtain summary judgment in cases of anesthesia mishaps, they assume it is because their state follows Captain of the Ship. Based on that assumption, they become prepared to concede. In all states, even in states which do not follow Captain of the Ship, there are theories by which a surgeon could be liable for an anesthesia mishap (whether the anesthesia is provided by an anesthesiologist or a CRNA). This does not mean that the plaintiff will prove facts which would implicate the surgeon.

To be accurate, Captain of the Ship refers only to situations when a surgeon or obstetrician is held liable for the negligence of another healthcare provider, but the surgeon or obstetrician is entirely free of negligence. It does not refer to cases where the surgeon or obstetrician may have liability for

something the surgeon or obstetrician has done. One reason for the confusion is that many cases involving vicarious liability come to the attention of an appellate court because one of the defendants has asked for summary judgment. Summary judgment is a legal technique which is used to avoid trial. Frequently, a defendant will try to have a case dismissed by seeking summary judgment. The defendant says if you assume that everything the plaintiff says is true, there is still no way that the plaintiff can recover against the defendant because there is no legal theory which would entitle the plaintiff to a recovery. When the court receives a request for summary judgment, it must examine the plaintiff's case and assume that everything that the plaintiff claims is true. What often happens in a summary judgment case is that the court engages in a theoretical discussion of possible causes of action which the plaintiff *might* be able to use to prevail at trial.

There are a number of theoretical ways a surgeon can be responsible when there is an anesthesia mishap. Even though a surgeon may be held responsible for an anesthesia mishap, it does not necessarily mean that the surgeon is being held vicariously liable for the negligence of the anesthesia provider. For example, surgeons have been held liable for positioning patients in an improper way, for leaving the operating room before patients were stabilized, for selecting an anesthesia provider who was unqualified, for failing to notice that the patient was not getting enough oxygen, or for failing to take appropriate action in the face of an anes-

sia emergency. In these examples, a surgeon can be held liable for an anesthesia mishap (whether the provider is an anesthesiologist or a CRNA). When there is an anesthesia mishap, the patient sues everyone in the operating room and the existence of any one of these possibilities would prevent the court from dismissing the surgeon by summary judgment. They are not, however, examples of vicarious liability. Moreover, none of them are examples of the Captain of the Ship doctrine.

History of Captain of the Ship

What is the doctrine of Captain of the Ship? Captain of the Ship was first introduced into the law of negligence by the case of *McConnell v Williams*, 361 Pa. 355 (1949). An obstetrician asked an intern “to be his assistant and take care of the baby at the time of the delivery.” When the operation took place, it was a very difficult delivery, which required the obstetrician’s complete attention. When the child was delivered, the obstetrician turned the child over to the intern for the purpose of tying the cord and applying a solution of silver nitrate into the infant’s eyes. Applying silver nitrate was a regularly established practice in obstetrical cases and was required by the rules and regulations of the Department of Health of the Commonwealth of Pennsylvania. One of the nurses present in the operating room noticed that the intern filled the syringe and squirted the solution once into the child’s left eye and twice into its right eye, putting too much of the solution into the right eye. Moreover, the nurse testified that the intern failed to irrigate the eye. The result was that the child lost sight in her right eye. The evidence showed that the insertion of silver nitrate was not a job which required any special skill and could have been performed by persons who were not educated in medicine in any way.

What made the case interesting was that the plaintiffs did not have any evidence that the obstetrician engaged in any act of negligence. The plaintiffs conceded that the defendant was an obstetrician of high repute and that the operation was entirely satisfactory and not subject to criticism. The only question in the case was whether the surgeon should be responsible for the negligence of the intern. At trial, the court listened to all of the evidence and then dismissed the case against the surgeon. Consequently, while this is *similar* to cases involving summary judgment, it is much different because testimony had already been heard. The court is not speculating, on a theoretical basis, about whether evidence could be introduced by the plaintiff of the obstetrician’s negligence. The plaintiff has already introduced evidence and none of it

suggested that the surgeon did anything wrong. Since the facts would not support a finding that the surgeon was negligent, the plaintiff developed an argument for the surgeon’s liability as a matter of law.

