The Abandonment of the Captain of the Ship Doctrine in Light of the Recent Developments in Philippine Surgery in the Context of the Operating Room

Rester John L. Nonato[*]

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I. INTRODUCTION

A. Background of the Study

> *With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work.*
>
> — The Hippocratic Oath[1]

1. Inside the Operating Room

All medical practitioners, including specialists, are bound to safeguard the welfare of their patients. Article II, Section 1 of the 1993 Code of Ethics of the Medical Profession in the Philippines[2] avers that "the physician's principal responsibility is to the patient's welfare, both insofar as his health or medical state is concerned as well as his status as a human being deserving of dignity and respect."[3]

This is all the more true when the patient is in the operating room undergoing surgery. It may be said that the patient's best interest is "at the

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★ '09 LL.M., *cum laude*, University of California Hastings College of Law; '06 J.D., *with honors*, Ateneo de Manila University School of Law. The Author is a Partner in the Nonato & Nonato Law Offices, practicing tax law, intellectual property law, corporate law, labor law, and civil litigation. He was a former Associate Director in Ernst and Young Philippines (SGV & Co.), a Tax Supervisor in KPMG Philippines, and an Associate Lawyer in the Siguion Reyna Montecillo & Ongsiako Law Offices. The Author previously wrote *The Biofuels Law and World Hunger*, 54 ATENEO L.J. 512 (2009). This Note is an abridged version of the Author's *Juris Doctor* Thesis, but updated with current Philippine jurisprudence as may be relevant.

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1. HIPPOCRATES, HIPPOCRATIC OATH (Francis Adams trans. 1849).
2. Philippine Medical Association, Code of Ethics of the Medical Profession in the Philippines (1993) [hereinafter 1993 Code of Ethics].
3. CODE OF ETHICS OF THE MEDICAL PROFESSION, art. II, § 1.

heart of medicine. It forms the core of the doctor-patient relationship and is the legal standard for the treatment and operation of patients."[4]

The Hippocratic Oath,[5] a pledge traditionally taken by duly licensed physicians in which certain ethical guidelines are laid out, mandates physicians to give primordial consideration to the health and welfare of their patients.[6] If a doctor fails to live up to this precept, he is made accountable for his actions.[7] Thus, vigilance in safeguarding the interests of one's patients must always be a standard for all doctors.

A synergy of professionals, armed with the skill and knowledge of their respective specializations, compose the team working inside the operating room. This usually includes the following professionals —

> *Surgeons* operate [in manual or operative means] so as to treat disease, repair injury, correct deformities, and improve the general health of the patient. Surgeons examine a patient first to determine whether an operation is needed, then choose the best way to operate. A medical history of the patient is most important; this includes information related to past surgeries and potential allergies to drugs.
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> ...
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> *Anesthesiologists/Anesthetists* [are those trained to administer anesthetics or] use drugs and gases to render patients unconscious during surgery. They obtain a detailed history from the patient and then make a decision concerning the type and amount of anesthesia to use during surgery. There are several types of anesthesia available, and anesthesiologists use them singly or in combination according to their judgment. During surgery, the anesthesiologist monitors the progress of the patient and informs the surgeon if any difficulties arise.
>
> ...
>
> *Hospital Nurses* ... [are those] who provide bedside nursing care and carry out the medical regimen prescribed by physicians ... Hospital nurses usually are assigned to groups of patients who require similar nursing care. For instance, some work with patients who are undergoing surgery or those who just had surgery; others specialize in the care of acutely ill children, trauma victims. Some may rotate among departments.[8]

2. The Captain of the Ship Doctrine

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4. TONY HOPE, ET AL., MEDICAL LAW AND ETHICS — THE CORE CURRICULUM 29 (2003 ed.).
5. HIPPOCRATES, *supra* note 1.
6. *Id.*
7. *Id.*
8. PEGGY S. STANFIELD & Y. H. HUI, INTRODUCTION TO THE HEALTH PROFESSIONS 106-07 & 132 (4th ed. 2002).

A question arises, however, as to who is to be held responsible for the injury suffered by the patient during a surgical operation. The Captain of the Ship Doctrine has been introduced into the medical profession to address this particular problem.[9] The doctrine states that the surgeon's mere presence in the operating room subjects the latter to legal liability for everyone's negligence in that room regardless of whether the surgeon is negligent.[10] The doctrine presumes that the surgeon is the person ultimately responsible for the care of the patient and is bound by his non-delegable duty to ensure that proper care is given in all circumstances.

The phrase "Captain of the Ship" in medical law was first used by the Supreme Court of Pennsylvania in *McConnell v. Williams*[11] in 1949. In the said decision, the court used an analogy from Maritime Law, in which a captain can be held liable for the actions of his crew in the ship.[12] The court in that case stated that

> it can readily be understood that in the course of an operation in the operating room of a hospital, and until the surgeon leaves that room at the conclusion of the operation ... he 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.[13]

This doctrine, however, has already been abandoned in most American jurisdictions.[14]

Nevertheless, the Captain of the Ship Doctrine has just been recently and formally introduced in the Philippines by the Supreme Court in *Ramos v. Court of Appeals*[15] on 29 December 1999. In this case, the plaintiff, Erlinda Ramos, was to undergo an operation for the removal of a stone in her gall

9. McConnell v. Williams, 65 A.2d 243, 246 (Pa. 1949) (U.S.).

10. Cantre v. Go, 522 SCRA 547, 548 (2007).

11. *McConnell*, 65 A.2d at 243.

12. *Id.* at 249.

13. *Id.*

14. *See* Thomas v. Hutchinson, 275 A.2d 23, 27-28 (Pa. 1971) (U.S.) [hereinafter *Thomas*]; Tonsic v. Wagner, 329 A.2d 497, 499-501 (Pa. 1974) (U.S.); Tappe v. Iowa Methodist Medical Center, 477 N.W.2d 396, 402-403 (Iowa 1991) (U.S.); Sesselman v. Muhlenberg Hospital, 124 N.J. Super. 285, 290 (App. Div. 1973) (U.S.); Nelson v. Trinity Medical Center, 419 N.W.2d 886, 892 (N.D. 1988) (U.S.); Baird v. Sickler, 69 Ohio St.2d 652, 656 (1982) (U.S); May v. Broun, 492 P.2d 776, 780 (Or. 1972) (U.S.); Sparger v. Worley Hospital, 547 S.W.2d 582, 585 (Tex. 1977) (U.S.); & Thomas v. Raleigh General Hospital, 358 S.E.2d 222, 225 (W. Va. 1987) (U.S.) [hereinafter *Raleigh*].

15. Ramos v. Court of Appeals, 321 SCRA 584 (1999) [hereinafter *Ramos 1999*].

bladder under Dr. Orlino Hosaka as her surgeon.[16] Dr. Perfecta Gutierrez, upon the recommendation of the surgeon to the patient, was to serve as the anesthesiologist.[17] As held by the Supreme Court, the patient suffered brain damage caused by the faulty management of the latter's airway during the anesthesia phase due to the negligence of Dr. Gutierrez in the operating room.[18] Moreover, the anesthesiologist also failed to conduct a preoperative anesthetic evaluation before the scheduled operation.[19]

Dr. Hosaka, as the surgeon, was found liable under the Captain of the Ship Doctrine.[20] As the so-called "Captain of the Ship," it is the surgeon's responsibility to see to it that those under him perform their task in the appropriate manner. The Court held that

> [r]espondent Dr. Hosaka's negligence can be found in his failure to exercise the proper authority (as the 'captain' of the operative team) in not determining if his anesthesiologist observed proper anesthesia protocols. In fact, no evidence on record exists to show that respondent Dr. Hosaka verified if respondent [Dr.] Gutierrez properly intubated the patient.[21]

Furthermore, it is important to note that the surgeon involved was not found liable under the Captain of the Ship Doctrine alone.[22] He was also considered accountable for having negligently scheduled another operation in a different hospital at the same time as that of the plaintiff's, and was in fact over three hours late for the latter's operation.[23] The Court concluded that, as a result, "he had little or no time to confer with his anesthesiologist regarding the anesthesia delivery. This indicates that he was remiss in his professional duties towards his patient."[24]

In a motion for reconsideration of the same case,[25] the Court on 11 April 2002, sustained its previous decision and observed that

> due regard for the peculiar factual circumstances obtaining in this case justify the application of the [Captain of the Ship Doctrine]. From the facts on record it can be logically inferred that Dr. Hosaka exercised a certain

16. *Id.* at 590.

17. *Id.* at 594.

18. *Id.* at 618-19.

19. *Id.*

20. *Id.* at 619-20.

21. *Ramos 1999*, 321 SCRA at 619-20.

22. *Id.*

23. *Id.*

24. *Id.*

25. Ramos, et al. v. Court of Appeals, 380 SCRA 467 (2002) [hereinafter *Ramos 2002*].

> degree of, at the very least, supervision over the procedure then being performed on Erlinda.
>
> ...
>
> While the professional services of Dr. Hosaka and Dr. Gutierrez were secured primarily for their performance of acts within their respective fields of expertise for the treatment of petitioner Erlinda, and that one does not exercise control over the other, they were certainly not completely independent of each other so as to absolve one from the negligent acts of the other physician.[26]

There is no dispute that surgeons may be held liable for damages caused by their own acts of negligence through medical malpractice or other claims.[27] But surgeons, because of the application of this doctrine, may now also be held legally responsible for damages resulting from the negligent acts or wrongdoings of other medical specialists with whom they work with in the operating room. To hold the surgeon responsible under the Captain of the Ship Doctrine, the patient only has to prove the negligent act of the person responsible in the operating room.[28] Whether the surgeon is negligent is irrelevant for purposes of this doctrine.

The negligent acts of nurses, who are employees of the hospitals, are governed by the Borrowed Servant Rule, which is completely distinct from the Captain of the Ship Doctrine. Under this principle, a surgeon in an operating room could be held accountable for the negligence of a circulating nurse, even though the nurse might be employed by the hospital.[29]

The definitive test for determining whether an employee is a "borrowed servant" was set forth in *U.S. Fidelity & Guaranty Co. v. Forrester.*[30] The evidence must show that the surgeon had complete control and direction of the servant for the occasion, that the hospital had no such control, and the surgeon had the exclusive right to discharge the servant.[31]

B. Statement of the Problem

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26. *Id.* at 490-93.
27. *See* Cruz v. Court of Appeals, 282 SCRA 188, 210 (1997). In this Case, petitioner was acquitted of reckless imprudence resulting in homicide, but was ordered to pay damages to answer for her negligence in the handling of the patient's treatment. *Id.*
28. TIMOTEO B. AQUINO, TORTS AND DAMAGES 207 (2013 ed.).
29. *See* ATTY. PETER N. NG & DR. PHILIPP U. PO, MEDICAL LAWS AND JURISPRUDENCE (LEGAL ASPECTS OF MEDICAL PRACTICE) 378-84 (2005 ed.).
30. U.S. Fidelity & Guaranty Co. v. Forrester, 230 Ga. 182 (1973) (U.S.).
31. *Id.* at 183.

How can surgeons effectively function and perform the tasks assigned to them in the operating room when their actions are constrained by the legal implications and consequences that may arise due to the Captain of the Ship Doctrine? It is of utmost importance that surgeons concentrate on the task to be performed rather than be concerned and be bothered with the tasks designated to other doctor-specialists. The patient's best interests must always be safeguarded.

It is a fact that the individuals working in the operating room are considered professionals in their own right. Surgeons and other specialists, such as anesthesiologists, act in accordance with the distinct and specialized knowledge and training that they have accordingly received. This is precisely the reason why "specialists" exist in the medical profession. For example, it is unlikely that a surgeon well-versed in heart surgery would also be at the same time highly knowledgeable with the administration of anesthesia to the patient. Furthermore, the increasing complexity and sophistication of the operating room facilities require the highly technical knowledge of the person handling the equipment beyond the scope of the knowledge of the operating surgeon thereby making supervision impossible. [32] Stated differently, considering the present developments in the Philippine medical profession, will a continued application of the Captain of the Ship Doctrine be justifiable and practicable? Or will such application prove to be an unjust and impractical doctrine to judge negligent actions? Moreover, does the Captain of the Ship Doctrine contradict the very essence of specialization in medical practice?

C. Objectives and Scope

This Note seeks to analyze the Captain of the Ship Doctrine in light of the current status of the Philippine medical profession in relation to the tasks to be performed in the operating room. The Author intends to study, analyze, explain, and clarify the nature and intricacies of the surgeon-patient relationship, the rationale of the introduction of the Captain of the Ship Doctrine, its abandonment in several jurisdictions, the distinctions between the practice of surgeons and anesthesiologists both of whom work together in the operating room, the antiquity and inapplicability of the reasons behind the doctrine as applied to the Philippine medical profession, and the developments in the Philippine hospital industry in relation to the rationale of the doctrine. This Note also includes an analysis of the case of *Ramos* in so far as it introduces the Captain of the Ship Doctrine in Philippine jurisprudence.

32. PEDRO P. SOLIS, MEDICAL JURISPRUDENCE — THE PRACTICE OF MEDICINE AND THE LAW 238 (1988).

Moreover, it shall also examine the present state of Philippine law with respect to medical negligence in order to prove that despite the absence of the Captain of the Ship Doctrine, the surgeon could still be held accountable for his negligent acts while inside the operating room.

The provisions of the 1993 Code of Medical Ethics of the Medical Profession of the Philippines, as amended by the House of Delegates of the Philippine Medical Association on 25 May 1993, shall be considered in this Note. However, in the analysis of *Ramos*, the provisions of the Code of Medical Ethics,[33] as amended on 21 May 1965, which was effective during the time the incident occurred, shall be considered.

D. Significance

There is a valid fear that surgeons would be unable to serve the best interests of their patients when they are unable to focus on their tasks. The present state of medical law even recognizes the fact that doctors should not be held liable for any erroneous medical opinion or judgment. As Louis Nizer said,

> [d]octors are protected by a special rule of law. They are not guarantors of care. They do not even warrant a good result. They are not insurers against mishaps or unusual consequences. Furthermore, they are not liable for honest mistakes of judgment. This rule of law is such a bulwark of defense for doctors.[34]

The continued existence of the Captain of the Ship Doctrine in the Philippines means that surgeons, who are not themselves negligent, would automatically be held accountable for the negligent acts of other specialists in the operating room without any means of defense in their own behalf. Its existence will be shown to run contrary to the present state of the Philippine medical profession. Should this doctrine be abandoned in the near future, it would allow the surgeon in question to avoid liability for the negligent acts of other professionals, whose actions properly pertain to the tasks assigned to them.

The doctor's patients would also benefit from the proposition of this Note. By allowing medical professionals to focus on the particular tasks assigned to them by virtue of their specialties, their safety and well-being in the operating room would furthermore be enhanced and safeguarded.

Through the abandonment of the Captain of the Ship Doctrine, legal practitioners will have to prove the negligence of specialists in the operating room. They cannot anymore rely on the presumption of negligence

33. Philippine Medical Association, Code of Ethics of the Medical Profession of the Philippines (1965) [hereinafter 1965 Code of Ethics].

34. LOUIS NIZER, MY LIFE IN COURT 400 (8th ed. 1972).

automatically attributed to the surgeon by virtue of the Captain of the Ship Doctrine.

In relation to this, a system must still be in place to guard against any negligent act by surgeons and other specialists inside the operating room. There are those

> [w]ho, in spite of their limited training and their desire to earn, may undertake sophisticated procedures in diagnosis and treatment. Some surgical interventions are done by physicians whose knowledge, experience, and training are limited, if not wanting. These conditions will create more probability of mishap or injury to the patient.[35]

Liability must properly fall to the person directly responsible for the negligent act in the operating room.

II. ABANDONMENT OF THE CAPTAIN OF THE SHIP DOCTRINE

A. Rationale of the Doctrine

> *The selection of rules from Anglo-American Law is proper and advisable: (a) because of the element of American culture that has been incorporated into Filipino life during nearly half a century of democratic apprenticeship under American auspices; (b) because in the foreseeable future, the economic relations between the two countries will continue; and (c) because the American and English Courts have developed certain equitable rules that are not recognized in the present Civil Code.*
>
> — Cezar S. Sangco [36]

In *Lewis v. Physicians Ins. Co. of Wisconsin*,[37] the Wisconsin Supreme Court in 2001 made the observation that the Captain of the Ship Doctrine is actually an outgrowth of another largely defunct doctrine, which is that of the "charitable immunity" for hospitals.[38] It was stated that "[c]haritable immunity was put in place during the 1940s because most hospitals at that time were charitable institutions dependent on donor largesse and unlikely to financially survive a negligence action."[39] The charitable nature of hospitals protected the latter from lawsuits. The Captain of the Ship Doctrine thereby was introduced to provide patients a viable avenue for recovery from injuries. Through this doctrine, the surgeon would be held liable for the

35. SOLIS, *supra* note 32, at 170.

36. CEZAR SANGCO, PHILIPPINE LAW ON TORTS AND DAMAGES xxxi - xxxii (1993 ED.).

37. Lewis v. Physicians Ins. Co. of Wisconsin, 243 Wis.2d 648 (2001) (U.S.).

38. *Id.* at 663-64.

39. Ellen K. Murphy, *"Captain of the Ship" Doctrine Continues to Take on Water*, 74 AORN J. 525, 526 (2000).

negligent acts committed by other health professionals in the operating room due to the fact that hospitals were then immune from legal actions.[40]

The scope of the doctrine was furthermore discussed in *Thomas v. Intermedics Orthopedics, Inc.*[41] Here, the liability of the surgeon under the Captain of the Ship Doctrine was delimited so as not to include negligent acts of non-medical practitioners and those which occur prior to the operation and also those outside the operating room.[42]

B. The Captain Under Maritime Law

The concept of the Captain of the Ship Doctrine is a product of an analogy made from the responsibilities of a ship captain under Maritime Law.[43] This is, however, questionable as the present responsibilities of the ship captain under Philippine laws is completely different from that of a medical surgeon.

Among the powers inherent in the position of captain, master, or patron of a vessel under Article 610 of the Code of Commerce of the Philippines is the power to "command the crew and direct ... [the vessel to the] port of destination."[44] A ship captain will be held civilly liable for failing to perform his obligation even if the cause of the breach is due to the actions or negligence of the ship's crew.[45] Article 614 of the Code of Commerce states that a captain who, having agreed to make a voyage fails to fulfill his obligation without being prevented by fortuitous accident or by *force majeure*, shall indemnify for all the losses his actions may cause, without prejudice to criminal penalties which may be proper.[46]

Moreover, Philippine jurisprudence has fortified the responsibilities of the ship captain or master with respect to the actions and conduct of the vessel's crew. In *Inter-Orient Maritime Enterprises, Inc. v. NLRC*,[47] the Court ruled that the role of the captain of a ship is analogous to that of a "Chief

40. *Lewis*, 243 Wis.2d. at 670-72.

41. Thomas v. Intermedics Orthopedics, Inc., 47 Cal. App. 4th 957 (Ct. App. 1996) (U.S.).

42. *Id.* at 970.

