IN THE

INDIANA SUPREME COURT

Cause No. 67A01-0603-CV-122

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| CHI YUN HO, M.D.,<br><br>Appellant-Defendant,<br><br>v.<br><br>LORETTA M. FRYE and THOMAS HOFFMAN, Personal Representative of the Estate of Charles Frye,<br><br>Appellees-Plaintiffs. | ) | Appeal from the Putnam Circuit Court<br><br>Trial Court Case No. 67C01-0210-PL-349<br><br>The Honorable Matthew L. Headley, Judge |

# *AMICI CURIAE* THE INDIANA STATE MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION'S BRIEF IN SUPPORT OF PETITION TO TRANSFER

Thomas J. Costakis, Attorney No. 4314-49
Libby Y. Mote, Attorney No. 20880-49A
KRIEG DeVAULT LLP
One Indiana Square, Suite 2800
Indianapolis, Indiana 46204
(317) 636-4341
FAX: (317) 636-1507

Attorneys for *Amici Curiae* the
Indiana State Medical Association and
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## QUESTION PRESENTED ON TRANSFER

Whether the "captain of the ship" doctrine remains a viable basis upon which to impose liability on a surgeon for the negligence of hospital surgical staff who are beyond the employ or control of the surgeon.

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## INTRODUCTION AND STATEMENT OF INTEREST

The mission of the Indiana State Medical Association ("ISMA") is to provide advocacy, leadership, representation, and services in the common best interests of its approximately 8,300 member physicians. The ISMA serves as the central voice for its member physicians on matters of public policy and seeks to foster better understanding of physicians in the community, the legislature, and in the courts.

The American Medical Association ("AMA"), through the Litigation Center of the AMA and the State Medical Societies, serves as the voice of America's medical profession in legal proceedings around the country. The AMA has approximately 240,000 members and is the largest organization of physicians, residents, and medical students in the United States. AMA's members practice in all areas of medical specialization and in every state, including Indiana.

Liability involving hospitals, surgeons, and surgical staff in operating rooms has evolved. Historically, hospitals enjoyed charitable immunity from malpractice claims and were viewed as merely "special hotels where patients could come to be treated by their private physician." Stephen H. Price, The Sinking of the "Captain of the Ship," 10 J. of Legal Med. 323 (1989); Ellen K. Murphy, "Captain of the Ship" Doctrine Continues to Take on Water, Ass'n of Operating Room Nurses J. (2001). In the operating room, the surgeon was seen as the "captain of the ship" in complete control of hospital personnel. Price, supra, at 323. The "captain of the ship" doctrine, interpreted to mean that the surgeon's mere presence in the operating room subjects him to liability for everyone's negligence in that room, emerged in 1949 and grew in popularity throughout the 1950s. Murphy, supra. Then-existing charitable immunity rules, together with hospitals' previously limited role in the delivery of health care, were driving forces in the "captain of the ship" doctrine's rise in popularity. Id. However, states began abandoning

the charitable immunity doctrine in the 1960s, and by the 1970s, the "captain of the ship" doctrine had likewise come under sharp criticism by the courts. Id.

Not only has there been a shift in the law, but the role of hospitals and surgeons has also changed as the practice of medicine has become more technologically sophisticated. Price, supra, at 323. A division of responsibility has developed in the operating room such that the surgeon no longer truly "controls" the hospital's nurses and surgical staff. Id. Recognizing both the demise of charitable immunity and the evolution of modern medicine, most jurisdictions have rejected an application of "captain of the ship" that assumes a surgeon has the right to control and must be held liable for the negligence of an assisting hospital employee simply because he is present in the operating room at the time of the employee's negligent act. Id. at 324.

Despite these trends, the Court of Appeals imposed upon Appellant-Defendant Chi Yun Ho ("Dr. Ho") "captain of the ship" liability for the negligence of the hospital's surgical nurse who was responsible for performing the sponge count. The Court of Appeals' decision imposes a standard of care that is outdated, unreasonable, and detrimental to all Indiana surgeons, including the physician members of ISMA and AMA.

## BACKGROUND AND PRIOR TREATMENT OF ISSUE ON TRANSFER

On October 20, 2000, Dr. Ho operated on Loretta M. Frye ("Frye") at the Putnam County Hospital (the "Hospital"). (Opinion at 2). Dr. Ho properly requested a sponge count confirming he had removed all of the sponges used in the procedure, and the surgical nurse employed by the Hospital reported to Dr. Ho that the sponge count was correct. (Id.). It was later discovered that a sponge had been left in Frye's abdomen during the surgery. (Id. at 2-3).