Vicarious liability

The plaintiff turned to the legal doctrine of vicarious liability. The history of vicarious liability, holding someone liable for the negligence of another, is a long and varying one. According to one of the leading authorities on the development of tort law, the idea of vicarious liability was common in primitive law where “owners” were liable for the negligence of servants, slaves, inanimate objects, and “wives” (Prosser, *Law of Torts*, page 470). By the 16th century, English law held that masters were not liable for the negligence of servants unless the master had commanded the particular act. However, as the industrial revolution developed, the concept of vicarious liability became more and more expanded.

Prosser discussed a number of possible justifications for vicarious liability. It could be based on control because the master had “set the whole thing in motion” and become responsible for what happens. In turn for the law’s permitting the master to employ the servant, there should be a corresponding responsibility for the servant’s actions. Finally, there was the “deep pocket” theory—the owner could more easily pay the damages than anyone else. Prosser concluded that none of these justified the doctrine and concluded that the doctrine of vicarious liability merely reflected a judgment by society as to how risks were to be allocated. Losses caused by negligence of employees were carried by the employer as a required cost of doing business. The employer profits by the action of the employee and should bear the damage. The employer is better able to absorb the cost and because negligence is a foreseeable aspect of business, vicarious liability allows the cost of negligence to be distributed among users through setting prices or obtaining liability insurance. In addition, by holding the employer responsible, the employer may be more careful in selection of employees and will take more precautions to see that activities are conducted safely.

The principles of vicarious liability were tested in *McConnell v Williams* against the business of healthcare. A newborn was damaged by the negligence of an underpaid hospital intern. How could the court impose liability on a deeper pocket? One deeper pocket was the hospital, but the hospital was a charity. The more attractive deeper pocket was the obstetrician. The only problem was that the obstetrician had never hired, never paid, and could not

discharge the intern who received a regular paycheck from the hospital. In no customary sense of the word "employ" could the obstetrician be said to be the "employer" of the intern. The Pennsylvania court came up with a rather ingenious method of dealing with these technical problems.

The court noted that under law a servant could have different masters at various times. For example, a person can work for an employment agency. He or she may be paid by the employment agency and fired or discharged by the employment agency, but when sent out to do a job, the "boss" is the client of the employment agency. The question in cases such as this is: Who is the controlling master at the time of the commission of the negligent act? At trial, the defendant obstetrician was asked a variety of questions which implicated the obstetrician in the actions of the intern.

First, the obstetrician testified that his agreement covered, and his liability was to continue, until the baby was turned over to the family doctor. Consequently, the negligence clearly occurred during the course of the obstetrician's intended treatment of the patient. Second, the obstetrician was not obligated to use a licensed physician to insert the silver nitrate and, therefore, the selection of the intern reflected the obstetrician's *choice*, an additional indication of control. Finally, the defendant had testified "that he had complete control of the operating room and of every person within it while the operation was in progress." As is typical of the personality of many surgeons and obstetricians when asked whether every person within the operating room was subject to his orders, his answer was a simple "sure," the intern was bound to carry out his orders. Well, if the surgeon had the right of control and the right to give orders which the negligent intern was obligated to carry out, then under classical tests of agency the surgeon was liable for the harm that was caused. "Responsibility is commensurate with authority."

Classical test of agency

Of course, this was not an example of "classical test of agency." The classical test of agency was that the servant had to be the employee of the master *and* under the master's control. Under the classical test of agency, this intern was, by no stretch of the imagination, an *employee* of the surgeon. Therefore, to bridge the gap between temporary control but no permanent employment, the court pointed to a familiar area of maritime law as support for its somewhat unorthodox conclusion. The surgeon "is in the same complete charge of those who are present and assisting him as is the captain of a ship over all on board, and that such supreme control is indeed

essential in view of the high degree of protection to which an anesthetized, unconscious patient is entitled."

Of course, maritime law had a totally different development than did tort law. The fact that the captain of a ship was liable for the negligence of all members of the crew had never been (and has never since been) applied to any other area of the law of negligence except medical malpractice. It is somewhat easy to see how a court was drawn into the simile of Captain of the Ship. The obstetrician testified about his control with the same confidence one expects of the Captain of a Ship that his orders will be carried out by everyone in the operating room. Yes, the intern and everyone in the room was under his control and, yes, the intern and everyone in the operating room was *bound* to carry out his orders.