43. AQUINO, *supra* note 28.

44. Code of Commerce [CODE OF COMMERCE], Title 2, § 2, art. 610, ¶ 2. The Code of Commerce was adopted from the Spanish Code of Commerce of 1885, which was modified by the *Comision de Codifacio de las Provincias de Ultramar* which later on resulted in our Code extended to the Philippines by royal decree (issued on 6 August 1888) of Queen Cristina of Spain, and took effect in the Philippines on 1 December 1888.

45. *Id.* arts. 614 & 618.

46. *Id.* art. 614.

47. Inter-Orient Maritime Enterprises, Inc. v. NLRC, 235 SCRA 268 (1994).

Executive Officer" as to the operation and preservation of the vessel during its voyage and the protection of the passengers, crew, and cargo.[48] He is considered as the commander and technical director of the vessel.[49] In furtherance of this role, "the captain has the control of all departments of service in the vessel, and a reasonable discretion as to its navigation."[50]

In *Far Eastern Shipping Company v. Court of Appeals*,[51] the Court, in making a distinction between the responsibilities of a harbor pilot and a master of the vessel, made the following observations —

> The master is not wholly absolved from his duties while a pilot is on board his vessel, and may advise with or offer suggestions to him. He is still in command of the vessel, except so far as her navigation is concerned, and must cause the ordinary work of the vessel to be properly carried on and the usual precaution taken. Thus, in particular, he is bound to see that there is sufficient watch on deck, and that the men are attentive to their duties, also that engines are stopped, towlines cast off, and the anchors clear and ready to go at the pilot's order.[52]

The responsibilities of a ship captain are not in any way similar to a surgeon. The ship captain is generally responsible for the overall operation and management of the vessel.[53] In contrast, the surgeon is only concerned with a particular portion or aspect of a surgical operation and not the whole procedure. The orientation and responsibilities of the surgeon will be furthermore discussed in the succeeding chapters of this Note.

C. Reasons for the Doctrine's Abandonment

The Captain of the Ship Doctrine originated from American jurisprudence.[54] However, due to the changes surrounding the medical profession, many of the courts that upheld the said doctrine have now abandoned the same or have refused to apply it in resolving present disputes involving negligence in the operating room.

The Wisconsin Supreme Court, in the case of *Lewis*, tackled the issue of whether a surgeon can be vicariously liable for the negligence of two hospital nurses who failed to count accurately the sponges used in a surgical

48. *Id.* at 276.

49. *Id.*

50. *Id.* at 278.

51. Far Eastern Shipping Company v. Court of Appeals, 297 SCRA 30 (1998).

52. *Id.* at 36.

53. Doctrine of Limited Liability of Shipowners and Ship Agents, 96 SCRA 309, 311 (1980) (citing CODE OF COMMERCE, art. 609).

54. *See McConnell*, 65 A.2d 243.

procedure.[55] The patient in whose body a laparotomy sponge had been left following a gall bladder surgery brought suit against the surgeon on the basis that the latter was liable for the negligence of the nurses in failing to accurately count the sponges.[56] The court refused to apply the Captain of the Ship Doctrine to the negligent acts of nurses.[57] Moreover, the court also held that the doctrine has already become antiquated and fails to reflect the emergence of present hospitals as modern health care facilities.[58]

The court averred that hospitals today have become big business ventures.[59] The evolution of the modern hospital must also bring about changes in the laws with respect to the hospital's responsibility and liability.[60] Today, hospitals are better situated to insure against liability.[61] Hospitals usually procure insurance to protect itself from liability.[62] The court also noted that the Captain of the Ship Doctrine is at odds with the corresponding diminishment of an individual surgeon's diminished "control of the modern operating room that is caused by increasing specialization and the division of responsibility."[63]

As a matter of fact, the Pennsylvania Supreme Court, the court which first introduced the Captain of the Ship Doctrine, has since abandoned the same in *Thomas v. Hutchinson*[64] and *Tonsic v. Wagner*[65] because of the demise of charitable immunity.

In *Thomas*, the surgeon was sought to be liable under the Captain of the Ship Doctrine for a sponge allegedly left in the plaintiff's body by resident surgeons who assisted in the surgery.[66] The court abandoned the Captain of the Ship Doctrine and resolved to determine whether or not the surgeon was directly negligent for immediately leaving the operating room and delegating the removal of sponges and closure of surgical incision to resident

55. *Lewis*, 243 Wis.2d at 650.

56. *Id.* at 651.

57. *Id.* at 666.

58. *Id.* at 663–65.

59. *Id.* at 665.

60. *Id.*

61. *Lewis*, 243 Wis.2d at 664.

62. *Id.*

63. *Id.* at 666 (citing Stephen H. Price, *The Sinking of the "Captain of the Ship:" Reexamining the Vicarious Liability of an Operating Surgeon for the Negligence of Assisting Hospital Personnel*, 10 J. LEGAL MED. 323, 340–41 (1989)).

64. *Thomas*, 275 A.2d at 23.

65. *Tonsic*, 329 A.2d at 497.

66. *Thomas*, 275 A.2d at 24.

surgeons.[67] The hospital was also determined to not be immune from suits considering the developments in the prevailing jurisprudence.[68]

In *Tonsic*, the hospital and the surgeon were alleged to have been negligent for failing to supervise the nurses in the counting of the instruments used in the surgical operation.[69] A kelly clamp was left in the abdomen of the patient thereby causing injuries to the latter.[70] The court based its findings of liability by determining whether the surgeon directly breached his duty of care to the patient.[71] As to the hospital, the court refused to apply the Charitable Immunity Doctrine because "[it] was not as a matter of law immunized from any liability for negligence of its personnel during an operation."[72]

In *Tappe v. Iowa Methodist Medical Center*,[73] the patient's guardian brought a civil action against the cardiologist, surgeon, perfusionist, and the hospital for the paralyzing stroke suffered by the patient during a heart bypass surgery.[74] The surgeon was sought to be responsible under the Captain of the Ship Doctrine.[75] The Iowa Supreme Court ruled that the Captain of the Ship Doctrine was already at odds with modern medical practice and thus refused to adopt it.[76] The court ratocinated that "[b]ecause of the wide sweep of the rule, and the modern view that surgeons are leaders of a team of specialists rather than captains of a crew, its application has been widely discredited."[77]

In *May v. Broun*,[78] an action was brought against the surgeon for the burns suffered by the patient during the use of an electrical cauterizing machine by another physician during surgery.[79] The Oregon Supreme Court acknowledged that the changes in the operating room have made it impossible for the surgeon to directly supervise all personnel and concluded that the Captain of the Ship Doctrine is no longer viable with the demise of

67. *Id.* at 25–28.

68. *Id.* at 27.

69. *Tonsic*, 329 A.2d at 498.

70. *Id.*

71. *Id.* at 500.

72. *Tappe*, 477 N.W.2d. at 397.

73. *Tappe*, 477 N.W.2d. at 396.

74. *Id.* at 398.

75. *Id.* at 402.

76. *Id.*

77. *Id.*

78. *May*, 492 P.2d at 776.

79. *Id.*

the charitable immunity, saying that "[i]n [the] absence of showing that [the] surgeon had [the] ability, consistent with their duty to patients upon whom they were performing surgery, to supervise or control directly [the] electrical cauterizing machine or its operation, the surgeon was not responsible."[80]

In *Schwartz v. Ghaly*,[81] the patient suffered a cardiac and respiratory arrest while in the hands of the anesthesiologist with a surgeon present in the operating room.[82] The North Dakota Supreme Court ruled that the application of the Captain of the Ship Doctrine overlooked the fact that the surgeon and the anesthesiologist are both specialists with different responsibilities, each responsible for the care of the patient within the realm of his or her own specialty.[83] The court held that "the essential question is whether one is subject to the control of another not only to the work to be done but also the manner of performing it."[84]

In *Thomas v. Raleigh General Hospital*,[85] the patient brought a medical malpractice action against the surgeon, hospital, and anesthesiologist for injuries sustained during the insertion and removal of the endotracheal tube, a procedure for which the anesthesiologist is responsible.[86] The West Virginia Court observed that the "majority of states which are now considering the Captain of the Ship Doctrine are rejecting it" and thereby also rejected the doctrine.[87] The court cited the fact that the field of medicine has become specialized such that surgeons can no longer be deemed as having control over the other personnel in the operating room.[88] The same court also ruled, in a different case, that the demise of the doctrine should be recognized by all health care providers, as well as their employing institutions.[89] In *Raleigh*, they categorically stated that "liability cannot be imposed upon the surgeon, under the Captain of the Ship Doctrine, for everything that goes on in the operating room."[90]

In *Franklin v. Gupta*,[91] the patient brought a malpractice action against the surgeon and the anesthesiologist for the injuries suffered by the patient

80. *Id.*

81. Schwartz v. Ghaly, 318 N.W.2d 294 (N.D. 1982) (U.S.).

82. *Id.* at 295.

83. *Id.* at 300.

84. *Id.* at 300–01.

85. *Raleigh*, 358 S.E.2d. at 222.

86. *Id.* at 223.

87. *Id.* at 224.

88. *Id.* at 225.

89. Peck v. C.J. Tegtmeyer, M.D., 834 F.Supp 903 (W. Va. Dist. Ct. 1992) (U.S.).

90. *Raleigh*, 358 S.E.2d at 225.

91. Franklin v. Gupta, 567 A.2d 524 (Md. Ct. Spec. App. 1990) (U.S.).

due to the failure of the anesthesiologist to appear in the scheduled surgical operation.[92] The Maryland Court absolved the surgeon from any liability thereby refusing the application of the Captain of the Ship Doctrine.[93] The court made the observation that the surgeon had no control over the anesthesiologist's decisions and actions.[94] "There was no evidence that [the surgeon] in any way supervised, controlled, attempted to supervise or control, or had the right or power to supervise or control conduct and decisions of [the anesthesiologist]."[95]

Other states which have previously adopted the Captain of the Ship Doctrine are also at an evolutionary stage wherein the doctrine's current applicability is being questioned and attacked.[96] For example, in the State of Montana, the Montana Medical Association has already proposed legislation eliminating the Captain of the Ship Doctrine and allowing a surgeon to defend a claim by pointing to the negligence of others.[97] The proposed legislation provides that a physician would have no vicarious liability or responsibility for any injury or death arising out of the services rendered by a health professional over whom the physician had no control.[98]

Moreover, although an Indiana Court in *Miller v. Ryan*[99] has technically used the term "Captain of the Ship" in reference to the surgeon, it still took into consideration the fact of whether or not the surgeon had actual control and dominion over the negligent person.[100] The case involved a medical malpractice action against the lead surgeon in the patient's bilateral foot surgery for the negligent actions of an assistant surgeon.[101] The court, in holding the lead surgeon liable, found that it was the primary surgeon who made the diagnoses and determined which procedures to perform, that it was he who convinced the patient to undergo surgery and told the patient that

92. *Id.* at 526.

93. *Id.* at 539.

94. *Id.*

95. *Franklin*, 567 A.2d at 539.

96. *See Thomas*, 275 A.2d at 23; *Tonsic*, 329 A.2d at 497; *Tappe*, 477 N.W.2d at 396; *Sesselman*, 124 N.J.Super at 285; *Nelson*, 419 N.W.2d at 886; *Baird*, 69 Ohio St. 2d 652; *May*, 492 P.2d at 776; *Sparger*, 547 S.W.2d at 582; & *Raleigh*, 358 S.E.2d at 222.

97. H.R. 59-HB 25, Reg. Sess., at 11 (Mont. 1999). *See also* MHA — An Association of Montana Health Care Providers, Key Points About Montana's Medical Liability Insurance Crisis, *available at* http://www.mtha.org/pdf/Med%20Mal%20Fact%20Sheet.pdf (last accessed Sep. 12, 2013).

98. *Id.*

99. Miller v. Ryan, 706 N.E.2d 244 (Ind. Ct. App. 1999) (U.S.).

100. *Id.* at 251.

101. *Id.* at 246.

he would be performing the procedures, and that it was he who dictated the operative note and never indicated in his notes that anyone other than himself was to perform the procedures.[102] Thus, while there is still no automatic liability attributed to the surgeon, control may (and in fact, must) still be established to hold the surgeon liable.

In *Harris v. Miller*,[103] a wrongful death action was brought against the orthopedic surgeon when complications arose during a laminectomy to repair the patient's ruptured disc.[104] The injury was caused by the negligent actions of an anesthetist.[105] The court ruled that "surgeons [are] no longer presumed to enjoy authoritative control of master of all who assist, [for purposes of imputing negligence]."[106]

The Courts of North Carolina,[107] New Jersey,[108] North Dakota,[109] Ohio,[110] Tennessee,[111] Rhode Island,[112] Mississippi,[113] California,[114] and Texas[115] have also abandoned or refused to apply the Captain of the Ship Doctrine.

American jurisprudence has undoubtedly been an influence in how the Philippine Supreme Court renders its case decisions. Pedro P. Solis says that "[t]he Philippines is a mirror image of the United States (U.S.) in this part of the globe. Whatever happens in the U.S., in most cases, will eventually happen in the Philippines."[116]

The various jurisdictions should be permitted to determine their own statutory and jurisprudential rules, as they find desirable, in light of their particular needs. The aforementioned courts, in abandoning the Captain of

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102. *Id.* at 250.

103. Harris v. Miller, 438 S.E.2d 731 (N.C. 1994) (U.S.).

104. *Id.* at 733.

105. *Id.* at 733-34.

106. *Id.* at 738.

107. *Id.*

108. *Sesselman*, 124 N.J.Super. at 290.

109. *Nelson*, 419 N.W.2d at 892.

110. *Baird*, 69 Ohio St.2d at 655.

111. Parker v. Vanderbilt University, 767 S.W.2d 412, 415 (Tenn. Ct. App. 1988) (U.S.).

112. Lauro v. Knowles, 739 A.2d 1183, 1187 (R.I. 1999) (U.S.).

113. Starcher v. Byrne, 687 So.2d 737, 742 (Miss. 1997) (U.S.).

114. *Thomas*, 47 Cal.App.4th at 970-71.

115. *Sparger*, 547 S.W.2d at 585.

116. SOLIS, *supra* note 32, at 170.

the Ship Doctrine, recognized the changes surrounding the medical professional and their patients, and its inconsistency with the said doctrine.

Although it is true that Philippine courts are not under any obligation to follow the trend in American jurisprudence, a careful consideration of the current state of Philippine medical practice as presented in this Note would show the current inapplicability of the Captain of the Ship Doctrine.

III. SPECIALISTS AS CAPTAINS OF THEIR OWN SHIPS

A. Specialization in the Medical Profession

> *I know of no teachers so powerful and persuasive as the little army of specialists. They carry no banners, they beat no drums; but where they are, men learn that bustle and push are not the equals of quiet genius and serene mystery.*
>
> — Justice Oliver W. Holmes Jr.[117]

The Philippine Supreme Court, in introducing the Captain of the Ship Doctrine in local jurisprudence, has failed to take into consideration the present developments in Philippine medical practice. Specialization is now the norm among doctors in the Philippines. Thus, the existence of control by surgeons over other professionals in the operating room under the said doctrine has become highly questionable.

A "profession" has been defined as a "group of men pursuing a learned art as a common calling in the spirit of public service — no less a public service because it may incidentally be a means of livelihood."[118] The following have been considered as features typical of professions:

(1) A commitment to serve the public good and provide an important public service;

(2) A great deal of generalized and systematized knowledge in order to practice the specific profession;

(3) The standards in carrying out professional work are set by the profession and there is an important element of self-regulation;

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117. Oliver B. Wendell Holmes Jr., Former Associate Justice of the Supreme Court of the United States, The Use of Law Schools, Remarks at the Harvard Law School Association on the 250th Anniversary of Harvard University at Cambridge (Nov. 5, 1886) (transcript *available at* http://archive.org/stream/speeches01holmgoog/speeches01holmgoog_djvu.txt (last accessed Sep. 12, 2013)).

118. In the Matter of the Petition for Authority to Continue Use of Firm Name "Ozaeta, Romulo, etc." 92 SCRA 1, 10 (1979) (citing Roscoe Pound, *The Lawyer from Antiquity to Modern Times*, *in* SURVEY OF THE LEGAL PROFESSION 5 (1953)).

(4) A certification or licensing procedure that determines who can be part of the specific profession; and

(5) The existence of a professional body that takes on a number of these aspects of a profession.[119]

These characteristics are present in the different specialized fields of medical practice in the Philippines.

Although physicians or doctors are already considered as professionals in the general sense, they may further be classified as such in accordance with the specialization that they have specifically acquired as compared to that of other doctors whose expertise is on another field in medicine. A "specialist" is "a physician who applies [oneself] to the study and practice of some particular branch of his [or her] profession."[120] Specialization is all about the identification of peers and colleagues so as to proficiently serve their patients' needs in areas beyond the present reach of the profession. The development of a specialty could be traced in terms of men, publication, and organization.[121]

Specialization is the product of evolution in the practice of medicine in the Philippines. Specialization "helps manage the increasing amount of knowledge that threatens to be overwhelming, and it also increases skills."[122] It is true that surgeons were once considered the over-all captains of the operating room. This is because of the fact that, among others, surgeons were initially also the anesthetists in the operating room.[123] Surgery's evolution from unilateral to collaborative had consequent effects to patients, of which is leading to a breakdown of the past surgeon's traditional role.

However, the tasks that need to be performed by doctors even became more complicated and several medical discoveries were also made. For example, due to the diversification of the drugs used as anesthesia and the different ways of introducing such anesthetics to the patient, a separate profession of physicians distinct from surgeons had to be born. This profession is that of the anesthesiologists. Anesthesiology is the clinical

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119. HOPE, ET AL., *supra* note 4, at 51.

120. Baker v. Hancock, 63 N.E. 323, 324 (Ind. Ct. App. 1902) (U.S.).

121. Richard J. Kitz, M.D. & Leroy D. Vandam M.D., *A History and the Scope of Anesthetic Practice*, *in* 1 ANESTHESIA 13 (Ronald D. Miller, M.D. ed. 1986).

122. Frances Margolin, Working Well, *available at* http://www.hhnmag.com/hhnmag/jsp/articledisplay.jsp?dcrpath=AHA/PubsNewsArticle/data/0305HHN_OutBox&domain=HHNMAG (last accessed Sep. 12, 2013).