The Fryes sought to hold Dr. Ho liable for negligence as a matter of law under the "captain of the ship" doctrine. (Appellees' App. at 77-78). According to the Fryes, the "captain of the ship" doctrine as articulated by this Court in Funk v. Bonham, 204 Ind. 170, 183 N.E. 312

(1932), "established that the doctor, not the nurse, is responsible for removal of the sponge and that this is a question of law, not a question of fact." (Appellees' App. at 77). Although the trial court proceeded to trial on the issues of liability and damages, the Court of Appeals applied "captain of the ship" to Dr. Ho, holding he was liable as a matter of law for the incorrect sponge count and remanding for a new trial on the issue of damages.

The Court of Appeals cited Funk for the proposition that "a surgeon cannot 'delegate the absolute authority and responsibility to a nurse or nurses to account for sponges and to thus escape responsibility himself.'" (Opinion at 13) (quoting Funk, 183 N.E. at 315-16). The Court of Appeals declined to consider any evidence that the surgical nurse present during Frye's procedure was an employee of the Hospital and charged with the duty to count sponges. (Opinion at 13). The Court of Appeals thus concluded as a matter of law that the Fryes were entitled to partial summary judgment on the question of Dr. Ho's liability.

The Court of Appeals' decision imposes upon Dr. Ho "captain of the ship" liability for the negligent acts and omissions of a Hospital employee, contrary to prevailing law in other jurisdictions and the current practice of medicine.[1] To the extent Funk (or the Court of Appeals' application of Funk) embraces the antiquated concept of "captain of the ship" in the context of the modern operating room, that holding should be abandoned by this Court.[2] The "captain of the ship" doctrine is no longer a viable basis upon which to impose liability on a surgeon for the negligence of hospital surgical staff who are beyond the surgeon's employ or control.

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[1] The Court of Appeals did not use the phrase "captain of the ship" in its opinion. Nevertheless, both the basis and the effect of its holding are clear.

[2] Funk did not use the phrase "captain of the ship." Subsequent caselaw recognizes Funk as the origin of the doctrine in Indiana. See Miller v. Ryan, 706 N.E.2d 244, 251 (Ind. Ct. App. 1999).

## ARGUMENT

## I. "CAPTAIN OF THE SHIP" DOCTRINE MUST BE CONSIDERED WITHIN HISTORICAL CONTEXT IN WHICH IT WAS ADOPTED.

### A. Hospitals Once Played A Different Role In The Delivery Of Health Care.

The role hospitals have played in the delivery of health care in the United States has changed dramatically.

> The hospital of the early to mid-nineteenth century would not be recognizable as such to a modern observer. "Respectable" people who fell sick or who were injured were treated by their doctors at home; only the lowest classes of society sought help in the "hospital," which was most often a separate wing on the almshouse. As late as 1873, there were only 178 hospitals in the United States, with a total of 50,000 beds. These hospitals were private charities, and their trustees were usually unable to raise sufficient funding to provide a pleasant stay.

Simmons v. Tuomey Reg'l Med. Ctr., 341 S.C. 32, 533 S.E.2d 312, 316 (2000) (citations omitted). Hospitals were once regarded less as comprehensive health care providers and more as "innkeeper[s], providing a facility for patients to be treated by their privately retained physicians." Price, supra, at 340; Franklin v. Gupta, 81 Md. App. 345, 567 A.2d 524, 535 (1990). Courts viewed hospitals "not as themselves providing medical care to patients, but as suppliers of the means by which doctors, nurses, and others provided such care." Kenneth S. Abraham & Paul C. Weiler, Enterprise Medical Liability and the Evolution of the American Health Care System, 108 Harv. L. Rev. 381, 386 (1994).

### B. Hospitals Previously Enjoyed Charitable Immunity From Malpractice Liability.

Until the 1940s, hospitals were protected from malpractice liability by charitable immunity. Simmons, 533 S.E.2d at 316; Shelley S. Fraser, Note, Hospital Liability: Drawing a Fine Line with Informed Consent in Today's Evolving Health Care Arena, 1 Ind. Health L. Rev. 253, 255 (2004). The doctrine, which originated in England, was first adopted in America by the Massachusetts Supreme Court in 1876. McDonald v. Massachusetts Gen. Hosp., 120 Mass. 432

(1876). The basis for that immunity was the perception that hospitals functioned as charitable organizations. Thompson v. Nason Hosp., 527 Pa. 330, 591 A.2d 703, 706 (1991); Abraham & Weiler, supra, at 386; Gary Jones, The Requirement that Private Hospitals Provide Emergency Care to Indigents as Eminent Domain, 20 J. Legis. 179, 181 (1994). Indiana followed this trend and adopted the rule of charitable immunity in St. Vincent's Hosp. v. Stine, 195 Ind. 350, 144 N.E. 537 (1924).