If that image existed in American hospitals in 1949 (which I doubt), it has long since disappeared by the 1990s. The operating room team today consists of a number of specialists working in collaboration. The members, each competent in his or her own right, work as a team, not as arms of the surgeon. The Captain of the Ship analogy while perhaps attractive to some surgeons is not the reality of a modern operating room. Consequently, Captain of the Ship has increasingly been attacked by courts to be replaced by the test of actual control, not the assumption of it. The question of control is a factual question to be determined from the facts and circumstances of the case.

When a "master" controls the acts of a "servant," the master is liable for the damages. In the *McConnell v Williams* case, the obstetrician testified that he was in control of the intern. This made him liable for the intern's negligence. Of course, persons familiar with healthcare understand that surgeons cannot control everything that goes on within the operating room. The surgeon or obstetrician is dependent on other team members to provide anesthesia, to count sponges, and to do numerous other activities which the surgeon could not possibly be responsible for and still pay attention to the actual surgery. Captain of the Ship has come to mean a doctrine which holds the surgeon liable for everyone in the operating room whether, in fact, the surgeon controlled those persons or not. The real problem has been that surgeons liked and identified with the romantic notion that they were the Captain of the Ship and were unwilling to admit that there were activities in the operating room which they did not control. I suspect, even in 1993, that the recognition of the limitations of the surgeon's ability to control everything in the operating room is probably greater in the legal community than it is among surgeons.

Captain of the Ship has, thus, enjoyed its moment in the sun and is now dying out as courts understand that surgeons are not Captains of the Ship, that surgeons are not able to control everything which occurs in the operating room, and that the operating team is a collaborative venture in which the members participate and contribute their expertise and talents. In the area of anesthesia, many courts have specifically rejected Captain of the Ship (see, for example, *Franklin v Gupta*, 81 Md. App. 345, 567 A.2d 524 (1990) and *Parker v Vanderbilt*, 767 S.W.2d 412 (Tenn. App., 1988)).

Analysis of the surgeon's actions

Whether a surgeon should be held liable for anesthesia mishaps is usually a complicated question. It first requires analysis of the surgeon's own actions. Was the surgeon doing something which resulted in harm to the patient? Did the surgeon position the patient's body in a way that caused damage? Should the surgeon have noticed that the patient was in distress? Should the surgeon have taken more direct action to save the patient? These concerns address the question of whether the surgeon is liable for the surgeon's own direct actions. They are not based on vicarious liability at all. Because these questions are factual questions, they usually cannot be answered short of a full trial. Summary judgment will not be available, and there will be yet another case in which a court will speculate on the ways in which a surgeon could be liable for an anesthesia mishap. These cases do not, however, represent vicarious liability. They are based

on the surgeon's own acts, own mistakes, and own liability. They are not examples of Captain of the Ship, and they are just as applicable to surgeons working with anesthesiologists as CRNAs.

If there is no evidence that the surgeon was negligent, the surgeon may, nonetheless, be held liable for the negligence of the anesthesia provider if the surgeon was in control of the provider. As we have said to the point of distraction, the question of whether a surgeon was in control is usually a factual question to be answered by the facts and circumstances of the case. There is nothing in the law, in the Joint Commission on Accreditation of Healthcare Organization's requirements, in AANA guidelines, or in accepted principles of healthcare practice which requires a surgeon to control the acts of an anesthesia provider. If the surgeon was in control, even these cases are not examples of Captain of the Ship. Captain of the Ship refers to a very small minority of cases where for one reason or another (usually as a result of poor legal scholarship or simple mistake) courts come to the conclusion that as a matter of law, not of fact, the surgeon is assumed to be in control of operating room personnel. Only this small minority of cases can be referred to as Captain of the Ship. As we have seen, the number of courts reaching this conclusion declines on a steady basis.

The problem has been that both surgeons and courts have been caught up in the illusion of Captain of the Ship—the courts, because it makes deciding cases easier when you do not have to look at the facts; and surgeons, because of the romantic identification of themselves as “Captains” of Ships.