123. *See* Claude A. Vachon, et al., From Victor Pauchet to Gaston Labat: The Transformation of Regional Anesthesia from a Surgeon's Practice to the Physician Anesthesiologist, *available at* http://www.anesthesia-analgesia.org/content/96/4/1193 (last accessed Sep. 12, 2013).

application of pharmacology and physiology. In simple terms, the main task of an anesthesiologist is to take away or ease the pain brought about by the surgical operation while at the same time avoiding any undesirable side effects or toxicity.[124]

Thus, physicians usually refer the patient to a specialist when the required treatment needs the application of an expertise in a particular field of medicine. Moreover, a physician may consult another doctor who specializes on a distinct area of medical practice. Article III, Section 4 of the 1993 Code of Ethics of the Medical Profession in the Philippines states —

> The physician is obligated to extend the common [c]ourtesies to his fellow physicians, particularly in situations where consultations are called. Similarly, physicians to whom a patient is referred for a particular purpose should return the patient to his original attending upon completion of his specific task.[125]

Where a general practitioner, in exercising the care and skill required of him, discovers or should know that the treatment for a particular patient is beyond his skill, ability, or capacity to treat, he is under a duty to refer the patient to a different or other treatment, or to seek consultation with a specialist.[126] As to the question of liability, the referring physician is not liable for the independent acts of a specialist to whom he has referred a patient, absent a showing that he was negligent in his selection of such specialist.[127]

It would be unlikely that a doctor who is already a specialist on a particular field in medicine be considered as a subordinate of the surgeon in charge. Thus, generally, the modern anesthesiologist does not work under the surgeon, but rather, works as a co-equal of the surgeon in the operating room.

Under the Captain of the Ship Doctrine, the law expects the surgeon to effectively supervise and control all actions of the doctors in the surgical team including other specialists in the operating room. The dilemma, however, is that the surgeon cannot be expected to be more knowledgeable than the specialist with regard to that aspect which required the expertise of the latter. When two or more independent physicians are caring for a patient, each is usually answerable for his own conduct.[128]

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124. Encyclopedia of Surgery, General Anesthesia, *available at* http://www.surgeryencyclopedia.com/A-Ce/Anesthesia-General.html (last accessed Sep. 12, 2013).

125. 1993 Code of Ethics, art. III, § 4.

126. Burks v. Meredith, 546 S.W. 2d 366, 370 (Tex. Civ. App. 1977) (U.S.).

127. Mincey v. Blando, 655 S.W. 2d 609, 612 (Mo. Ct. App. 1983) (U.S.).

128. LOUIS JOHN REGAN, ET AL., DOCTOR AND PATIENT AND THE LAW 362-63 (4th ed. 1962).

The law recognizes that there are different schools of medicine.[129] Surgery requires a sound grasp of anatomy, fast diagnostic instincts, steady hands, and superhuman stamina. The surgeon examines, diagnoses, and treats by surgical means diseases and injuries, after reviewing case histories and obtaining data through interviews and interactions with their patients.[130] Surgeons examine patients and determine whether x-rays and clinical laboratory tests are required, then interpret test results and evaluate examination findings. Surgeons perform procedures, of which may include thoracic, plastic, brain, and orthopedic operations.[131]

The surgeon therefore cannot be considered as an authority in the manner of administration of anesthesia to the patient. It is precisely for this reason why the patient needs to hire an anesthesiologist aside from the surgeon.

The New Civil Code of the Philippines[132] (NCC) has also distinguished surgeons from ordinary physicians thereby recognizing its uniqueness as a specialty. Article 1027 of the Code, in enumerating the persons who are incapable of succeeding, includes "[a]ny physician, *surgeon*, nurse, health officer[,] or druggist who took care of the testator during his last illness[.]"[133]

The Revised Penal Code of the Philippines[134] (RPC) has also recognized the uniqueness of surgeons as compared to other physicians. Thus, Article 174 avers the following —

> Article 174. *False medical certificates, false certificates of merits or service, etc.* – The penalties of *arresto mayor* in its maximum period to *prison correccional* in its minimum period and a fine not to exceed 1,000 pesos shall be imposed upon:
>
> (1) Any physician or *surgeon* who, in connection with the practice of his profession, shall issue a false certificate[.][135]

Anesthesiology as a specialty is now also an established and independent discipline of medicine in the Philippines.[136] Anesthesia allows patients to

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129. Floyd v. Michie, 11 S.W. 2d 657, 659 (Tex. Civ. App. 1928) (U.S.).

130. Interview with Dr. Edgardo Cortez, President, Philippine College of Surgeons, in St. Luke's Hospital, Quezon City, Philippines (Nov. 18, 2004).

131. *See* Beth Greenwood, What Does a General Surgeon Do?, *available at* http://everydaylife.globalpost.com/general-surgeon-do-8397.html (last accessed Sep. 12, 2013).

132. An Act to Ordain and Institute the Civil Code of the Philippines [CIVIL CODE], Republic Act. No. 386 (1950).

133. *Id.* art. 1027 (emphasis supplied).

134. An Act Revising the Penal Code and Other Penal Laws [REVISED PENAL CODE], Act No. 3815 (1932).

135. *Id.* art. 174 (emphasis supplied).

undergo surgery and other procedures without the distress and pain that they would otherwise experience. The choice of whether to use an anesthetic, the type of drug to be administered, the dosage of the drug required, and the proper anesthetic technique is a complex one, requiring considerations of both patient and surgical factors.

The American Board of Anesthesiology has defined Anesthesiology as a practice of medicine dealing with:

> (1) The assessment of, consultation for[,] and preparation of patients for anesthesia;
>
> (2) The provision of insensibility to pain during surgical, obstetrical, therapeutic[,] and diagnostic procedures, and the management of patients so affected;
>
> (3) The monitoring and restoration of homeostasis during the perioperative period, as well as homeostasis in the critically ill, injured, or otherwise seriously ill patient;
>
> (4) The diagnosis and treatment of painful syndromes;
>
> (5) The clinical management and teaching of cardiac and pulmonary resuscitation;
>
> (6) The evaluation of respiratory function and application of respiratory therapy in all its forms;
>
> (7) The supervision, teaching, and evaluation of performance of both medical and paramedical personnel involved in anesthesia, respiratory[,] and critical care.
>
> (8) The conduct of research at the clinical and basic science levels to explain and improve the care of patients; and
>
> (9) The administrative involvement in hospitals, medical schools, and outpatient facilities necessary to implement these responsibilities.[137]

Anesthesiology has obviously come of age in the Philippines. Luis F. Torres says that "[l]ike all scientific specialties within the realm of medicine, it is always aware of new developments in advancing the frontiers of the specialty, at the same time contributing to and maintaining its growth."[138]

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136. Searching for Anesthesiology as a specialty in a directory for Philippine doctors results in over a thousand results. *See* Doctors by Specialty, *available at* http://www.thefilipinodoctor.com/search.php?keyword=Anesthesiology&specid=20080002&specmark=1 (last accessed Sep. 12, 2013).

137. University of Missouri School of Medicine, Student Goals and Training, *available at* http://medicine.missouri.edu/anest/students.html (last accessed Sep. 12, 2013).

138. Luis F. Torres, *A Surgeon looks at Anesthesiology*, 2 PHIL. J. ANESTHESIOL. 1, 1 (1974).

When a patient selects a practitioner of a recognized school of treatment, he or she adopts the kind of treatment common to that school, or in other words, he or she is presumed to elect that the treatment shall be according to the system or school of medicine to which such practitioner belongs, and "he or she cannot afterward complain that the care received fell short of the standards" of another specialty.[139] The patient is bound by the skill and expertise of the profession to which the particular specialist belongs.

The Supreme Court has also recognized the differences between a general practitioner and a specialist doctor. In *Reyes v. Sisters of Mercy Hospital*,[140] the Court refused to consider the statements of the doctor presented as an expert witness on the ground that the latter is not a specialist on the field of medicine he is to testify on.[141]

It is important to note that all specialists, before becoming such, must first of all be physicians. Thus, in matters where common knowledge in medicine would already suffice, the surgeon and the anesthesiologist are both considered competent to advise one another and to act on the matter. For example, the surgeon and the anesthesiologist must coordinate with one another in the monitoring of the patient's general condition and vital signs pre-, per-, and post-operatively.[142]

Other doctor-specialists were also formed as a result of the developments in the Philippine medical profession, such as its decentralization. This includes family physicians, obstetricians, gynecologists, pathologists, radiologists, pediatrics, cardiologists, and internists.

B. Separate Identities Outside the Operating Room

1. Training Required

> *Medical education is a reflection of medical practice; it is not education that will change the practitioners, but reformed practice that will redesign medical education.*
>
> — George Silver[143]

The practice of medicine is a "right earned through years of education, training, and by first obtaining a license from the state through professional

139. Botehlo v. Bycura, 282 S.C. 578, 585 (Ct. App. 1984) (U.S.).

140. Reyes v. Sisters of Mercy Hospital, 341 SCRA 760, 773 (2000).

141. *Id.* at 774.

142. *See* American Society of Anesthesiologists, The Role of the Anesthesiologist, *available at* http://www.lifelinetomodernmedicine.com/Who-Is-An-Anesthesiologist/The-Role-of-the-Anesthesiologist.aspx (last accessed Sep. 12, 2013).

143. JOHN SPENCER, GP TOMORROW 60 (Jamie Harrison and Tim Van Zwanenberg eds., 2002).

board examinations."[144] This is due to the public interest involved in the medical profession. [145]

As a prerequisite for the practice of medicine, one must have first satisfactorily passed the Board Examination conducted by the Philippine Board of Medical Education, and must then become a holder of a valid Certificate of Registration.[146] A candidate for the said Board Examination must be a holder of a degree of Doctor of Medicine and must have also completed a year of technical training known as an internship.[147] Every physician who desires to specialize on a particular field in medicine must therefore first undergo and comply with these general requirements.

The Philippine Supreme Court itself in *Felix v. Buenasada*[148] recognized the importance of residency training for specialists, holding that "[r]esidency is the step taken by a physician right after post-graduate internship and after hurdling the Medical Licensure Examinations prior to his recognition as a specialist or sub-specialist in a given field."[149] The Court also made the following important observations —

> A physician who desires to specialize in Cardiology takes a required three-year accredited residency in Internal Medicine (four years in DOH hospitals) and moves on to a two or three-year fellowship or residency in Cardiology before he is allowed to take the specialty examinations given by the appropriate accrediting college. In a similar manner, the accredited Psychiatrist goes through the same stepladder process which culminates in his recognition as a fellow or diplomate (or both) of the Psychiatry Specialty Board. This upward movement from residency to specialist rank, institutionalized in the residency training process, guarantees minimum standards and skills and ensures that the physician claiming to be a specialist will not be set loose on the community without the basic knowledge and skills of his specialty. Because acceptance and promotion requirements are stringent, competitive, and based on merit, acceptance to a first year residency program is no guaranty that the physician will complete the program. Attrition rates are high. Some programs are pyramidal. Promotion to the next post-graduate year is based on merit and performance determined by periodic evaluations and examinations of knowledge, skills[,] and bedside manner. Under this system, residents, [especially] those in university teaching hospitals[,] enjoy their right to security of tenure only to the extent that they periodically make the grade, making the situation quite unique as far as physicians undergoing post-graduate residencies and fellowships are concerned.

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144. *Reyes*, 341 SCRA at 779.

145. *Id.*

146. The Medical Act of 1959, Republic Act No. 2382, art. 3, § 8 (1959).

147. *Id.* art. 3, § 9.

148. Felix v. Buenasada, 240 SCRA 139 (1995).

149. *Id.* at 149.

...

> While physicians (or consultants) of specialist rank are not subject to the same stringent evaluation procedures, specialty societies require continuing education as a requirement for accreditation in good standing, in addition to peer review processes based on performance, mortality and morbidity audits, feedback from residents, interns and medical students[,] and research output. The nature of the contracts of resident physicians meets traditional tests for determining employer-employee relationships, but because the focus of residency is training, they are neither here nor there. Moreover, stringent standards and requirements for renewal of specialist-rank positions or for promotion to the next post-graduate residency year are necessary because lives are ultimately at stake.[150]

The Philippine government, in its administration of public hospitals and medical centers, has also recognized the distinctions among specialists-doctors. As early as 1988, the Department of Health (DOH) issued Department Order No. 347,

> which required board certification as a requisite for the renewal of different specialist positions in public medical centers, hospitals[,] and agencies under the said department. Specifically, Department Order No. 347 provided that specialists working in various hospitals and branches of the [DOH] be recognized as 'Fellows' of their respective specialty societies and/or 'Diplomates' of their specialty boards or both. The Order was issued for the purpose of upgrading the quality of specialists in DOH hospitals by requiring them to first pass ... (tedious) theoretical and clinical (bedside) examination given by their recognized specialty boards, in keeping up with international standards of medical practice.[151]

These examinations differ depending on the administering specialty board or organization.

Before one is to be considered as a fully-fledged surgeon, one has to first undergo a very rigorous process of schooling and training. After four years of medical school, one has to undergo a one-year post-graduate internship program before going through another five years of training on general surgery.[152] An examination is then conducted by the Philippine Board of Surgery under the Philippine College of Surgeons before one is to be considered as a "Diplomate" in the said specialty tribunal for surgeons. The examination to be given is divided into two parts — written and oral — the latter involving an interview wherein the applicant's decision making skills on diagnosis, treatment, capability to solve several problems on complications that may arise, and follow-up procedures are evaluated.

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150. *Id.* at 140-41.

151. *Id.* at 145.

152. Interview with Dr. Edgardo Cortez, *supra* note 130.

After two more years of surgical practice in an accredited hospital, one then becomes qualified to become a "Fellow" in the Philippine College of Surgeons. The prospective fellow's ethical actions and reputation during the said two years of medical practice is to be taken into consideration by the Philippine Board of Surgery.

On the other hand, before one becomes a duly certified "Diplomate" in the Philippine Society of Anesthesiologists, one must first undergo three years of residency training in an accredited hospital, take the written examination of the Philippine Board of Anesthesiology under the said specialty tribunal, then practice for two more years.[153] By the fifth year, the candidate must take an oral and practical examination since anesthesiology requires psychomotor skills in the administration of drugs used as anesthesia.[154] Anesthesia is a distinct specialty with its own specialized education and training.

Each specialist, before becoming one, must therefore first undergo the necessary training, which necessarily depends on the field of medicine he or she decides to become an expert in. Thus, the surgeon and the anesthesiologist, as specialists in their respective medical practices, are products of different skill enhancement programs designed to sharpen the knowledge and skills on their chosen medical expertise.

A distinction must be made between a specialist and a board-eligible physician. A board-eligible physician is one who has undergone the required training in a distinct field of medicine but failed or did not take the examinations necessary for one to be certified as a specialist by the administering board. A specialist, in the strict sense, is one who has undergone the necessary training and has been certified as either a "Diplomate" or a "Fellow" by the specialty board concerned. Both specialists and board-eligible physicians are qualified to practice a distinct field of medicine such as surgery and anesthesiology. However, most hospitals in urban areas and all training hospitals require physicians to be first certified by the corresponding specialty boards before being allowed to practice on a particular field of medicine.[155]

2. Professional Organizations

The standards in carrying out professional work are set by the specialists themselves and there is an important element of self-regulation.[156] Where

153. Speech of Amicus Curiae Dr. Lydia M. Egay, Transcript of Stenographic Notes, Ramos v. Court of Appeals, March 19, 2001 at 179.

154. *Id.*

155. Interview with Dr. Edgardo Cortez, *supra* note 130.

156. HOPE, ET AL., *supra* note 4, at 60.

once there were only "doctors" or general practitioners, a system of specialty boards developed and flourished starting in the 1930s.[157] Article VI, Section 3 of the 1993 Code of Ethics of the Medical Profession in the Philippines states that "[s]ome of the obligations of a physician are best complied with by an organized professional body, and to the extent that this is necessary and important, a physician has the duty to associate [oneself] with and participate in these efforts."[158]

The Philippine Medical Association under the Professional Regulation Commission is the umbrella organization of the medical profession in the country. It was founded on 15 September 1903, at a time when the Philippines was still under American rule.[159] The association aims "to bring together the entire medical profession in the country under one roof[,] [and] to serve as an authoritative source of information on health, disease[,] and medical practice."[160] The said organization has committed itself to serve its members through increased benefits, enhanced professional development, and the promotion and defense of the rights and privileges of the medical profession in the Philippines.

As of 2010, the members of the Philippine Medical Association are 69,000 or 64% of all Philippine doctors.[161] It has eight specialty divisions and 30 affiliates and sub-specialties.[162] The organization's specialty divisions are represented by the Philippine Society of Anesthesiologists, Philippine College of Physicians, Philippine College of Surgeons, Philippine Academy of Family Physicians, Philippine Obstetrical and Gynecological Society, Philippine Society of Pathologists, Inc., Philippine Pediatric Society, and the Philippine College of Radiology.[163]

The Philippine College of Surgeons, as the professional organization of Filipino surgeons, is committed to preserve and promote health by providing the highest standards of surgical practice through continuing surgical

157. Margolin, *supra* note 122.

158. 1993 Code of Ethics, art. VI, § 3.

159. Trivias About the Philippine Medical Association, *available at* http://www.philippine-trivia.com/trivias/institutions-society/trivias-about-the-philippine-medical-association.html (last accessed Sep. 12, 2013).

160. *Id.*

161. Candice Montenegro, Medical association wants membership mandatory for doctors, *available at* http://www.gmanetwork.com/news/story/205805/news/nation/medical-association-wants-membership-mandatory-for-doctors (last accessed Sep. 12, 2013).

162. Philippine Medical Association (PMA), PMA Organization, *available at* https://www.philippinemedicalassociation.org/specialties.php (last accessed Sep. 12, 2013).

163. *Id.*

education, relevant research, a pro-active approach to health-related legislation and policy making, and the upliftment of the welfare of its members.[164] The organization also regularly organizes conventions and conferences to update its members of recent developments regarding the profession of surgery. The Philippine College of Surgeons inculcates professional ethics and integrity, compassion and sympathy, competence and respect for each other, collegiality, honesty, sincerity, and transparency, a sustained commitment, and social responsibility among its members.

On 14 December 1993, then President Fidel V. Ramos through Proclamation No. 312 declared the second week of December of every year as "Surgeon's Week."[165] It recognizes the fact that the practice of surgery plays a vital part in saving lives and maintaining good health, which are essential and indispensable to the well-being of the Filipino people and to the success of nation-building.

Sub-specialties in the medical field of surgery have also formed associations for the advancement of their respective professions. These organizations, which are affiliated with the Philippine College of Surgeons, include the Philippine Society of Otolaryngology Head & Neck Surgery, Philippine Academy of Ophthalmology, Philippine Association of Plastic Reconstructive & Aesthetic Surgeons, Philippine Association of Thoracic & Cardiovascular Surgery, Inc., Philippine Orthopedic Association, Philippine Society of Colon and Rectal Surgeons, Philippine Society of Pediatric Surgeons, and the Academy of Filipino Neurosurgeons.[166]

On the other hand, the specialty of anesthesiology in the Philippines has attained full maturity through the establishment of the Philippine Society of Anesthesiologists and its certifying board, by affiliation and membership in international organizations, and the establishment of the Anesthesiology Center for the Western Pacific, which is run and administered by Filipino anesthesiologists.[167]

The Philippine Society of Anesthesiologists, as the professional organization of Filipino anesthesiologists, is cognizant of its duties and responsibilities to its members and the Filipino nation, and has affirmed its commitment to promote and maintain a community of anesthesiologists who shall practice safe and quality anesthesia care in the pursuit of serving

164. Official Facebook Page of the Philippine College of Surgeons, *available at* https://www.facebook.com/pages/Philippine-College-of-Surgeons-Foundation-Inc/147743648574191?sk=info (last accessed Sep. 12, 2013).