Courts across the country eventually abandoned charitable immunity during the 1950s and 1960s. Murphy, supra; Jones, supra, at 181. As it turns out, the Massachusetts court in McDonald was unaware that the doctrine of charitable immunity had actually been repudiated in the English courts ten years earlier. Harris v. Young Women's Christian Ass'n, 250 Ind. 491, 237 N.E.2d 242, 243-44 (1968). This Court followed suit and abolished charitable immunity in 1968. Id. at 245. This Court in Harris explained:

> In the year 1924 when this Court wrote the case of [St. Vincent's v. Stine], this Court found that at least twenty (20) States granted charitable immunity and only three (3) did not. As of this writing, the great majority of the States deny immunity and perhaps only eight (8) or ten (10) States, including Indiana, hold to the doctrine which we believe was ill conceived and has certainly outlived any usefulness it may have had at one time.

Id., 237 N.E.2d at 245.

Indiana has also struck down the prohibition against imposing liability against a hospital for injuries sustained during a surgical procedure performed at that facility. See Sloan v. Metro. Health Council, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987); Ind. Code § 34-18-2-14 (including hospitals and hospital employees as "health care providers" who can be held liable for malpractice). Therefore, injured patients in Indiana now have available remedies against hospitals and hospital employees.

### C. With The Abandonment Of Charitable Immunity, Changes In Hospitals' Role In The Delivery Of Health Care Have Occurred As Well.

In the last fifty years, "hospitals have evolved into highly sophisticated corporations operating primarily on a fee-for-service basis." Thompson, 591 A.2d at 706; Fraser, supra, at 255 (observing that "hospitals became more like businesses"). "The corporate hospital of today has assumed the role of a comprehensive health center with responsibility for arranging and coordinating the total health care of its patients." Thompson, 591 A.2d at 706 (stating that "as a result of this metamorphosis, hospital immunity was eliminated"). The South Carolina Supreme Court summarized the metamorphosis of hospitals:

> Hospitals and the medical sciences improved dramatically throughout the twentieth century, and with those improvements came a concomitant increase in the importance of hospitals' role in providing medical care. Today, hospitals compete aggressively in providing the latest medical technology and the best facilities, as well as in attracting patients and physicians who will funnel patients to them. . . . Among the many forces that have caused this sea change are the commercialization of the practice of medicine, the public's demand for access to modern medical technology, the prevalence and impact of government-funded programs such as Medicare and Medicaid, and the rise of managed care in the private sector.

Simmons, 533 S.E.2d at 317. As full-care modern health facilities, hospitals are no longer mere structures where physicians treat and care for their patients. Lewis v. Physicians Ins. Co., 243 Wis.2d 648, 627 N.W.2d 484, 492 (2001). It is against this historical backdrop that the continued utility of "captain of the ship" must be considered.

## II. "CAPTAIN OF THE SHIP" DOCTRINE IS NO LONGER VIABLE BASIS UPON WHICH TO IMPOSE LIABILITY AND SHOULD BE ABANDONED.

### A. With The Demise Of Charitable Immunity, The Original Premise Of The "Captain of the Ship" Doctrine Has Been Undermined.

The Pennsylvania Supreme Court became the first to employ the "captain of the ship" metaphor to describe an operating room surgeon's right to control assisting hospital personnel. McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949). The "captain of the ship" doctrine

was an outgrowth of the now largely defunct charitable immunity doctrine. Lewis, 627 N.W.2d at 492. To provide some form of recovery for plaintiffs in the face of charitable immunity, the "captain of the ship" doctrine enabled them to hold a doctor liable for the negligence of assisting hospital employees. Id. "Under this doctrine, a surgeon is likened to the captain of a ship, in that it is his duty to control everything going on in the operating room. Thus, liability is imposed by virtue of the surgeon's status and without any showing of actual control by the surgeon." Franklin, 567 A.2d at 535 (citation omitted); Baird v. Sickler, 69 Ohio St.2d 652, 433 N.E.2d 593 (1982) (explaining "captain of the ship" doctrine as rule which holds surgeon responsible for all that transpires in operating room).

The initial premise of the "captain of the ship" doctrine was that if surgeons could not be held liable for the negligent performance of the duties of those working under them, the law would fail in large measure to afford a means of redress for preventable injuries sustained during the course of operations. Thomas v. Hutchinson, 442 Pa. 118, 275 A.2d 23 (1971). Therefore, the "captain of the ship" theory created a means of recovery at a time when many hospitals were protected by charitable immunity. Braick v. New York State Dep't of Health, 13 A.D.3d 740, 786 N.Y.S.2d 599, 601 (App. Div. 3d Dep't 2004). Courts "turned to the private operating surgeon with hospital staff privileges who 'not only had the deepest pocket but often the only pocket from which the injured patient could recover.'" Price, supra, at 332 (citation omitted).

When states began abolishing charitable immunity, however, the primary justification for the "captain of the ship" doctrine was lost. Id.; Braick, 786 N.Y.S.2d at 607 (noting that doctrine has "waned as a viable theory with the decline of the charitable immunity doctrine"). Shortly after its abandonment of charitable immunity in Flagiello v. Pennsylvania Hosp., 417 Pa. 486, 208 A.2d 193 (1965), the Pennsylvania Supreme Court also rejected the "captain of the ship"

doctrine. Price, supra, at 333. Courts from around the country have followed suit,[3] often in cases like this one in which a sponge count by a surgical nurse was at issue.[4]

### B. Abandonment Of "Captain Of The Ship" Doctrine Is Consistent With Modern Medicine.

Abandonment of the "captain of the ship" doctrine is not only logical given the abrogation of charitable immunity, but consistent with modern medicine. Indeed, the "captain of the ship" doctrine "is at odds with the corresponding diminishment of an individual doctor's control of the modern operating room that is caused by increasing specialization and division of

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[3] Braick, 786 N.Y.S.2d at 601 (declining to apply "captain of the ship" rule, noting that "surgical procedures vary in terms of the number and types of medical personnel present and the respective roles of those individuals"); Johnston v. Southwest Louisiana Ass'n, 693 So.2d 1195, 1200 (La. App. 3 Cir. 4/2/97) (noting that any liability for surgeon must be based on surgeon's control of hospital's employee, not merely on status as surgeon); Holger v. Irish, 316 Or. 402, 851 P.2d 1122, 1127 (1993) (observing that Oregon has not adopted "captain of the ship" rule); Tappe v. Iowa Methodist Med. Ctr., 477 N.W.2d 396, 403 (Iowa 1991) (observing that majority of courts shun "captain of the ship" doctrine and that Iowa has never specifically recognized it); Sparger v. Worley Hosp., Inc., 547 S.W.2d 582, 585 (Tex. 1977) (disapproving of cases "insofar as they suggest that a surgeon's mere presence in the operating room makes him liable as a matter of law for the negligence of other persons."); Sesselman v. Muhlenberg Hosp., 124 N.J. Super. 285, 306 A.2d 474, 476 (App. Div. 1973) (noting that New Jersey has expressly rejected "captain of the ship" doctrine); Parker v. Vanderbilt Univ., 767 S.W.2d 412, 419 (Tenn. Ct. App. 1988) (stating that actual agency principles rather than "captain of the ship" doctrine should govern liability of surgeon).

[4] Grant v. Touro Infirmary, 254 La. 204, 223 So.2d 148, 154 (1969) (rejecting blanket imposition of liability upon surgeon for nurse's negligent sponge count where nurse was hospital employee); Guell v. Tenney, 262 Mass. 54, 159 N.E. 451, 451 (1928) (stating that surgeon could not be held liable for negligence of nurse in making incorrect sponge count); Olander v. Johnson, 258 Ill. App. 89 (1930) (concluding that where nurse made mistake in sponge count and surgeon inquired about sponge count and made visual examination without discovering error, "we do not see how he could have been expected to do more"); Butler-Tulio v. Scroggins, 139 Md. App. 122, 774 A.2d 1209, 1229 (2001) ("Because 'captain of the ship' doctrine no longer has any vitality in Maryland, and . . . there was no evidence that Dr. Scroggins did in fact control the details of the nurse's work [with respect to counting needles]," trial court did not err in declining to instruct jury as to "captain of the ship" doctrine); Rogers v. Duke, 766 S.W.2d 547, 550 (Tex. App.-Houston [1st Dist.] 1989) (declining to impose "captain of the ship" liability on surgeon where circulating nurse and scrub personnel shared responsibility of counting sponges and did so in accordance with established hospital procedures, without surgeon's direct supervision); Van Hook v. Anderson, 64 Wash. App. 353, 824 P.2d 509, 515 (1992) (declining to impose "captain of the ship" liability on surgeon where nurses were employed by hospital, method used to count sponges were established by hospital policy, nurses made routine count and orally informed surgeon, and "nothing suggests that the defendant had any reason to doubt the information that they gave him, that he had any reason to assume control over when or how they counted the sponges, or that he ever assumed such control").