165. Office of the President, Declaring the Second Week of Every Year as Surgeon's Week, Proclamation No. 318 (Dec. 14, 1993).

166. Philippine College of Surgeons, Surgical Specialty Societies, *available at* http://pcs.org.ph/committee-officers/ (last accessed Sep. 12, 2013).

167. Torres, *supra* note 138, at 2.

the interests of its members, their patients and the nation.[168] The organization also regularly organizes conventions and conferences to update their members of recent developments regarding the profession of anesthesiology. The Philippine Society of Anesthesiologists aims to inculcate a commitment to quality care, concern for its member's welfare, professional growth, and social consciousness among its members.[169]

The International Standard IEC 60601-2-13, also known as the "Particular Requirements for the Safety of Anesthetic Workstations," has recently been approved by the Bureau of Product Standards of the Philippine Society of Anesthesiologists in the year 2005 thereby serving as the current standard to be complied with for anesthetic workstations in the country today.

On 20 January 1984, then President Ferdinand E. Marcos, through Executive Order No. 933,[170] exempted all promotional materials imported by the Philippine Society of Anesthesiologists, as the host of the World Congress of Anesthesiologists held in the same year, from custom duties, taxes, and other assessments.[171] This was in recognition of the importance of the society's role in the development of medical practice in the country.[172]

Moreover, on 17 September 1993, then President Ramos, through Proclamation No. 263,[173] also declared the period from 17-23 October 1993 of every year as "Anesthesiology Week."[174] The week is intended to mark years of relentless, unflagging, and earnest efforts in uplifting the medical standards of practice for the art of anesthesia in the Philippines.

As professional organizations and specialty regulatory bodies, said entities have their own respective publications. The Philippine College of Surgeons has introduced its own official publication on March 1955 and is currently named "The Pulse Monitor Journal." On the other hand, "The Philippine

168. Philippine Society of Anesthesiologists, Mission and Vision, *available at* http://www.psa-ph.org/about-us/mission-vision (last accessed Sep. 12, 2013).

169. *Id.*

170. Office of the President, Exempting Promotional Materials, Promotional Materials, Consumables and Other Give-Aways from Customs Duties and Taxes for the Use of Delegates to the 8th World Congress of Anaesthesiologists Hosted by the Philippine Society of Anaesthesiologists, Executive Order No. 933 (Jan. 20, 1984).

171. *Id.*

172. *Id.*

173. Office of the President, Declaring the Period from October 17 to 23, 1993, as Anesthesiology Week, Proclamation No. 263 (Sep. 27, 1993).

174. *Id.*

Journal of Anesthesiology" has been the official newsletter of the Philippine Society of Anesthesiologists since 1970.

C. Medical Clearances

A medical clearance is usually required when the patient has already been previously diagnosed by a specialist for a particular disease, illness, or injury, which would substantially affect the normal manner of conducting surgery.[175] The surgeon, after reviewing the medical history and background of the patient, usually requires such clearance from a specialist belonging to a particular field in medicine before deciding to proceed with the surgical operation.[176] The anesthesiologist, on the other hand, based on his or her own evaluation may also require a medical clearance from a specialist with regard to the patient's capability to withstand or undergo particular drugs to be used as an anesthetic.

It is important to emphasize that both the surgeon and the anesthesiologist separately and independently make their own evaluation and decision to determine whether a medical clearance is required from a particular specialist before a surgical operation.

It is the specialist alone who can release such medical clearance. The issuance of the clearance would be based on the specialist's interpretation. Such interpretation is a product of the specialist's skill, knowledge, and experience on the particular field of medicine that he or she is engaged in. The requirement of a medical clearance is in recognition of the fact that specialists other than surgeons and anesthesiologists also have their own separate identities as compared to that of other doctors belonging to different and other medical fields.

Moreover, the surgeon or the anesthesiologist, respectively, shall make the decision of whether or not to proceed with the surgical operation or whether or not a particular drug is to be used as an anesthetic regardless of what the medical clearance contains subject of course to the patient's approval. The medical clearance therefore is only considered as a mere recommendation or opinion by the issuing specialist. If the patient is injured or dies in the operating room as a result of the erroneous and negligent issuance of the medical clearance by the specialist, it is the doctor who makes the decision that would be held liable. Said doctor as mentioned may either be the surgeon or the anesthesiologist.

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175. *See* Paul Lee & Miriam Rabkin, Preoperative Assessment, *available at* http://www.medicineclinic.org/AmbulatorySyllabus4/FINAL%20Preop.htm (last accessed Sep. 12, 2013).

176. Interview with Dr. Benigno Sulit, Jr., Head of the Ethics and Malpractice Committee, Philippine Society of Anesthesiologists, in Greenhills, San Juan City, Philippines (Nov. 13, 2004).

D. Referrals to Internists

There are instances, however, when a medical clearance is not required, such as when the patient has not been previously diagnosed for any illness or disease, which would then substantially affect the manner of conducting surgery or the administration of anesthesia. Nevertheless, the surgeon or the anesthesiologist has the option of referring the patient's case to an internist.[177] This decision is made independently by either the surgeon or the anesthesiologist. It is important to reiterate that specialists such as surgeons and anesthesiologists are duty bound to consult their brethren belonging to other fields in medicine so as to ensure the safety and general well-being of the patient while undergoing surgery.

An internist "is a physician who specializes in the diagnosis and medical treatment of adults."[178] Internists belong to a specialty called internal medicine. Thus, they are considered specialists in their own right. Subspecialties of internal medicine include allergy and immunology, cardiology, endocrinology or hormone disorders, hematology or blood disorders, infectious diseases, gastroenterology or diseases of the gut, nephrology or kidney diseases, oncology or cancer, pulmonology or lung disorders, rheumatology or arthritis, and musculoskeletal disorders.[179]

An internist is usually called upon to provide the necessary knowledge on a particular field in medicine that surgeons and anesthesiologists do not adequately possess. Internists give suggestions to either the surgeon or the anesthesiologist on the precautions that need to be made and on the procedures that need to be undertaken to ensure the success of the surgical operation or the proper administration of anesthesia. The internist may opt to be present in the operating room to monitor the patient if he or she feels it is necessary.

Once a patient in the operating room is injured or dies due to the failure of the surgeon or the anesthesiologist to comply with the internist's opinion, the person conducting the surgical operation or the person administering the anesthetic shall be held liable for such negligent act. The internist will only be held accountable for his opinion if it was negligently or improperly made.

E. Responsibilities in the Operating Room

177. Interview with Dr. Edgardo Cortez, *supra* note 130.

178. American College of Physicians, What's an "Internist?," *available at* http://www.acponline.org/patients_families/about_internal_medicine/ (last accessed Sep. 12, 2013).

179. American College of Physicians, Internal Medicine Subspecialties, *available at* http://www.acponline.org/patients_families/about_internal_medicine/subspecialties/ (last accessed Sep. 12, 2013).

If specialists treat each other, undergo schooling, training and regulation, and organize themselves as co-equals outside the operating room, there is no reason why such specialists are not to be considered as co-equals inside the operating room. Moreover, health professionals in the operating room are assigned to perform specific tasks, which properly correspond to their respective expertise.

In its Manual of Procedures for Hospitals,[180] the DOH has specified the actions that need to be undertaken in the operating room and the persons responsible for such actions during the pre-operative stage, post-operative stage, and the operation itself.[181] The tasks assigned to health professions while inside the operating room are therefore well-defined.

The anesthesiologist is responsible for the pre-operative anesthetic evaluation of the patient before the surgical operation.[182] The evaluation would allow the anesthesiologist to decide which drug to use and which procedure to utilize in the administration of the anesthetic during the surgical operation. He or she is in charge of determining the medical status of the patient, developing the anesthesia plan, and acquainting the patient or the responsible adult, particularly if the patient may have some mental handicaps.[183] This gives the anesthesiologist the opportunity to alleviate anxiety, explain techniques and risks to the patient, and procure the necessary consent from the patient with regard to the anesthesia plan.

Before the surgeon operates on the patient, the anesthesiologist must first check the medicines needed for the operation, prescribe substitutes for medicines which are not available, and induct the anesthesia to the patient. The anesthesiologist gives fluids and blood transfusions during surgery, and if tourniquets are used, is responsible for informing the circulating nurse of the time for the next patient to be pre-medicated.[184] It is the anesthesiologist who decides whether or not anesthesia is to be administered to the patient, and the type of anesthesia to be used.[185] He or she then informs the surgeon of the functionary capacity and limitations of certain systems which may be affected by the anesthetic agent or the technique that is to be used.[186]

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180. Department of Health, Manual of Procedures for Hospitals (Jan. 6, 1994).

181. *Id.* at 25-26.

182. *Id.* at 23.

183. A.M. Capron, *Human Experimentation*, *in* MEDICAL ETHICS 182 (Robert M. Veatch ed., 1997).

184. *See* Anesthesia Service Medical Group, Frequently Asked Questions, *available at* http://www.asmgmd.com/faq.html (last accessed Sep. 12, 2013).

185. Capron, *supra* note 183, at 182.

186. *Id.* at 182-83.

The surgeon, on the other hand, is responsible for the surgical aspect of the welfare of the patient from the time he or she carries out the main operation until the latter closes the incision made. A proper scrub with the approved drying, gowning, and gloving technique must also be done.[187]

Surgeons basically try to cure the patient by inflicting damage to a portion of the latter's body usually through incisions. On the other hand, anesthesiologists render parts of the body pain-free to facilitate the incisions made by the surgeon. Both the surgeon and the anesthesiologist, though independent, must rely on one another to ensure a successful surgical operation.

Surgeons, for performing acts in relation to their specialty, have been adjudged liable in the Philippines for their negligence in the operating room. In *Delgado v. Austria*,[188] damages were awarded against the surgeon for performing an operation on a wound which eventually turned into a permanent deformity.[189] In *Bernal, et al. v. Alonzo, et al.*,[190] the surgeon involved was found liable for leaving a surgical pack in the abdominal cavity of the patient after a caesarian operation, of which, resulted to four unnecessary operations and caused her inability to bear further children.[191]

On the other hand, surgeons have been absolved of any liability in the Philippines due to the absence of negligence while conducting the operation. In *Abaya, et al. v. Favis*,[192] the surgeon who performed a tonsillectomy, which resulted to the death of the patient, was freed of any liability.[193] In this case, the Court ruled that the plaintiffs had not met their burden of establishing by preponderance of evidence that the surgeon was negligent, and the causal connection between the surgeon's negligence and the death of the patient.[194]

In *Ramos*, the Court, even without applying the Captain of the Ship Doctrine, could have found the surgeon liable for negligence.[195] Dr. Hosaka, the surgeon, was remiss in his duty of attending to petitioner Erlinda Ramos promptly, for he arrived more than three hours late for the scheduled

187. *See* Association of Surgical Technologists (AST), AST Recommended Standards of Practice for the Surgical Scrub, *available at* http://www.ast.org/pdf/Standards_of_Practice/RSOP_Surgical_Scrub.pdf (last accessed Sep. 12, 2013).

188. Delgado v. Austria, CA-G.R. No. 20589-R, Aug. 7. 1959.

189. *Id.*

190. Bernas, et al. v. Alonso, et al., 12 C.A. Rpt. 2d 792 (1967).

191. *Id.* at 801-802.

192. Abaya, et al. v. Favis, 3 C.A. Rpt. 2d 450 (1963).

193. *Id.* at 459.

194. *Id.*

195. *Ramos 1999*, 321 SCRA at 607.

operation.[196] The surgeon also scheduled two procedures on the same day, just 30 minutes apart from each other, at different hospitals.[197] The patient, while waiting, was kept in a state of uncertainty of whether or not the surgical operation would still push through.[198] The surgeon's acts clearly run contrary to the degree of diligence that he is expected to exercise by his profession.

In the same case, the anesthesiologist was clearly negligent for his failure to observe the proper procedure for administering the anesthesia.[199] The Court made the following observations —

> The cyanosis (bluish discoloration of the skin or mucous membranes caused by lack of oxygen or abnormal hemoglobin in the blood) and enlargement of the stomach of Erlinda *indicate*[*s*] *that the endotracheal tube was improperly inserted into the esophagus instead of the trachea.* Consequently, oxygen was delivered not to the lungs but to the gastrointestinal tract. This conclusion is supported by the fact that Erlinda was placed in trendelenburg position. This indicates that there was a decrease of blood supply to the patient's brain. The brain was thus temporarily deprived of oxygen supply causing Erlinda to go into coma.[200]

Anesthesiologists have also been found liable by Philippine courts for negligence with respect to the tasks attributed to their specialty. In *Carillo v. People*,[201] the anesthesiologist was found negligent for overdose as a result of the arbitrary administration of Nubain, a pain killer, without the benefit of prior weighing of the patient's body mass, which weight should have determined the proper dosage of the drug.[202] The administration of anesthesia is a task for which the anesthesiologist should be responsible.

Health professionals in the operating room are assigned specific tasks that need to be performed. Each hospital also has an Operating Room Management Team (ORMAT) as part of its organization. Its purpose is to outline and specify the duties and responsibilities of each health professional inside the operating room. The committee is charged with the general functions of planning, organizing, implementing, directing, and coordinating all activities in the operating room.[203] Considering the duties and

196. *Id.* at 620.

197. *Id.*

198. *Id.* at 591.

199. *Id.* at 619.

200. *Ramos 2002*, 380 SCRA at 488 (emphasis supplied).

201. Carillo v. People, 229 SCRA 386 (1994).

202. *Id.* at 392.

203. *See* Reynaldo O. Joson, Short Course on Hospital Organization and Management of Selected Clinical, Ancillary, and Support Departments, *available*

responsibilities of the ORMAT, the head of the operating room is not actually the surgeon, but the ORMAT Chairman.[204]

A surgeon is not ordinarily liable for the negligence of the anesthesiologist provided the latter is qualified, responsible, and not acting under the direction of the surgeon in carrying out the purpose of his employment.[205] Likewise, the anesthesiologist who administers the anesthetic to the patient is not liable for the negligence of the operating surgeon.

During the deliberations on the case of *Ramos*, Dr. Egay as one of the *amicus curiae* invited by the Supreme Court answered a query from one of the justices relating to how responsibilities in the operating room are allocated. Her reply should have been given greater weight by the justices in resolving the case. Dr. Egay stated that "we just look at the events as related to anesthesia and anesthesia alone and the person administering that will have to be responsible for it."[206]

The anesthesiologist is a co-equal professional of surgeons even in those institutions in which a division or section of anesthesia is a subsection of the overall department of surgery.[207] Normally, he or she neither directs nor controls the activities of each other in the operating room.[208]

The historical development of surgery and anesthesiology has made the anesthetist an expert in providing analgesia, homeostasis of the internal environment or respiratory, circulatory and metabolic resuscitation, continuous titrated therapy, and applied pharmacology.[209] Due to these reasons, the Captain of the Ship Doctrine has been expressly rejected by most courts in regard to the accredited anesthesiologist.[210]

As a consequence of specialization among medical professionals in certain fields, each group takes responsibility for only a part of a task, looks at

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at http://hospmgt.tripod.com/hosp_org_mgt_short_course_or_rj_08nov18.htm (last accessed Sep. 12, 2013).

204. *Id.*

205. *See* Wiley v. Wharton, 41 N.E.2d 255 (Ohio Ct. App. 1941) (U.S.); *Nelson* 209 N.W.2d 409; & Rhodes v. Lamar, 145 Okla. 223 (1930) (U.S.).

206. Speech of Dr. Lydia Egay, *supra* note 153, at 194.

207. Kitz & Vandam, *supra* note 121, at 53.

208. *See* Spannaus v. Otolaryngology Clinic, 308 Minn. 334 (1976) (U.S.) & Marvulli v. Elshire, 27 Cal.App.3d 180 (Ct. App. 1972) (U.S.).

209. Herman H. Delooz, *The Place of the Anesthetist in the Medical Hospital Team*, *in* 29 ACTA MEDICA BELGICA, ACTA ANAESTHESIOLOGICA BELGICA 29 (1978).

210. *See* Foster v. Englewood Hosp Ass'n, 19 Ill.App.3d 1055, 1060 (Ct. App. 1974) (U.S.); *Sesselman*, 124 N.J.Super at 290; & *Sparger*, 547 S.W.2d at 585.

it from a narrow perspective, and has no basis from which to see another perspective.[211]

An operating surgeon is not an insurer against the negligence of an anesthesiologist, who, as the physician administering the anesthetic, functions as an independent professional not subject to the surgeon's control.[212] Thus, the operating surgeon is not liable for the negligence of the anesthesiologist where each doctor has been employed to perform his separate work independently of the other.[213] Conversely, the physician who merely administers the anesthetic to a patient operated on is not liable for the negligence of the operating surgeon.[214]

Moreover, to determine the presence of negligence by specialists in the operating room, clinical guidelines have been drafted and adopted by their respective specialty boards. Each group of specialists has its own set of guidelines to follow. Clinical or practice guidelines are "quality-improving strategies."[215] They assist the specialist to make the proper decision when faced with a particular medical problem. Physicians, surgeons, and other health-care providers are bound to follow methods generally approved and recognized in their professions.[216]

The Philippine College of Surgeons has its own set of evidence-based clinical Guidelines. Presently, said Guidelines cover the diagnosis and treatment of acute appendicitis, important aspects in the case of critically ill surgical patients, antibiotic prophylaxis in elective surgical procedures, and the diagnosis and treatment of cholecystitis.[217]

The Philippine Society of Anesthesiologists has based its clinical Guidelines on those formulated by the American Society of Anesthesiologists.[218] These include guidelines for pre-anesthesia care, basic anesthesia monitoring, post-anesthesia care, critical care in anesthesiology,

211. Margolin, *supra* note 122.

212. Thompson v. Presbyterian Hosp., 652 P.2d 260, 265 (Okla. 1982) (U.S.).

213. *Wiley*, 41 N.E.2d at 255.

214. Jett v. Linville, 259 S.W. 43, 45 (Ky. Ct. App. 1924) (U.S.).

215. Exeter Medical Library, Sources for Practical Guidelines, *available at* http://services.exeter.ac.uk/eml/guidelin.html (last accessed Sep. 12, 2013).

216. Hudson v. Weiland, 8 So.2d 37 (Fla. 1942) (U.S.).

217. Philippine College of Surgeons, Articles, *available at* http://pcs.org.ph/articles/ (last accessed Sep. 12, 2013).

218. Interview with Dr. Benigno Sulit, Jr., *supra* note 176.

and delegation of technical anesthesia functions to non-physician personnel.[219]

The evidence-based clinical practice Guidelines of the Philippine Society of Anesthesiologists focuses on pre-anesthetic care and monitoring, remote anesthesia equipment requirements, clinical anesthesia practice guidelines, and recommendations for minimum anesthesia requirements for hospitals.[220]

These Guidelines are a product of in-depth research, experiments, and studies by the specialists' respective professional organizations. However, it merely serves as an outline of conduct for surgeons and anesthesiologists, as the case may be, while inside the operating room. They still must have the capacity to immediately adjust and react to complications that may possibly happen while the surgical operation is being conducted or while the anesthesia is being administered. It is by doing so that their expertise and skill in a particular field of medicine becomes highly valuable and useful.