responsibility." Lewis, 627 N.W.2d at 493 (citing Price, supra, for discussion of operating surgeon's loss of control over operating room due to increase in hospitals' medical services, sophistication, and specialization, which improves patient care). As the West Virginia Supreme Court said in rejecting "captain of the ship":

> The trend toward specialization in medicine has created situations where surgeons do not always have the right to control all personnel within the operating room.... An assignment of liability based on a theory of actual control more realistically reflects the actual relationship which exists in the modern operating room.

Thomas v. Raleigh Gen. Hosp., 178 W.Va. 138, 358 S.E.2d 222, 225 (1987).

Modern surgical operations now require "team performance where the nurses and other personnel assisting in the operating room are not at all times under the immediate supervision and control of the operating surgeon." Parker v. St. Paul Fire & Marine Ins. Co., 335 So.2d 725, 734 (La. App. 2d Cir. 1976); Tappe, 477 N.W.2d at 402-03 (reiterating modern view that surgeons are leaders of "team of specialists rather than captains of a crew").[5] Moreover,

> Surgeons are operating more and more in a highly mechanized environment wholly created by hospitals. Much highly technical equipment, now considered necessary, is furnished by the hospital and operated by personnel which the hospital hires and trains. As a result, in most instances, a surgeon cannot actually have direct supervision or control over such equipment and the persons who operate it even when he is present, if he is going to give the concentration and attention to the surgery which his patient has the right to expect.

May v. Broun, 261 Or. 28, 492 P.2d 776, 781 (1972).

May raises a graver concern: not only is the "captain of the ship" theory contrary to modern medical practice, but it has the potential to undermine patient care.

> The physician is simply unable to supervise every act performed during a complex operation and should not be charged with responsibility for purely administrative acts requiring no special skills or training. Moreover, the hospital in reality has the right to control these administrative acts, and hospital regulations generally prescribe the manner in which they are to be performed.

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[5] Dr. Ho testified that the staff worked "like [a] surgical team" in the operating room. (Appellant's App. at 51).

Note, Separation of Responsibility in the Operating Room: The Borrowed Servant, the Captain of the Ship, and the Scope of Surgeon's Vicarious Liability, 49 Notre Dame L. Rev. 933, 939 and 943 (1974).

## III. COURT OF APPEALS' APPLICATION OF "CAPTAIN OF THE SHIP DOCTRINE IS CONTRARY TO PREVAILING LAW AND REALITIES OF THE MODERN OPERATING ROOM.

The Court of Appeals invoked Funk for the rule that "a surgeon cannot 'delegate the absolute authority and responsibility to a nurse or nurses to account for sponges and to thus escape responsibility himself.'" (Opinion at 13) (quoting Funk, 183 N.E. at 315-16). The Court of Appeals declined to consider any evidence that the surgical nurse was an employee of the Hospital charged with the duty to count the sponges. (Opinion at 13). The Court of Appeals imposed "captain of the ship" liability on Dr. Ho for the negligence of the Hospital's surgical nurse, based solely on his status as the surgeon in the operating room and without regard to his ability to control the activities assigned to the nurse by the Hospital.

Funk (and the Court of Appeals' application thereof) has "outlived any usefulness it may have had at one time." Harris, 237 N.E.2d at 245 (describing demise of charitable immunity). When Funk adopted the "captain of the ship" doctrine, charitable immunity still existed in Indiana. Funk relied on authority from jurisdictions that have abandoned charitable immunity and "captain of the ship" in the 75 years since it was decided. See Baird, 433 N.E.2d at 595 (refusing to resurrect "now abjectly discredited 'captain of the ship' doctrine" and impose upon surgeon "duty of overseeing all that occurs in the highly technical milieu in which he works"). Today, patients injured during surgery have recourse against hospitals and hospital employees. See Argument, Section I.B., supra.

Funk is not only outdated in terms of prevailing jurisprudence, but it does not accurately reflect the modern practice of medicine. Counting sponges was the surgical nurse's responsibility pursuant to Hospital policy. (Appellant's App. at 51-52). "Each hospital policy has their own procedures [for counting sponges]" and "the procedure is done so that two nurses or operating room technicians will do the count together." (Appellant's App. at 77). Surgical nurses were trained to perform sponge counts as part of their job. (Appellant's App. at 113, 126-27). No further action was required of the surgeon after the sponge count was reported. (Appellant's App. at 126-27). This evidence accurately reflects the environment in which physicians now practice medicine.

Indeed, authorities have recognized that courts endorsing a negligence per se rule under facts similar to those at issue here "make the fallacious assumption that a surgeon visually or manually can detect a remaining sponge with ease." Price, supra, at 338.

> . . . . In fact, it is quite difficult to visually detect a blood-soaked sponge inside a patient's body. . . . Moreover, a patient may be physically harmed by a surgeon's manual probing of the patient's internal organs in search of a sponge. . . . It is therefore not generally good medical practice for the surgeon to conduct such a manual search unless the nurse reports that a sponge is missing. . . . Technically, the surgeon cannot physically control the nurses' sponge count because "he has no power to influence the coordinating between eye, hand, and voice which is necessary to correct counting of sponges. . . . Even if the surgeon could technically control the sponge count, the surgeon simply does not have the opportunity to control it. . . .[6]

Price, supra, at n.65 (internal citations omitted). Accordingly, the "captain of the ship" doctrine as applied in Funk and embraced by the Court of Appeals in this case does not conform to recognized standards of medical care and cannot be used to impose liability upon surgeons for all negligence occurring in the operating room.

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[6] There was testimony that sponges get smaller during surgery and can be difficult to find. (Appellant's App. at 126).

## CONCLUSION

In Huber v. Protestant Deaconess Hosp. Ass'n, 127 Ind. App. 565, 133 N.E.2d 864 (1957), the Court of Appeals recognized:

> In this age of specialization in the practice of medicine it is the duty and function of courts of law to apply rules of law with an intelligent understanding of developing civilization in the field of medicine and surgery.

Id. at 869-70. The "captain of the ship" doctrine is an antiquated theory that is no longer consistent with the law and the realities of the modern operating room. Accordingly, this Court should grant transfer and vacate the Court of Appeals' decision.

Respectfully submitted,

Thomas J. Costakis, Attorney No. 4314-49

Libby Y. Mote, Attorney No. 20880-49A
KRIEG DeVAULT LLP
One Indiana Square, Suite 2800
Indianapolis, Indiana 46204
(317) 636-4341
FAX: (317) 636-1507

Attorneys for *Amici Curiae* the
Indiana State Medical Association and
the American Medical Association

## WORD COUNT CERTIFICATE

The undersigned counsel verifies that the foregoing *Amici Curiae* Brief in Support of Petition to Transfer (excluding cover page, table of contents, table of authorities, word count certificate, certificate of service, and signature block) contains 4,147 words as determined by the word count of the word processing system used to prepare this Brief, specifically Microsoft Word, which is no more than the 4,200 words permitted by Ind. Appellate Rule 44(E).

Libby Y. Mote

## CERTIFICATE OF SERVICE

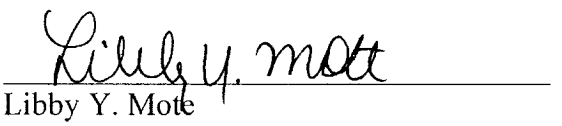
The undersigned certifies that a copy of the foregoing was served upon the following counsel of record by United States Mail, first class, postage prepaid, this 30th day of May, 2007:

Edna M. Koch
Jennifer A. Strickland-Padgett
ZEIGLER COHEN & KOCH
9465 Counselors Row, Suite 104
Indianapolis, Indiana 46240

Daniel M. Mills
MILLS LAW OFFICE
701 North Walnut Street
P.O. Box 39
Bloomington, Indiana 47402

William C. Lloyd
LLOYD LAW OFFICE
403 East Sixth Street
Bloomington, Indiana 47408

E. Paige Freitag
BAUER & DENSFORD
608 West Third Street
P.O. Box 1332
Bloomington, Indiana 47402



Libby Y. Mote

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