A surgeon must be prepared for every possible thing that may happen in the operating room. The surgeon must be able to make the right decision the very first time, at the very moment the problem is encountered during surgery.[221]

Nevertheless, "no error occurs when the Court applies to a medical specialist the standard of care required of a general practitioner."[222] It is due to the fact that medical specialists owe to their patients a higher degree of care than that required of general practitioners.[223]

Considering that specialists, including surgeons and anesthesiologists, are first of all physicians, their conduct inside the operating room is governed by the Code of Ethics imposed by the Philippine Medical Association. Article II, Section 1 of the Code of Ethics of the Medical Profession in the Philippines states the following —

219. American Society of Anesthesiologists, Standards, Statements, Guidelines, and Other Documents, *available at* http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx (last accessed Sep. 12, 2013).

220. Philippine Society of Anesthesiologists, Publications, *available at* http://www.psa-ph.org/downloads/publications (last accessed Sep. 12, 2013).

221. Alex Calderon, *The Making of a Surgeon*, 9 MEDICAL OBSERVER 10 (October 2000).

222. Oko v. Rogers, 466 N.E.2d 658, 660 (Ill. App. Ct. 1943) (U.S.).

223. *See, e.g.*, Reeg v. Shaughnessy, 570 F.2d 309 (10th Cir. 1983) (U.S.); McPhee v. Reichel, 461 F.2d 947 (3d Cir. 1972) (U.S.); & Nolen v. U.S., 571 F.Supp. 295 (D. 1983) (U.S.).

> The physician's principal responsibility is to the patient's welfare, both insofar as his health or medical state is concerned as well as his status as a human being deserving of dignity and respect.[224]

Both the surgeon and the anesthesiologist are therefore still bound to exercise due diligence to safeguard the general welfare of the patient while undergoing surgery. As to the matter involving the general safety and well-being of the patient during surgery, the surgeon takes the supervisory role of the team involved in the operation.

However, when performing the tasks that are specifically assigned to them by virtue of their expertise on either surgery or anesthesiology, they are expected to exercise the standard of care common to other surgeons or anesthesiologists, respectively.

IV. SUFFICIENCY OF PHILIPPINE LAW IN GOVERNING THE SURGEON'S NEGLIGENT ACTS

> *Useless laws weaken the necessary laws.*
>
> — Charles de Monstesquieu[225]

Even in the absence of the Captain of the Ship Doctrine, Philippine law is still capable of properly addressing any negligent act by surgeons in the operating room. Towards this end, Philippine law ensures that the actions of the surgeon are consistent with the welfare of the patient.

An action for damages for the negligent acts of the defendant may be based on contract, quasi-delict, [226] or delict. The principles on the presumption of negligence shall also apply. Under the current state of Philippine law, the negligent surgeon may not only be held civilly liable, but may also be criminally responsible. A surgeon may be found civilly liable based on the legal principles of *culpa contractual*, quasi-delict, *respondeat superior*, *res ipsa loquitur*, and the presence of an agency relationship. Criminal liability, on the other hand, will be governed by the provisions of the RPC.

A. Culpa Contractual

Culpa contractual is governed by the NCC provisions on Obligations and Contracts, specifically Articles 1170 to 1174. Article 1170 states that "[t]hose who in the performance of their obligations are guilty of fraud, negligence,

224. 1993 Code of Ethics, art. II, § 1.

225. CHARLES DE MONTESQUIEU, THE SPIRIT OF THE LAWS 616 (Anne M. Cohler, et al. eds., 1748).

226. CIVIL CODE, art. 2176.

or delay, and those who in any manner contravene the tenor thereof, are liable for damages."[227]

Moreover, Article 1173 provides that "[t]he fault or negligence of the obligor consists in the omission of that diligence which is required by the nature of the obligation and corresponds with the circumstances of the persons, of the time and of the place."[228] Under the law, the responsibility arising from negligence in the performance of every kind of obligation is demandable, but such liability may be regulated by the courts, according to the circumstances.[229]

Surgeons, upon being engaged for their services in the operating room, are bound by contract to exercise the standard of care expected from their specialized profession. The contractual relationship between the patient and the surgeon is distinct from those entered into by the former with other specialists whose expertise are required in the operating room.

When there is a contractual relationship existing between the patient and the surgeon, their stipulations, primarily, and the pertinent provisions of the NCC on Obligations and Contracts, suppletorily, shall govern.

B. Quasi-Delict

The concept of quasi-delict designates negligence as a separate source of obligation because it "more nearly corresponds to the Roman Law classification of obligations and is in harmony with the nature of this kind of liability."[230]

Article 2176 of the NCC states that "[w]hoever by act or omission causes damage to another, there being fault or negligence, ... if there is no pre-existing contractual relation between the parties, is called a quasi-delict[.]"[231]

The basic governing law on vicarious civil liability arising from quasi-delicts is Article 2180 of the NCC, which reads as follows —

> Art. 2180. The obligation imposed by Article 2176 is demandable not only for one's own acts or omissions, but also for those of persons for whom one is responsible.
>
> The father and, in case of his death or incapacity, the mother, are responsible for the damages caused by the minor children who live in their company.

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227. *Id.* art. 1170.

228. *Id.* art. 1173.

229. *Id.* art. 1172.

230. Report of the Code Commission on the Proposed Civil Code of the Philippines 161 (1948).

231. CIVIL CODE, art. 2176.

> Guardians are liable for damages caused by the minors or incapacitated persons who are under their authority and live in their company.
>
> The owners and managers of an establishment or enterprise are likewise responsible for damages caused by their employees in the service of the branches in which the latter are employed or on the occasion of their functions.
>
> Employers shall be liable for the damages caused by their employees and household helpers acting within the scope of their assigned tasks, even though the former are not engaged in any business or industry.
>
> The State is responsible in like manner when it acts through a special agent; but not when the damage has been caused by the official to whom the task done properly pertains, in which case what is provided in [A]rticle 2176 shall be applicable.
>
> Lastly, teachers or heads of establishments of arts and trades shall be liable for damages caused by their pupils and students or apprentices, so long as they remain in their custody.
>
> The responsibility treated of in this article shall cease when the persons herein mentioned prove that they observed all the diligence of a good father of a family to prevent damage.[232]

The basis of vicarious liability is the need to include responsibility for the negligence of those persons "whose acts or omissions are imputable by legal fiction[,] to others who are in a position to exercise an absolute or limited control over them."[233]

The essential requisites for a quasi-delictual action are: (1) an act or omission constituting fault or negligence; (2) damage caused by the said act or omission; and (3) the causal relation between the damage and the act or omission.[234]

In the context of medical malpractice suits, hospital institutions can be held directly liable for their own negligent acts, and can also be held vicariously liable for the negligent acts of their own employees.[235] Vicarious liability means that a party is held responsible not for its own negligence, but for the negligence of another.[236] For instance, "[a] hospital might be held liable for its own negligence where ... it fails to investigate the credentials of

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232. *Id.* art. 2180.

233. Tamargo v. Court of Appeals, 209 SCRA 518, 523 (1992).

234. Taylor v. Manila Electric Company, 16 Phil. 8, 28 (1910).

235. The Brad Hendricks Law Firm, Medical Negligence Information Center, *available at* http://www.bradhendricks.com/CM/FSDP/PracticeCenter/Personal-Injury/Medical-Malpractice.asp?focus=topic&id=2 (last accessed Sep. 12, 2013).

236. *Id.*

a doctor before granting him the privilege to practice at the hospital."[237] The doctrine of vicarious liability in relation to the surgeon will be discussed in greater detail below.

C. Respondeat Superior

The doctrine of *respondeat superior* does not require any negligence from the surgeon who is at the same time the employer of the person directly responsible. The surgeon is vicariously liable for the acts of his or her employees when the same are performed within the scope and course of their employment. Liability under this doctrine is based on the surgeon's relationship with the wrongdoer. An employer-employee relationship must be present at the time of the commission of the negligent act.

Two elements must first exist before a surgeon can be found liable for an assistant's negligent actions under the doctrine of *respondeat superior.*[238] First, the assistant must perform negligently in the assistant-patient encounter.[239] Thus, a patient trying to prove negligence must allege specific negligent acts. Second, the element of control is decided by determining whether a master and servant relationship exists.[240] If the contract between the hospital and doctor gives the hospital substantial control over the doctor's choice of patients, or if the hospital furnishes the necessary equipment, an employer-employee relationship can be deemed to have existed.[241]

The fact that an assistant to a physician or surgeon is a member of the same or similar profession does not make the doctrine of *respondeat superior* inapplicable.[242] A distinction must, however, be made between the doctrine of *respondeat superior* and the Captain of the Ship Doctrine. On one hand, a surgeon can be held liable under the doctrine of *respondeat superior* due to the existence of an employer-employee relationship with the person directly negligent. On the other hand, a surgeon is considered responsible for the negligent acts of other medical professionals on the presumption that the former is the chief executive of the operating room.

In *Holger v. Irish*,[243] the Court rejected the notion that a doctor could be held either directly liable or liable under the doctrine of *respondeat superior*,

237. *Id.*

238. Chris L. Gore, *A Physician's Liability for Mistakes of a Physician Assistant*, 21 J. LEGAL MED. 125, 136 (2000).

239. *Id.*

240. *Id.*

241. Roger Braden and Jennifer Lawrence, *Medical Malpractice: Understanding the Evolution — Rebuking the Revolution*, 25 N. KY. L. REV. 675, 680 (1998).

242. *See* Barnes v. Mitchell, 67 N.W.2d 208, 213 (Mich. 1954) (U.S.) & Simons v. Northern PR Co., 22 P.2d 609, 613 (Mont. 1933) (U.S.).

243. Holger v. Irish, 851 P.2d 1122 (1993) (U.S.).

where there was (1) no evidence of the doctor's personal responsibility for the instrumentality causing the injury and (2) no evidence of the doctor's supervision or control.[244]

Physicians are generally not liable for the negligent acts of hospital attendants, nurses, or interns who are not their employees.[245] On the other hand, they are liable for the negligent acts of hospital employees, nurses, or interns, who are not their employees, where such negligence is discoverable by them in the exercise of ordinary care.[246]

The surgeon may be held liable for the negligent hiring, training, supervision, or monitoring of an employee, or for failing to establish required or appropriate policies to ensure that the employees understand their responsibilities and job requirements.[247] Physicians have a non-delegable duty of due care to their patients and are responsible for an injury done to a patient through the want of proper skill and care of their assistants or employees.[248] This includes or covers other physicians employed by the surgeon. This is due to the fact that the surgeon or physician in question could have prevented the negligent act of his employee.

In *Lewis*, where the application of the Captain of the Ship Doctrine was not upheld, the court observed that the result of the case would have been different if the person responsible was the employee of the surgeon.[249]

D. Res Ipsa Loquitur

The doctrine of *res ipsa loquitur*, which literally means that the thing speaks for itself, states that

> [w]here the thing which causes the injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of an explanation by the defendant, that the accident arose from the want of care.[250]

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244. *Id.* at 1129.

245. Stephens v. Williams, 147 So. 608 (Ala. 1933) (U.S.).

246. Harris v. Fall, 177 F. 79 (1910) (U.S.).

247. *See* Healthcare Providers Insurance Exchange, Physician Liability for Non-Physician Clinicians, *available at* http://www.hpix-ins.com/pdf/Expired-Modules/Physician-Liability-for-Non-Physician-Clinicians.pdf (last accessed Sep. 12, 2013).

248. Harlan v. Bryant, 87 F.2d 170, 174 (7th Cir. 1936) (U.S.).

249. *Lewis*, 243 Wis.2d at 665-68.

250. Ma-ao Sugar Central Co., Inc. v. Court of Appeals, 189 SCRA 88, 92 (1990) (citing Layugan v. Intermediate Appellate Court, 167 SCRA 363, 376 (1988)).

Certain elements must therefore be present for the doctrine to apply. First, the accident must be of a kind that does not normally happen in the absence of someone's negligence. Second, the accident must be caused by an instrument that is within the exclusive control of the defendant. "Instruments" include other persons who may be under the control of the defendant. Lastly, the plaintiff must not be negligent. The surgeon is presumed to be negligent under this principle.[251]

The Court in *Batiquin v. Court of Appeals*[252] found the surgeon liable for leaving a piece of rubber inside the patient by applying the doctrine of *res ipsa loquitur.* The Court stated that

> [i]n the instant case, all the requisites for recourse to the doctrine are present. First, the entire proceedings of the caesarean section were under the exclusive control of Dr. Batiquin. In this light, the private respondents were bereft of direct evidence as to the actual culprit or the exact cause of the foreign object finding its way into private respondent Villegas'[s] body, which, needless to say, does not occur unless through the intersection of negligence. Second, since aside from the caesarean section, private respondent Villegas underwent no other operation which could have caused the offending piece of rubber to appear in her uterus, it stands to reason that such could only have been a by-product of the caesarean section performed by Dr. Batiquin. The petitioners, in this regard, failed to overcome the presumption of negligence arising from resort to the doctrine of *res ipsa loquitur.* Dr. Batiquin is therefore liable for negligently leaving behind a piece of rubber in private respondent Villegas's abdomen and for all the adverse effects thereof.[253]

The fundamental element under this doctrine is the "control of the instrumentality" which caused the damage or injury to the victim. Such element of control must be shown to be within the immediate dominion of the defendant involved.

The doctrine of *res ipsa loquitur,* however, is not applicable if there is proof of absence or presence of negligence. Said doctrine merely creates a *prima facie* case and applies only in the absence of proof of the circumstances under which the negligent act was performed.[254] This doctrine may therefore be attacked through the presentation of contrary evidence.

The doctrine has been applied in the following situations: leaving of a foreign object in the body of the patient after an operation;[255] injuries sustained on a healthy part of the body which was not under or in the area

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251. D.M. Consunji, Inc., v. Court of Appeals, 357 SCRA 249, 258-59 (2001).

252. Batiquin v. Court of Appeals, 258 SCRA 334 (1996).

253. *Id.* at 345-46.

254. Martinez v. Van Buskirk, 18 Phil. 79, 85 (1910).

255. Armstrong v. Wallace, 8 Cal.App.2d 429, 431 (Ct. App. 1935) (U.S.).

of treatment;[256] removal of the wrong part of the body when another part was intended;[257] knocking out of a tooth while a patient's jaw was under anesthetic for the removal of his tonsils;[258] and loss of an eye while the patient plaintiff was under the influence of anesthetic, during or following an operation for appendicitis,[259] among others.

E. Agency Relationship

Article 1868 of the NCC states that "[b]y the contract of agency[,] a person binds himself to render some service or to do something in representation or on behalf of another, with the consent or authority of the latter."[260] An agency relationship requires the presence of consent where the object of the contract is the execution of a juridical act in relation to third persons. The agent must act in representation of another, and within the scope of his given authority.[261]

The consent that is involved in the contract of agency may either be express or implied.[262] It may be "implied from the acts of the principal, from the [latter's] silence or lack of action, or [from the latter's] failure to repudiate the agency, knowing that another person is acting on his behalf without authority."[263] An act of ratification by the principal also signifies the existence of an agency relationship.[264]

Thus, a surgeon, whether the Captain of the Ship Doctrine is applied, may be held liable for the negligent acts of another specialist if an agency relationship exists between them. A surgeon who retains authority or control over the procedures of an anesthesiologist may be held liable, on an agency theory, for the negligent acts of the said anesthesiologist.[265] The surgeon need not expressly appoint the specialist as his or her agent, as long as the former's acts imply the existence of such a relationship and provided that the latter acts within the scope of the authority given.

256. Thomsen v. Burgeson, 79 P.2d 136 (Cal. Ct. App. 1938) (U.S.).

257. Griffin v. Norman, 192 NYS 322 (1922) (U.S.).

258. Brown v. Shortlidge, 277 P. 134 (Cal. Ct. App. 1929) (U.S.).

259. Voss v. Bridwell, 364 P.2d 955, 969 (Kan. 1961) (U.S.).

260. CIVIL CODE, art. 1868.

261. Sargasso Construction & Development Corporation/Pick & Shovel, Inc./Atlantic Erectors, Inc. (Joint Venture) v. Philippine Ports Authority, 623 SCRA 260, 279-80 (2010).

262. *Id.* art. 1869.

263. CIVIL CODE, art. 1869.

264. Gutierrez Hermanos v. Orense, 28 Phil. 571, 579 (1914).

265. Schneider v. A. Einstein Med. Ctr., Etc., 247 Pa.Super. 348, 366 (1977) (U.S.).

The agent must act in representation of the principal. The Rhode Island Supreme Court in *Lauro v. Knowles*[266] carefully approached the topic at hand by noting that with or without the Captain of the Ship Doctrine, surgeons could still be liable for acts relating to anesthesia only if the anesthesia personnel were their agents.[267] The court thereby set forth the following basic elements to show an agency relationship: first, the surgeon must manifest that the anesthetist acts in his or her behalf;[268] second, the anesthetist must accept the undertaking;[269] and lastly, the parties must agree that the surgeon will be in control of the undertaking involved.[270]

Despite the fact that surgeons usually recommend to their patients the anesthesiologist of whom they would prefer to work with, the ultimate choice of who the anesthesiologist would be, still rests with the patient concerned.[271] The anesthesiologist is not the agent of the surgeon unless the aforementioned elements of an agency relationship are present. Thus, any negligent act by the anesthesiologist will not make the surgeon liable nor will the anesthesiologist be held liable for the negligent acts of the surgeon.

F. Criminal Negligence

Surgeons may also be held criminally liable for their negligent acts in the operating room. Criminal negligence under the RPC must, however, be distinguished from intentional crimes. In intentional crimes, the act itself is punished, while "in negligence or imprudence, what is principally penalized is the mental attitude or condition behind the act, the dangerous recklessness, or lack of care or foresight."[272]

The governing provision of the RPC covering criminal negligence is Article 365 which states the following —

> Art. 365. Imprudence and negligence. Any person who, by reckless imprudence, shall commit any act which, had it been intentional, would constitute a grave felony, shall suffer the penalty of *arresto mayor* in its maximum period to *prision correccional* in its medium period; if it would have constituted a less grave felony, the penalty of *arresto mayor* in its minimum and medium periods shall be imposed; if it would have constituted a light felony, the penalty of *arresto menor* in its maximum period shall be imposed.

266. *Lauro*, 739 A.2d at 1183.

267. *Id.* at 1185.

268. *Id.*

269. *Id.*

270. *Id.*

271. Interview with Dr. Edgardo Cortez, *supra* note 130.

272. People v. Cano, 17 SCRA 237, 241 (citing Quizon v. The Justice of the Peace of Pampanga, et al., 97 Phil. 342, 345 (1955)).

> Any person who, by simple imprudence or negligence, shall commit an act which would otherwise constitute a grave felony, shall suffer the penalty of *arresto mayor* in its medium and maximum periods; if it would have constituted a less serious felony, the penalty of *arresto mayor* in its minimum period shall be imposed.
>
> ...
>
> A fine not exceeding [₱200.00] and censure shall be imposed upon any person who, by simple imprudence or negligence, shall cause some wrong which, if done maliciously, would have constituted a light felony.
>
> ...
>
> Reckless imprudence consists in voluntary, but without malice, doing or failing to do an act from which material damage results by reason of inexcusable lack of precaution on the part of the person performing or failing to perform such act, taking into consideration his employment or occupation, degree of intelligence, physical condition and other circumstances regarding persons, time[,] and place.
>
> Simple imprudence consists in the lack of precaution displayed in those cases in which the damage impending to be caused is not immediate nor the danger clearly manifest.
>
> The penalty next higher in degree to those provided for in this article shall be imposed upon the offender who fails to lend on the spot to the injured parties such help as may be in this hand to give.[273]

The elements of the crime of reckless imprudence are the following:

(1) that the offender does or fails to do an act;

(2) that the doing or the failure to do that act is voluntary;

(3) that it be without malice;

(4) that material damage results from the reckless imprudence; and

(5) that there is inexcusable lack of precaution on the part of the offender, taking into consideration his employment or occupation, degree of intelligence, physical condition, and other circumstances regarding persons, time and place.[274]

Aside from the aforementioned penal provision, the surgeon may also be held criminally responsible under other provisions of the RPC provided that the elements of the crime alleged to be committed has been proven beyond reasonable doubt.

G. Administrative Liability

273. REVISED PENAL CODE, art. 365.

274. Cruz v. Court of Appeals, 282 SCRA 188, 189 (1997).

The Ethics Committees of the Philippine Medical Association and the Board of Medical Examiners under the Professional Regulation Commission are open to receive, investigate, and apply appropriate sanctions on doctors guilty of malpractice. Article VII of the 1993 Code of Ethics of the Medical Profession in the Philippines states that

> [v]iolations of the provisions of the Code shall continue to be unethical and unprofessional conduct, and shall be grounds for reprimand, suspension[,] or expulsion as recommended by the Ethics Committee after due process and approved by the Board of Governors. In addition, should the violation be sufficiently grievous, the Board of Governors may on the basis of the violations, endorse the case of the Professional Regulation Commission for possible revocation of registration.[275]

Whenever a complaint under oath is received, said bodies are empowered by law to initiate an investigation of any person, whether a private individual or professional, local or foreign, for the practice of the regulated profession without being authorized by law or without being registered with and licensed by the concerned regulatory board and issued the corresponding license or temporary/special permit, and committing the prohibited acts provided in the regulatory laws of the various professions.[276]

Moreover, the Board of Medical Examiners under Republic Act No. 2383, otherwise known as the Medical Act of 1959, can conduct an administrative investigation upon the filing of a written complaint against a physician, who may be a specialist.[277] The Board can only suspend or revoke the certificate of registration of the specialist if the latter is found guilty of the complaint charged.[278] Minor penalties may be imposed in the form of reprimand or apology but never imprisonment or fine.[279]

The aggrieved patient may also file an administrative complaint against the negligent doctor before the ethics and grievance committee of the hospital, if there be any.[280] The Code of Ethics of the Medical Profession of the Philippines and the Hippocratic Oath of doctors shall be taken into consideration.

V. AN ANALYSIS OF RAMOS V. COURT OF APPEALS

275. 1993 Code of Ethics, art. VII.

276. Professional Regulation Commission, Legal and Other Regulatory Services, *available at* http://www.prc.gov.ph/services/?id=17 (last accessed Sep. 12, 2013).

277. The Medical Act of 1959, § 22.

278. *Id.*

279. *Id.* § 24.

280. Philippine Medical Association, Philippine Medical Association Declaration on the Rights and Obligations of the Patient (Aug. 16, 2005).

A. Right to One's Profession

It is clear that the Philippine Supreme Court erroneously applied the Captain of the Ship Doctrine in *Ramos*. The Court failed to take into account the changes that have occurred in the medical profession since the year 1949, the date when the Captain of the Ship Doctrine was first introduced by an American court.

Moreover, it can be observed that the defendants in the aforementioned case mainly relied on American jurisprudence without supporting their claims of specialization among doctors in the Philippines. Article 12 of the NCC states that "[a] custom must be proved as a fact, according to the rules of evidence."[281] The Court could have possibly ruled differently if such claims were substantiated.

Although it is true that Philippine courts do not necessarily follow the trend in American jurisprudence, the Captain of the Ship Doctrine has become inconsistent with the present scenario facing Philippine medical practitioners. Modern technology and medicine, the trend towards specialization, and patient empowerment are just some of the developments in Philippine medical practice that goes against the present application of the Captain of the Ship Doctrine.

The Philippine Constitution, specifically Section 1 of Article III, guarantees that "[n]o person shall be deprived of life, liberty, or property without due process of law[.]"[282] It has been recognized that one's employment, profession, trade, or calling is a property right, and the wrongful interference therewith is an actionable wrong.[283] It is not reasonable for one to be held responsible for the acts of a person when the former has no control or supervision over the latter through the application of the Captain of the Ship Doctrine, of which is an interpretation by the Supreme Court of our laws on negligence. Article 8 of the NCC provides that "[j]udicial decisions applying or interpreting the laws ... shall form a part of the legal system of the Philippines."[284] This is consistent with the legal maxim of *legis interpretado legis vim obtinet* which states that the interpretation placed upon the written law by a competent court has the force of law.[285] The doctrine is applied whether or not the surgeons are themselves negligent in the operating room. Moreover, as mentioned, the introduction of the doctrine has no substantial basis taking into consideration the prevailing situation in the Philippine medical profession.

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281. CIVIL CODE, art. 12.

282. PHIL. CONST. art. III, § 1.

283. Crespo v. Provincial Board of Nueva Ecija, 160 SCRA 66, 68 (1988).

284. CIVIL CODE, art. 8.

285. Pesca v. Pesca, 356 SCRA 588, 593 (2001).

B. Patient, Surgeon, and Anesthesiologist

1. Doctor and Patient Relationship

In the case at hand, the patient, Ms. Ramos, asked her surgeon, Dr. Hosaka, to look for a good anesthesiologist.[286] Dr. Hosaka, in turn, selected Dr. Gutierrez for that purpose.[287] The patient, in effect, delegated the task of selecting an anesthesiologist to the surgeon.

This fact alone, however, should not be sufficient to render the surgeon liable for any negligent act by the anesthesiologist. It should therefore still be the patient who should bear the responsibility for the anesthesiologist's actions. The patient could have selected the anesthesiologist but opted to delegate the task to the surgeon. The surgeon-patient contractual relationship must be considered distinct and independent from the anesthesiologist-patient contractual relationship.

By delegating the task of selecting the anesthesiologist, the surgeon becomes the agent of the patient for that particular and specific purpose. Article 1868 of the NCC states that "[b]y the contract of agency[,] a person binds himself to render some service or to do something in representation or on behalf of another, with the consent or authority of the latter."[288] Agency is a relationship which implies the power of an agent to contract with a third person on behalf of the principal.

By asking the surgeon to look for an anesthesiologist, the patient gave her consent to the surgeon to establish the contractual relationship between her and the anesthesiologist. The object of the agency contract is the execution of the juridical act of selecting an anesthesiologist. The surgeon-agent is obliged to exercise reasonable care, skill, and diligence in the performance of the juridical act. Agents do not bind themselves not to make any mistakes nor to exercise the highest skill or degree of diligence, instead, they agree to exercise reasonable skill and to take the usual precautions in the performance of the task assigned.[289]

The surgeon, who is the agent of the patient, therefore must act within the scope of his or her authority as a representative of the patient and not for himself or herself. The surgeon, Dr. Hosaka, is deemed to have performed his obligation of looking for a "good" anesthesiologist for the patient as the anesthesiologist chosen, Dr. Gutierrez, has already worked with the surgeon involved in several prior surgical operations without any complications or

286. *Ramos 1999*, 321 SCRA at 590.

287. *Id.*

288. CIVIL CODE, art. 1868.

289. British Airways v. Court of Appeals, 285 SCRA 450, 463 (1998).

problems.[290] Prior to the incident which resulted to the case tackled, Dr. Hosaka had no reason to believe that Dr. Gutierrez was in any way incompetent as an anesthesiologist.

The obligation of looking for a "good" anesthesiologist must refer to the competence of the professional sought to be engaged and must not be construed as a guarantee that the chosen specialist would not perform any negligent acts in the operating room. A competent specialist is one who has undergone the required training for the medical procedure required to be performed. The Court, in fact, made the statement that the surgeon "represented to petitioners that Dr. Gutierrez possessed the necessary competence and skills."[291]

Negligent acts may also be performed by a specialist. Any breach caused by the surgeon-agent of this particular obligation would render the latter liable under the existing agency relationship and not under the Captain of the Ship Doctrine, which is a distinct and separate legal principle.

The fact that the surgeon, Dr. Hosaka, had always conducted surgical operations with Dr. Gutierrez, as the anesthesiologist in the operating room, does not automatically lead to the conclusion that the surgeon is to be deemed liable for the negligent acts of the anesthesiologist. Each patient, upon every consultation or transaction, enters into a separate and distinct contractual relationship with both the surgeon and the anesthesiologist. In fact, the surgeon is not at all required or mandated to engage a particular anesthesiologist upon conducting surgery. If the surgeon repeatedly recommends a particular anesthesiologist in every operation, this would only be due to the confidence and trust already reposed to the chosen anesthesiologist's work.

2. Patient Empowerment

The current and modern practice of patient empowerment among doctors in the Philippines ensures that the patient always has a direct participation in his own medical treatment and well-being. This gives the patient, Ms. Ramos, complete freedom in the selection of the specialists who would be involved in her surgical operation.

Usually, the surgeon, with regard to the choice of the anesthesiologist, merely refers the patient to said specialist. There is no compulsion or imposition involved. Even if a surgeon has the authority from his or her patient to select another specialist such as an anesthesiologist, such patient may still always reject the choice made by the surgeon. The patient always has the option to select another specialist such as an anesthesiologist, who in

290. *Ramos 1999*, 321 SCRA at 590.

291. *Ramos 2002*, 380 SCRA at 490.

his or her opinion is better qualified and capable to render the services needed to be performed in the operating room than the specialist chosen by the surgeon. Thus, even if Dr. Hosaka has already selected Dr. Gutierrez as the anesthesiologist, the patient still has the option to either concur on the choice of the surgeon or to engage another specialist belonging to the same medical field.

Moreover, it is important to note that despite the fact that the surgeon arrived three hours behind schedule for the operation, the patient still opted to continue with the surgery.[292] The patient would have had the valid option of postponing the operation given the delay involved.

C. Standard of Care Required

Physicians who hold themselves out as having special knowledge and skill in a particular field in medicine are required to bring to the discharge of their duty such knowledge and skill to the patient, employing them as such, as a specialist.[293] Dr. Hosaka and Dr. Gutierrez were engaged by the patient as her surgeon and anesthesiologist, respectively. Thus, Dr. Hosaka was bound to bring to the discharge of his duty such knowledge and skill as a duly trained surgeon. On the other hand, Dr. Gutierrez was bound to bring to the discharge of her duty such knowledge and skill as a duly trained anesthesiologist.

The standard of care that must be exercised by a particular specialist in a particular practice in medicine differs with that of another specialist whose expertise is on another field in medicine. Thus, the standard of care to be exercised by the surgeon, Dr. Hosaka, differs with those expected from the anesthesiologist, Dr. Gutierrez. This is due to the variances existing between the surgeon's and the anesthesiologist's required skills, knowledge, training, and experience. Surgeons attempt to cure the patient by causing injury to the latter usually through incisions. On the other hand, anesthesiologists render parts of the patient's body pain-free to facilitate the incisions made by the surgeon.

Moreover, both the surgeon and the anesthesiologist were performing their designated tasks under the clinical guidelines issued by the Philippine College of Surgeons and the Philippine Society of Anesthesiologists, respectively. The clinical guidelines were not taken into consideration by the Supreme Court. If they were considered, the Court could have examined and identified the responsibilities of both the surgeon and the anesthesiologist in relation to the procedures involved in the surgical operation. Moreover, these guidelines are proof of the fact of specialization in the Philippine medical profession.

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292. *Id.* at 473.

293. *See* Wilson v. Swanson, [1956] S.C.R. 804 (1956) (Can.).

The Supreme Court should have also taken into consideration the Code of Ethics of the Philippine Medical Profession in resolving the dispute. This important document was never even mentioned in the case. In fact, the Supreme Court had already previously made use of the Code of Ethics in *Carillo*.[294] The Code of Ethics, as amended on 21 May 1965, governed the actions of both the surgeon and the anesthesiologist at the time Ms. Ramos was being operated upon on 17 June 1985. This is important as the Code of Ethics has since been amended on 25 May 1993 by the House of Delegates of the Philippine Medical Association. Specialization has already been recognized in the 1965 version of the Code of Ethics of the Medical Profession of the Philippines, specifically Article IV, Section 3, which states that

> [i]n difficult and serious cases or in those which are outside the competence of the attending physician, he [or she] should always suggest and ask consultation. Only experienced physicians who are senior to the attending physician or who have had special training and experience in a particular line of medicine should be selected by the latter as consultants.[295]

Moreover, Article IV, Section 11 of the same version of the Code of Ethics of the Medical Profession in the Philippines avers the following —

> Cases which appear to be out of the proper line of practice of the physician in charge of or refractory in spite of the usual clinical treatment, or with a grave prognosis should be referred to those who specialize in that class of ailments. It is desirable that the patient brings with him a letter of introduction giving the history of the case, its diagnosis and treatment, and all the details that may be of service to the specialist. The latter should, in turn reply in writing to the physician in charge, giving his opinion of the case together with the course of treatment he recommends. These opinions or suggestions must be regarded as strictly confidential.[296]

D. Acts of Negligence

In light of their independence in the operating room, the negligence of both Dr. Hosaka and Dr. Gutierrez will now be analyzed in this Note. Although the Supreme Court in *Ramos* correctly found the surgeon, Dr. Hosaka, negligent for arriving three hours late for the planned operation and for scheduling another operation in a different hospital at the same time as that of the victim's, it however cannot hold the surgeon responsible for the negligent acts of the anesthesiologist, Dr. Gutierrez, by the mere fact that the latter was chosen by the former.[297]

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294. *Carillo*, 229 SCRA at 396-97.

295. 1965 Code of Ethics, art. IV, § 3.

296. *Id.* art. IV, § 11.

297. *Ramos 1999*, 321 SCRA at 620.

The anesthesiologist in this case was found negligent in the care of the patient in the anesthesia phase. Dr. Gutierrez failed to make the required pre-operative anesthetic evaluation and was unable to properly intubate the patient.[298] Dr. Gutierrez, herself, admitted that she experienced some difficulty in the endotracheal intubation of the patient.[299] Furthermore, Dr. Gutierrez could not account for at least 10 minutes of what had happened during the administration of anesthesia on Ms. Ramos.[300]

The anesthesiologist was found negligent for being unable to conduct a pre-operative interview or evaluation of the patient.[301] During the day of the operation itself, Dr. Gutierrez was unaware of the physiological make-up and anesthetic needs of the patient.[302] In fact, Dr. Gutierrez only met the patient an hour before the scheduled operation.[303] The Court found this omission as an act of "exceptional negligence and professional irresponsibility."[304] This task is essential as it determines the drug to be used, the amount or volume of the said drug, and the manner of introduction thereof. Any erroneous miscalculation of the same could become fatal for the patient.

The surgeon could not be held liable for the act of the anesthesiologist on matters with regard to the latter's expertise. The surgeon's skill and training do not cover procedures in the operation that relate to the anesthesiologist's specialty. Moreover, the surgeon could not be expected to intervene in an alleged error in an operation or procedure if said doctor is not acquainted with the task where the error was committed. The requirement of conducting a preoperative anesthetic evaluation and the complicated task of intubation is an act distinctly performed by those who belong to the profession of anesthesiology.[305]

The Supreme Court also took judicial notice of the fact that, as to anesthesia procedures, "even an ordinary person can tell if it was administered properly."[306] The Court also found the surgeon, Dr. Hosaka,

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298. *Id.* at 628.

299. *Ramos 2002*, 380 SCRA at 482.

300. *Id.* at 483.

301. *Id.* at 479.

302. *Id.*

303. *Id.* at 480.

304. *Id.*

305. Jose M. Soliz, et al., Airway Management: A Review and Update, *available at* http://archive.ispub.com/journal/the-internet-journal-of-anesthesiology/volume-6-number-1/airway-management-a-review-and-update.html (last accessed Sep. 12, 2013).

306. *Ramos 1999*, 321 SCRA at 610.

liable under the Captain of the Ship Doctrine for failing to verify whether the anesthesiologist properly intubated the patient.[307]

It is true that an ordinary person including a surgeon could determine if the anesthetic procedure was correctly administered through the external manifestations coming from the patient after the said task has been performed. However, an ordinary person, even the surgeon, cannot determine whether an anesthesia procedure is being correctly carried out during that particular time of execution. Thus, any external manifestations of any error could only be determined after the fact of performing the operative procedure specifically assigned to the specialist.

The surgeon has no way of knowing whether the anesthesiologist's actions conform to the normal manner of dispensing anesthesia. It is only the anesthesiologist performing the task or another anesthesiologist, on account of their specialized skill and training, who can determine whether the anesthetic procedure was properly administered. The surgeon is not trained nor experienced in these types of procedures.

In the aforementioned case, the patient, after the faulty intubation, developed bluish discolorations on the nail beds of her left hand.[308] The surgeon in fact, after noticing the said symptom, immediately issued an order for someone to call a certain Dr. Calderon, another anesthesiologist, for assistance.[309] The surgeon, during the time when the anesthesiologist is performing the task distinct to the expertise of the latter's profession, can at most only observe but not intervene in that part of the operation. Likewise, the anesthesiologist is also not permitted to intervene in the tasks intended or attributed to be executed by surgeons. There must be trust and rapport between the two specialists to secure the general well-being of the patient. The surgeon could only intervene when it is necessary to safeguard the welfare of the patient. This is in accordance with the surgeon's supervisory role in the operating room with respect to the general well-being of the patient.

Upon making the aforementioned observation, the surgeon or the anesthesiologist, as the case may be, must ask for assistance or do everything in his or her power to correct the error committed by his or her colleague in the operating room. Dr. Hosaka in fact, when asking for additional assistance after noticing the bluish coloration in the patient's nail beds, requested for another anesthesiologist, who is also expected to have the knowledge or skill required on that part of the procedure, and not any other specialist.[310]

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307. *Id.* at 620.

308. *Id.* at 591.

309. *Id.*

310. *Id.*

Moreover, Sections 14 and 15 of the 1965 Code of Ethics state the following —

> Sec.14. A physician should not take charge of or prescribe for a patient already under the care of another physician, unless the case is one of emergency, or the physician in attendance has relinquished the case, or the services of the attending physician has been dispensed with.
>
> Sec.15. A physician should never examine or treat a hospitalized patient of another without the latter's knowledge and consent except in cases of emergency, but in the latter instance, the physician should not continue the treatment but return the patient to his attending physician after the emergency has passed.[311]

The anesthesiologist is also expected to do the same with regard to the task specifically assigned to the surgeon. It is with this point of view that counsel for Dr. Hosaka admitted that in practice, the anesthesiologist would also have to observe the surgeon's acts during the surgical process and call the attention of the surgeon whenever necessary in the course of the treatment.[312] Jurisprudence elucidates —

> Each, in serving with the other, is rightly held answerable for his own conduct, as well [as] for all the wrongful acts and omissions of the other which he observes and lets go on without objection, or which in the exercise of reasonable diligence under the circumstances he should have observed.[313]

It would be quite impossible for surgeons to do the tasks assigned to them and at the same time monitor the actions of other medical professionals in the operating room. However, if the surgeon indeed exercises supervision or control over other specialists such as that of an anesthesiologist, he or she therefore exposes himself or herself to liability for their negligent acts. In this particular situation, the anesthesiologist or any other specialist who performs a particular task under the control or supervision of the surgeon thereby acts in behalf of the said surgeon.

E. Hospital Not Immune from Suits

The patient, Ms. Ramos, was operated upon on 17 June 1985 in De Los Santos Medical Center.[314] During that time, Philippine hospitals were already being managed as business ventures. This trend continues even today.[315] This is inconsistent with the circumstances prevailing in 1949 when

311. 1965 Code of Ethics, art. IV, §§ 14-15.

312. *Ramos 2002*, 380 SCRA at 495.

313. Morey v. Thybo, 199 F. 760, 762 (7th Cir. 1912) (U.S.).

314. *Ramos 1999*, 321 SCRA at 590.

315. *See* Raisa Marielle Serafica, Modernization of gov't hospital raises fears of privatization, *available at* http://www.rappler.com/move-ph/issues/budget-

the Captain of the Ship Doctrine was first introduced into jurisprudence. The doctrine was developed due to the fact that most hospitals then were charitable institutions immune from lawsuits. On the contrary, both public and private hospitals in the Philippines have now transformed themselves into financially independent business institutions.

Moreover, Philippine hospitals are not immune from legal suits as a consequence of their own actions and to that of their employees's negligent acts. De Los Santos Medical Center has no immunity from court actions as it has, in fact, been impleaded as one of the defendants in this case. The antiquity of the Captain of the Ship Doctrine therefore cannot be simply denied.

F. Civil Liability of the Doctors

The introduction of the Captain of the Ship Doctrine has only confused the manner in which our laws on negligence are to be interpreted. Even without the doctrine, Philippine law is in itself already sufficient to determine the liability of doctors for their negligent actions in the operating room.

The civil liability of the surgeon shall be determined through an analysis of the different principles of law that may be applicable given the circumstances of the case. Each legal principle shall be discussed taking into consideration its pertinent elements and requisites.

Article 1868 of the NCC states that "[b]y the contract of agency[,] a person binds himself to render some service or to do something in representation or in behalf of another, with the consent or authority of the latter."[316] Thus, an agency relationship may exist between the surgeon and the anesthesiologist provided that there be a proper implied or express consent between them to establish the said relationship, a proper object or task at hand in the surgical operation, and that the agent act within the scope of his authority as the representative of the surgeon.

Article 1910 of the NCC states that "[t]he principal must comply with all the obligations[,] which the agent may have contracted within the scope of his authority."[317] As for any obligation wherein the agent has exceeded his or her power, the principal is not bound except when the latter ratifies it expressly or tacitly.[318] Furthermore, Article 1909 of the NCC avers that

watch/featured/30121-modernization-poc-fears-healthcare-privatization (last accessed Sep. 12, 2013) & Doris C. Dumlao, *Ayala Land ventures into hospital business*, PHIL. DAILY. INQ., July 3, 2013, *available at* http://business.inquirer.net/130127/ayala-land-ventures-into-hospital-business (last accessed Sep. 12, 2013).

316. CIVIL CODE, art. 1868.

317. *Id.* art. 1910.

318. Filipinas Life Insurance v. Pedroso, 543 SCRA 542, 547. (2008).

"[t]he agent is responsible not only for fraud, but also for negligence, which shall be judged with more or less rigor by the courts, according to whether the agency was or was not for compensation."[319] Any breach caused by the physician-agent would render the latter liable under the existing agency relationship and not under the Captain of the Ship Doctrine.

Thus, the anesthesiologist-agent could be held liable for his or her own negligent acts in the operating room while the surgeon-principal can also be held responsible for said acts if so made within the scope of the agent's authority unless the principal ratifies the same either expressly or impliedly. There is, however, no indication in the aforementioned case that the anesthesiologist, Dr. Gutierrez, became the agent of the surgeon, Dr. Hosaka, either expressly or impliedly in the intubation of the patient. As mentioned, the contract entered into by the patient with the surgeon is distinct and separate from that of the anesthesiologist.

The agency relationship discussed above is distinct from the agency relationship existing between the surgeon, Dr. Hosaka, and the patient, Ms. Ramos, for the purpose of selecting an anesthesiologist in her behalf.

If the specialist who committed the negligent act is employed by the surgeon for the purpose of assisting him or her in the operating room, the surgeon may be held responsible under the doctrine of *respondeat superior.* Liability under this doctrine is based on the surgeon's legal connection with the wrongdoer. Specifically, an employer-employee relationship must be present between them at the time the negligent act was committed.

There is no indication in the aforementioned case that the negligent anesthesiologist, Dr. Gutierrez, was in any way an employee of the surgeon, Dr. Hosaka. The existence of an employer-employee relationship may be determined by considering the following elements: "a) the selection and engagement of the employee; b) the payment of wages; c) the power of dismissal; and d) the employer's power to control the employee with respect to the means and methods by which the work is to be accomplished."[320]

Dr. Hosaka had no control over the actions of Dr. Gutierrez, specifically in the act of intubation, which is a procedure commonly performed and assigned to anesthesiologists. Moreover, the services of Dr. Gutierrez were engaged by Ms. Ramos through Dr. Hosaka, who was acting as the agent of the said patient. The anesthesiologist was not hired as an employee of the surgeon. This being so, the anesthesiologist did not receive wages from the said surgeon. Furthermore, since the anesthesiologist was not employed by the surgeon, the latter has no power of dismissal over the former.

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319. CIVIL CODE, art 1909.

320. Brotherhood Labor Unity Movement of the Philippines v. Zamora, 147 SCRA 49, 54 (1987).

A surgeon may also be held responsible under the tort doctrine of *res ipsa loquitur*. The accident involved under this principle must be of a kind that does not normally happen under ordinary circumstances and the cause of such accident must be due to an instrumentality under the immediate control of the surgeon. Such instrumentality may include other persons, such as another specialist who may be under the control of the surgeon.

This doctrine, however, is not applicable in this particular case. Although the error that occurred in the operating room does not normally happen under ordinary circumstances, Dr. Gutierrez was not acting as an instrument of Dr. Hosaka when the former was administering the anesthesia to the patient.

The concept of strict liability in Philippine Civil Law is also inapplicable. A case is one of strict liability when "neither care nor negligence, neither good nor bad faith, neither knowledge nor ignorance will save the defendant."[321] The NCC imposes strict liability against the possessor of an animal,[322] head of a family that lives in a building where things are thrown or falling from the same,[323] owners of enterprises and other employers for the death or injuries of their employees,[324] and owners or possessors of property where a nuisance is found.[325] The origin of the liability "is the defendant's intentional behavior in exposing those in his vicinity to such a risk."[326]

The provisions imposing strict liability are based on the fact of control of the person to be held liable over the objects or other persons causing the injuries to a third party. The persons automatically held liable under this concept have the opportunity to prevent the act which caused the injury from happening. The possessor of the animal could have exercised the necessary precautions to prevent any possible escape or loss of the same. The head of a family that lives in a building and the owner or possessor of property where a nuisance is found also have a sense of responsibility to watch over their respective properties to avoid any untoward incidents from happening against other persons. Lastly, the owner of enterprises and employers has control and supervision over the acts of their employees.

The surgeon, Dr. Hosaka, does not exercise control over any other medical professionals present in the operating room. In the first place, he has no right to do so as his competence is limited only to those matters involving

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321. AQUINO, *supra* note 28.

322. CIVIL CODE, art. 2183.

323. *Id.* art. 2193.

324. *Id.* art. 1711.

325. *Id.* art. 696.

326. WILLIAM PROSSER, LAW ON TORTS 494 (4th ed. 1978).

the skill of surgeons. The anesthesiologist as well as other specialists present is not the subordinates of the surgeon. Dr. Hosaka could not have therefore prevented the negligent act of Dr. Gutierrez on a matter requiring the expertise of anesthesiologists. Thus, the concept of strict liability could not be applied against surgeons not exercising any degree of control over other persons causing the injuries arising from a negligent act. As mentioned in the preceding paragraphs, neither can Dr. Gutierrez be considered an employee of Dr. Hosaka to justify the application of the concept of strict liability involving employers.

The liability of both the surgeon and the anesthesiologist could be alternatively based on the civil concepts of quasi-delict or *culpa contractual*. The existence of a contract does not preclude the commission of a quasi-delict. Previously, the Court already held that "[w]hen an act which constitutes a breach of contract would have itself constituted a source of a quasi-delictual liability had no contract existed between the parties, the contract can be said to have been breached by tort, thereby allowing the rules on torts to apply."[327] Even without the existence of the surgeon-patient contractual relationship or the anesthesiologist-patient contractual relationship, the acts of both doctors would still constitute negligence.

The civil liability of the surgeon, Dr. Hosaka, could be based on either quasi-delict or on a violation of his contractual agreement with the patient. The surgeon cannot be held liable under the Captain of the Ship Doctrine. Having been engaged as the surgeon by the patient, he or she is bound to exercise the standard of care and diligence expected of all surgeons. The surgeon arrived three hours late for the patient's operation and scheduled another operation in a different hospital at the same time as that of the patient's.[328] This negligent act was in violation of the standard of care that Dr. Hosaka was bound to exercise, and consequently, is to be considered as a breach of his contract with the patient.

This negligent act of the surgeon undoubtedly contributed to the tragedy that occurred in the operating room. Article 1173 of the NCC defines negligence as the "omission of that degree of diligence which is required by the nature of the obligation and corresponding to the circumstances of the persons, time, and place."[329] The following elements must, however, be proved by a preponderance of evidence. The Supreme Court, in resolving the case, made the following pertinent observation —

> The unreasonable delay in petitioner Erlinda's scheduled operation subjected her to continued starvation and consequently, to the risk of acidosis, or the condition of decreased alkalinity of the blood and tissues,

327. Light Rail Transit Authority v. Navidad, 397 SCRA 75, 83 (2003).

328. *Ramos 1999*, 321 SCRA at 620.

329. CIVIL CODE, art. 1173.

> marked by sickly sweet breath, headache, nausea and vomiting, and visual disturbances. The long period that Dr. Hosaka made Erlinda wait for him certainly aggravated the anxiety that she must have been feeling at the time. *It could be safely said that her anxiety adversely affected the administration of anesthesia on her. As explained by Dr. Camagay, the patient's anxiety usually causes the outpouring of adrenaline which in turn results in high blood pressure or disturbances in the heart rhythm*[.][330]

Article 2176 of the NCC states that "[w]hoever by act or omission causes damage to another, there being fault or negligence" shall be liable under quasi-delict.[331] A quasi-delictual action must be able to prove the act or omission constituting the fault or negligence, damage caused by the said act or omission, and the causal relation between the damage and the act or omission.[332]

An alternative cause of action to hold Dr. Hosaka civilly liable could be based on quasi-delict. As mentioned, Dr. Hosaka scheduled another operation in another hospital at almost the same time that he was supposed to operate on Ms. Ramos and arrived three hours late for the latter's operation.[333] The unreasonable delay of the surgeon contributed to the erroneous administration of anesthesia by Dr. Gutierrez due to the "outpouring of adrenaline which in turn resulted in high blood pressure or disturbances in the heart rhythm" of the patient.[334] The patient thereby became comatose and never again regained consciousness.

The civil liability of the anesthesiologist, Dr. Gutierrez, could also be alternatively based on either the contractual relationship existing between them or on quasi-delict. Having been engaged by the patient as the anesthesiologist for her operation, Dr. Gutierrez was bound to exercise due care and diligence in the administration of anesthesia. In doing so, the standards of the profession of anesthesiology must be complied with. This contract, as mentioned, is distinct from the contract entered into by the patient with the surgeon.

The act of intubation and the requirement of a pre-operative anesthetic evaluation is a task distinctly peculiar to anesthesiologists. As the anesthesiologist engaged by the patient, Dr. Gutierrez was bound to exercise due diligence and care before and during the administration of anesthesia. The failure to make the pre-operative evaluation and being unable to properly intubate the patient is attributed to the negligence of Dr. Gutierrez,

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330. *Ramos 2002*, 380 SCRA at 496 (emphasis supplied).

331. CIVIL CODE, art. 2176.

332. *Taylor*, 16 Phil. at 28 & Philippine Bank of Commerce v. Court of Appeals, 269 SCRA 695, 702-03 (1997).

333. *Ramos 1999*, 321 SCRA at 620.

334. *Ramos 2002*, 380 SCRA at 496.

of which is considered as a breach of her contract with the patient. Due to said negligent acts, the patient remained in a comatose condition since the operation until her death. These elements must again be established through a preponderance of evidence.

The anesthesiologist, Dr. Gutierrez, could also be held civilly liable under the concept of quasi-delict. Dr. Gutierrez failed to conduct the pre-operative anesthetic evaluation and was unable to properly intubate the patient thereby directly causing the injury of the patient, Ms. Ramos.[335] The patient became comatose and never regained consciousness until the time of her death.

With respect to the civil liability of the surgeon and the anesthesiologist based on quasi-delict, both doctors may be held solidarily liable as joint tortfeasors. Article 2194 of the NCC provides that "[t]he responsibility of two or more persons who are liable for quasi-delict is solidary."[336] As previously ratiocinated by the Court, "[j]oint tortfeasors are all the persons who command, instigate, promote, encourage, advise, countenance, cooperate in, [or] aid or abet the commission of a tort[.]"[337] It is not necessary that the cooperation should be direct. Solidary liability exists not only if the defendants conspired to bring about the result but also in cases where causes are independent of each other.[338] The negligent actions of both the surgeon and the anesthesiologist led to the tragic injury suffered by the patient, although the causes of the same are independent from one another.

G. Administrative Liability of the Doctors

The patient could have also filed an administrative case against the surgeon, Dr. Hosaka, before the Ethics Committee of the Philippine Medical Association. Article II, Section 1 of the 1965 version of the Code of Ethics of the Medical Profession in the Philippines provides the following —

> A physician should attend to his patients faithfully and conscientiously. He should secure for them all possible benefits that may depend upon his professional skill and care. As the sole tribunal to adjudge the physician's failure to fulfill his obligation to his patients is, in most cases, his own conscience, and violation of this rule on his part is discreditable and inexcusable.[339]

The anesthesiologist, Dr. Gutierrez, may also be administratively responsible for her actions in the operating room. She is bound by the Code

335. *Ramos 1999*, 321 SCRA at 628.

336. CIVIL CODE, art. 2194.

337. Worcester v. Ocampo, 22 Phil. 42, 95 (1912).

338. AQUINO, *supra* note 28.

339. 1965 Code of Ethics, art. II, § 1.

of Ethics of the Medical Profession to exercise due care in the performance of the tasks assigned to her.

H. Criminal Liability of the Doctors

The anesthesiologist may be prosecuted for the Crime of Reckless Imprudence Resulting to Serious Physical Injuries under Article 365 in relation to Article 263 of the RPC. Here, the *culpa* or the negligent act itself is the crime punished. The intention of the doctor is immaterial for purposes of determining her liability under this particular crime. The guilt of the accused must be shown beyond reasonable doubt. Based on the Rules on Evidence, "[m]oral certainty only is required, or that degree of proof which produces conviction in an unprejudiced mind."[340]

Reckless imprudence, as defined under Article 365 of the RPC, consists of

> voluntarily, but without malice, doing or failing to do an act from which material damage results by reason of inexcusable lack of precaution on the part of the person performing or failing to perform such act, taking into consideration his employment or occupation, degree of intelligence, physical condition and other circumstances regarding persons, time and place.[341]
>
> Had the act been intentional, it would constitute a felony.[342]

The act of the anesthesiologist, Dr. Gutierrez, of failing to properly intubate the patient and being unable to conduct a proper preoperative evaluation constitutes reckless imprudence. Said actions were done voluntarily and without malice. The patient, due to the actions of the anesthesiologist, remained in a comatose condition since her surgical operation thereby suffering material damage. Her act manifests an inexcusable lack of precaution on her part as a medical specialist on the field of anesthesiology. The Supreme Court, as mentioned, considered the anesthesiologist's omissions as acts of "exceptional negligence and professional irresponsibility."[343]

The act of the anesthesiologist, Dr. Gutierrez, had it been intentional, could be considered as a crime of serious physical injuries. The crime of serious physical injuries is committed when the injured person becomes insane, imbecile, impotent, or blind in consequence of the physical injuries inflicted or when the victim becomes incapacitated for the work in which he was theretofore habitually engaged, in consequence of the physical injuries

340. REVISED RULES ON EVIDENCE, rule 133, § 2.

341. REVISED PENAL CODE, art. 365.

342. LUIS B. REYES, 2 THE REVISED PENAL CODE: CRIMINAL LAW 1050 (2008 ed.).

343. *Ramos 1999*, 321 SCRA at 612.

inflicted.[344] The patient, Ms. Ramos, due to the internal injuries suffered as a result of the faulty intubation by the anesthesiologist, remained in a comatose condition and never woke up from such a predicament. The patient while in such a condition was incapacitated not only in the performance of her work but also in the manner she could have lived her life.

As to the anesthesiologist, an alternative cause of action for the latter's civil liability could be based on her aforementioned criminal act. The RPC, specifically Article 100, states that "every person criminally liable for a felony is also civilly liable."[345] This is, however, subject to the rule provided for in Article 2177 of the NCC which states that "the plaintiff cannot recover damages twice for the same act or omission of the defendant."[346]

On the other hand, the negligent act of the surgeon, Dr. Hosaka, is punishable under Article 365 of the RPC for the crime of simple imprudence. Such type of imprudence consists "in the lack of precaution displayed in those cases in which the damage impending to be caused is not immediate nor the danger clearly manifest."[347]

The negligent act of the surgeon of failing to arrive on time for the surgical operation and the act of scheduling another operation in another hospital at almost the same time was not immediately life-destructive to the patient. However, as discussed above, the surgeon's actions contributed to the complications which arose during the anesthesia stage of the surgical operation thereby causing the injuries suffered by the patient. An alternative cause of action for the recovery of civil damages as against the surgeon may also be based on the imputed criminal act of the latter.

VI. CONCLUSION

If we desire respect for the law, we must first make the law respectable.

— Justice Louis D. Brandeis[348]

It is true "that the law must be kept up to date, responsive to the continuing process of social change."[349] Concepts and doctrines from the law's past may

344. REVISED PENAL CODE, art. 263.

345. *Id.* art. 100.

346. CIVIL CODE, art. 2177.

347. REVISED PENAL CODE, art. 365.

348. Brandeis University, Justice Louis D. Brandeis, *available at* http://www.brandeis.edu/legacyfund/bio.html (last accessed Sep. 12, 2013).

349. Harry W. Jones, *An Invitation to Jurisprudence*, 74 COLUM. L. REV. 1024, 1031 (1974).

offer the wrong answers for today's legal problems.[350] When the reason for the law ceases, the law itself must likewise cease.[351]

The Captain of the Ship Doctrine is already not in tune with the present state of the Philippine medical profession, specifically with the manner in which surgery is being currently conducted and other recent developments such as the practice among doctors of empowering their patients. Rather than bringing about order and setting a system of determining who is liable for the negligent act, the doctrine only inhibits and contributes to the confusion with regard to the degree of care that a surgeon has to exercise while inside the operating room. The continued application of the doctrine would also be inimical to patients in general.

Although it is true that American jurisprudence, the source of the doctrine, has already abandoned the Captain of the Ship doctrine, the Philippine Supreme Court in determining whether the said doctrine still applies in the Philippine setting, needs only examine the current state of the medical profession in the country in the context of its practices inside the operating room.

Surgeons, on account of their specialized training and skill, cannot be expected to also become experts in other fields of medicine where other specialists already practice in. The surgeon is the master of his or her own self in the task to be performed, which involves the application of his or her particular expertise. He or she is considered, in other words, the captain of his or her own ship.

Specialization has been and is still currently the practice among doctors in the Philippines. Surgeons and anesthesiologists are considered specialists in their respective medical fields. Both kinds specializations require graduation from approved medical schools, and internships and resident trainings in their particular specialties.[352] In support of the same, certain institutions have been established to further strengthen and support this phenomenon among doctors. Thus, regulatory bodies such as the Philippine College of Surgeons and the Philippine Society of Anesthesiologists were established.

The principal actors in the operating room include the surgeon and the anesthesiologist. The surgeon and the anesthesiologist treat each other as co-equals outside the operating room and there is no reason why they should not treat each other in the same manner while inside the operating room. Each person has a specific task to perform during the surgical operation. It is at this instance where they make use and apply their specialized skill,

350. *Id.*

351. People v. Almuete, 69 SCRA 410, 413 (1976).

352. THE NEW LEXICON ILLUSTRATED MEDICAL ENCYCLOPEDIA AND GUIDE TO FAMILY HEALTH 29 (Robert E. Rothenberg, M.D. ed., 1988).

training, and experience to the respective tasks at hand. Each is expected to perform their tasks well and to treat each other as co-professionals.

The surgeon is not an authority in the administration of anesthesia nor is the anesthesiologist an authority on the manner of conducting surgery. It is the surgeon who decides whether or not to proceed with the operation and the manner thereof. On the other hand, it is the anesthesiologist who decides whether or not anesthesia is to be administered to the patient, and the particular anesthesia to be used. Thus, a surgeon cannot just interfere while the anesthesiologist is performing a sensitive procedure unique to the latter's profession or expertise in the operating room and vice versa.

The standard of care that surgeons are required to undertake is also different from those of the anesthesiologists. A specialist's legal duty to the patient concerned is generally considered to be that of an average specialist in a particular field of medicine from which he belongs.

However, all the main actors in the operating room have a common duty to exercise due diligence towards the safety and welfare of the patient while the latter is undergoing surgery. Thus, once a negligent act is manifested during a surgical operation, each party whether a surgeon or an anesthesiologist has a duty to bring to the attention of the specialist the error made or committed. If necessary, he or she shall thereby intervene so as to secure the welfare of the patient. It is only in this particular aspect where the surgeon exercises a supervisory role.

As to liability, however, the surgeon should not be held responsible for the negligent acts of other specialists during a procedure which requires the application of the latter's medical expertise. The surgeon has no control over the actions of other specialists such as that of the anesthesiologist. The surgeon may supervise over matters which all physicians are expected to have knowledge on. However, specialists are still the captains of their own ships with regard to the procedure attributed to their particular profession. The surgeon, however, should not be negligent. Likewise, other specialists could not overrule the surgeon on matters which require the application of the surgeon's unique and specialized skill, training, and experience.

Collaboration between and among specialists therefore becomes of utmost importance. "When two or more physicians are involved in the treatment of a patient, they are required to coordinate their evidence and communicate in a manner that best serves the patient's well-being."[353] As challenges become more complex, no one organization or sector can resolve the conflicting and overlapping tasks that may exist between specialists in the operating room. Institutional teams composed of different medical practitioners and health professionals representing their respective specialties

353. Bass v. Barksdale, 671 S.W.2d 476, 491 (Tenn. Ct. App. 1984) (U.S.).

have been organized to address this particular problem by defining "zones of collaboration" with other specialists, understanding and determining who needs to be at the operating table at a particular time, and how to get them there.[354]

Trust therefore becomes an important ingredient in collaborative tasks involving specialists. Everyone needs to build trust by being dependable themselves, by appropriately subordinating one's own interests to the group, and by bringing one's specialized expertise and resources to the operating table and taking advantage of the specialized expertise, skill, and resources of other specialists.[355]

The applicability of the Captain of the Ship Doctrine in the Philippine scenario is obviously questionable due to its inconsistency with the situation of the times. The preservation of the status quo under the present doctrine would only result in an injustice to specialists in the medical field. It would ignore the fact of specialization as being the present norm among medical doctors. Requiring the surgeon to be well-versed with tasks pertaining to the anesthesiologists would only contribute to the confusion and would not allow the former to concentrate on the work specifically attributable to surgeons. The same is also true from the point of view of anesthesiologists with respect to tasks attributable to surgeons.

The Philippine Government, through the DOH, has recognized the fact of specialization as an undeniable reality. Thus, the Manual of Procedures for Hospitals was created thereby assigning the responsibility and liability for certain acts during a surgical operation to a particular individual in the operating room. The tasks assigned to health professions inside the operating room are therefore well defined.

Moreover, hospitals in the Philippines have organized Operating Room Management Committees as part of its organization. Said committees, aside from the aforementioned manual issued by the DOH, designate the tasks that are assigned to health professionals in the operating room, which correspond to their respective expertise.

Furthermore, evidence-based clinical guidelines were adopted by the professional regulatory organizations of both surgeons and anesthesiologists to serve as an outline of conduct while said professionals are at work in the operating room. Nevertheless, since specialists are also physicians, they are also bound by the Code of Ethics imposed by the Philippine Medical Association while inside the operating room.

It is, however, in situations not covered by these clinical guidelines, such as when surgical complications occur, that the expertise of specialists

354. Margolin, *supra* note 122.

355. *Id.*

becomes very important. It is during this time when specialists make use of their particular skill, training, and experience in the field of medicine they specifically practice in. The ability of specialists to decide when to stray away from the evidence-based clinical guidelines prescribed by their respective professional organizations due to complications arising in surgery demonstrates the specialists' unique and distinct skill and expertise in a particular field of medicine. By doing so, the well-being and safety of the patient while inside the operating room is ensured.

It is also the surgeon or the anesthesiologist, respectively, who makes the ultimate decision of whether or not to proceed with the surgical operation or whether or not to use a particular drug as an anesthetic regardless of the contents of the requested medical clearance issued by a particular specialist other than the surgeon and the anesthesiologist.

In instances when a medical clearance is not required and an internist is asked for an opinion before an operation, it is still the consulting surgeon or anesthesiologist who decides whether or not to comply with the internist's recommendations. Thus, liability would still fall on the surgeon or anesthesiologist for negligently failing to take into consideration the issued medical clearance and the internist's medical inputs.

Hospitals are currently managed and treated as business ventures in the Philippines. Moreover, hospitals are not in any way immune from lawsuits. This goes against the very reason why the Captain of the Ship Doctrine was established in the first place. The doctrine was introduced due to the fact that most hospitals then were charitable institutions immune from lawsuits. Even government-owned hospitals are now becoming more financially self-sufficient and independent.

Furthermore, Philippine law is currently already sufficient to determine and pinpoint the liability of the surgeon inside the operating room. Generally, the surgeon should be held liable for his or her own negligent acts, of which is the proximate cause of the injury or death of the patient. The surgeon, however, may also still be held accountable for the negligent acts of other parties in the operating room such as that of another specialist if there be an employer-employee relationship, agency relationship, or through the doctrine of *res ipsa loquitur*. The surgeon's civil liability may also be determined under the legal principles of *culpa contractual* and quasi-delict. The surgeon may also be held criminally liable and administratively responsible for his negligent acts in the operating room.

VII. RECOMMENDATION

A. Determining the Surgeon and Specialist's Liability

Recognizing the developments in Philippine surgery and the existing laws that govern the negligent acts of medical practitioners, the Captain of the

Ship Doctrine must therefore be abandoned and a practical, just, and comprehensive law that would properly determine surgeon's and specialist's liability for negligent acts inside the operating room must be enacted by the Congress of the Philippines. The said law may be drafted as follows:

REPUBLIC OF THE PHILIPPINES

HOUSE OF REPRESENTATIVES

QUEZON CITY

House Bill No. XXXX

AN ACT DETERMINING THE LIABILITY OF SURGEONS AND SPECIALISTS FOR NEGLIGENT ACTS IN THE OPERATING ROOM

Be it enacted by the Senate and the House of Representatives of the Philippines in Congress assembled:

Section 1. *Short Title.* — This Act shall be known as the "Comprehensive Surgeon's and Specialists' Liability Act of 2013."

Section 2. *Declaration of Policy* — It is the policy of the State to ensure the safety of and well-being of patients by providing them with professional medical care. The State shall also guarantee that no person, including doctors, shall be deprived of one's profession without due process of law. Moreover, the State recognizes the fact of specialization among doctors in the Philippine medical profession including those whose expertise is performed in the operating room.

Section 3. *Definition of Terms* — Unless the context otherwise requires, the following terms shall have the following meanings:

> "Surgeons" — shall refer to doctors who operate in manual or operative means so as to treat disease, repair injury, correct deformities, and improve the general health of the patient. Such term shall include general surgeons and subspecialists in the field of surgery.
>
> "Specialists" — shall refer to doctors who are trained in a particular field in medicine and are duly certified by their respective specialist boards.
>
> "Patients" — shall refer to people requiring medical attention from any doctor.
>
> "Operating Room" — shall refer to a specially equipped room, usually in a hospital, where surgical procedures are performed.

Section 4. *Liability of the Surgeon* — The surgeon shall not be liable for any negligent act occurring in the operating room unless:

(1) The surgeon is negligent. The negligent acts of the surgeon include but shall not be limited to the following:

(a) When the surgeon failed to properly perform his or her duties in the operating room under the standards set by his profession;

(b) When the surgeon should have noticed that the patient was already in distress but failed to do so; or

(c) When the surgeon should have taken a more direct action to save the patient who was in distress but failed to do so.

(2) The surgeon is responsible for the actions of the person negligent or specialist under the Civil Code and other laws.

Section 5. *Liability of the Negligent Specialist Other Than the Surgeon* — The liability of the negligent specialist other than the surgeon shall be determined under the appropriate provisions of the Civil Code and other laws.

Section 6. *Other Remedies* — Patients shall not be deprived of any remedy available to them under applicable laws against the parties responsible for the acts committed in the operating room resulting to injury to said patients.

Section 7. *Information Dissemination* — The Department of Health, in coordination with the Philippine Medical Association and other specialists' organizations, shall conduct an information dissemination campaign to inform the public of their legal rights as patients in the operating room.

Section 8. *Implementing Rules and Regulations* — The Department of Health in coordination with the Philippine Medical Association and other specialists' organizations shall formulate, within 90 days upon the effectivity of this Act, the implementing rules and regulations for the manner in which the information dissemination under Section 8 is to be conducted.

Section 9. *Appropriations* — The amount necessary to carry out Section 8 of this Act shall be included in the budget of the Department of Health in the General Appropriations Act of the year following its enactment into law and thereafter.

Section 10. *Repealing Clause* — All Laws, Presidential Decrees, Executive orders, Proclamations, and/or Administrative Regulations, which are inconsistent with the provisions of this Act, are hereby amended, modified, superseded or repealed accordingly.

Section 11. *Effectivity* — This Act shall take effect 15 days after its publication in the Official Gazette or in at least two newspapers of general circulation.

Signed and Approved:

President of the Senate Speaker of the House of Representatives

President of the Philippines

An analysis of the surgeon's own actions must first be made by the courts to determine whether or not the surgeon is negligent. The surgeon, under these circumstances, will not be held liable under the Captain of the Ship Doctrine. Any damages for which he may be held responsible is a result of his own negligent acts thereby resulting to his liability.

If the surgeon is not in any way negligent, an examination of the actions of the specialist other than the surgeon shall be made by the courts. The specialist's responsibility with regard to the injuries suffered by the patient in the operating room shall be determined. If the specialist is negligent, the courts shall then determine if the surgeon is legally responsible for the negligent actions of the specialist. The surgeon shall be held responsible if an agency relationship or an employer-employee relationship exists between the latter and the person negligent. The surgeon is not liable under the Captain of the Ship Doctrine.

The criminal liability of the surgeon shall also be determined taking into consideration the provisions of the RPC and other special penal statutes. The administrative liability of the surgeon shall also be determined taking into consideration the Code of Ethics of the Medical Profession of the Philippines and the Hippocratic Oath. Such determination shall be done without any application of the Captain of the Ship Doctrine.

Although an express jurisprudential announcement of the abandonment of the Captain of the Ship Doctrine is possible, the proposed law could immediately clarify the surgeon's liability for negligent acts occurring in the operating room. Moreover, the time when such jurisprudential abandonment would occur is also uncertain. For the doctrine to be abandoned through this particular method, a case involving the liability of a surgeon for the negligent acts of other specialists in the operating room must first reach the courts.

Moreover, through the abandonment of the Captain of the Ship Doctrine, doctors would be encouraged to testify in court against another doctor who is allegedly negligent. Considering that their liabilities are distinct from one another with regard to the tasks attached to their respective specialties, doctors would be more willing to serve as witnesses without fear of incurring liability. This is consistent with their duty of reverence, fidelity, truthfulness, and confidence towards their patients.

Moreover, persons involved in the operating room other than the doctors may also be presented as witnesses against the specialist who is

allegedly negligent. This includes nurses, medical technicians, and other hospital personnel. To further determine negligence, expert testimonies should thereby also be presented. Medical transcriptions may also be used as supplementary evidence.

B. Medical Professionals

Aside from the abandonment of the doctrine, it is also recommended that conferences and seminars be conducted by the specialists' organizations to further the knowledge of surgeons, anesthesiologists, and other specialists on their responsibilities and the consequences of their actions in the operating room. By doing so, negligent actions would be deterred, thus, benefiting the patient's safety and welfare.

Institutional teams or committees composed of medical professionals representing their respective specialties must also be organized through their corresponding specialty organizations. The committee's aim is to define what "zones of collaboration" are to understand and determine the tasks that need to be undertaken as a team. Such tasks must be distinguished from the procedures which require the doctor's specialty or expertise.

The endpoint must always be the patient's safety and general welfare. In case of any negligent act occurring within the aforementioned zones, the liability shall be shared among the collaborating medical professionals composing the team at that particular time of the surgical operation.

C. Students of Medicine

The responsibilities, legal implications, and consequences of the actions of specialists in the operating room shall also be integrated as part of the topics taught to students of medicine in the Philippines. This subject may be tackled as one of the topics in the course of "Medical Jurisprudence," which is currently part of the curriculum of medical schools. By doing so, future medical practitioners will not only be more knowledgeable of their legal responsibilities but would also be better equipped as they face the day to day challenges of practicing their chosen medical specialties.

D. Patients, General Public, and Other Stakeholders

Moreover, an information dissemination campaign must be conducted by the DOH, in coordination with the specialist's organizations and the Philippine Medical Association, to inform the public of their legal rights as patients. These may be done through the publication of articles in newspapers, magazines, journals, and internet websites, and the distribution of pamphlets with the required information in public and private hospitals, clinics, and government health centers. With respect to the DOH, sufficient funding must be made available for this particular purpose.

E. Legal Reforms

The issue of liability, however, would not end by the mere abandonment of the Captain of the Ship Doctrine. It calls for more serious efforts on the part of our lawmakers to study the relevance of laws governing the medical profession in general. The doctrine is but part of the legal system in Philippine medicine that need reforms.

Serious efforts must also be made among health professionals, specialist organizations, patient groups, human rights advocates, other interest groups, and the government sector to push for the changes that need to be undertaken. It is also recommended that said efforts be supported by further studies and researches from both the academe and the health professionals.

F. Hospitals

Hospitals in the Philippines should be strict in the acceptance and accreditation of medical staff members who are specialists. By doing so, hospitals and patients are assured that the surgeons and other specialists they are dealing with are either "Diplomates" or "Fellows" in their respective fields. This not only ensures the capability of doctors and other health professionals, but would also guarantee quality in the medical treatment received by patients.

Hospitals should also be encouraged to establish "ethics and grievance committees" as part of their organization. By doing so, both the patient and the doctor will be benefitted. Patients, through this venue, will be able to seek redress from the alleged negligent actions of their surgeon, anesthesiologist, or other specialist. On the other hand, health practitioners will be able to provide the necessary justifications and explanations for their actions. The reconciliation and the settlement of the disputes involved must be encouraged by the committee. Furthermore, the introduction of an ethics committee in the hospital organization will lessen and minimize the number of cases being filed in Philippine courts, thus, contributing to a more effective and efficient court system. This would, in other words, relieve the courts of a considerable number of avoidable cases.

It is, however, suggested that further studies be made to determine the feasibility of making the formation of an ethics and grievance committee as one of the requirements for procuring a license to operate a hospital. Republic Act No. 4226,[356] otherwise known as the Hospital Licensure Act, does not currently require hospitals to form such a committee.

356. An Act Requiring the Licensure of All Hospitals in the Philippines and Authoring the Bureau of Medical Services to Serve as the Licensing Agency [Hospital Licensure Act], Republic Act No. 4226 (1965).

The abandonment of the Captain of the Ship Doctrine should also be supported by reforms in hospital management in matters involving the operating room. Accidents in the operating room may still occur despite the exercise of diligence among and between health professionals. This must include an analysis of the hospital's infrastructure and facilities, the required hospital equipment, the factors contributing to health service delivery, and aspects that are beyond human lapses but are necessary to provide sound hospital environment to patients. This may be done through the Philippine Hospital Association in coordination with the DOH, health professional organizations, and other stakeholders. If this would then be realized, it is a possibility that negligence in the operating room would be avoided, if not minimized.

In light of the discussion above and the ruling of the Supreme Court in the recent case of *Professional Services, Inc. v. Agana*,[357] it is also emphasized that the hospital is not left defenseless on any allegation of negligence based on Article 2180 of the NCC. Although the hospital is presumed negligent due to the reckless acts of its doctors, the hospital may rebut such presumption upon presentation of proof that it exercised the diligence of a good father of a family.

357. Professional Services, Inc. v. Agana, 513 SCRA 478 (2007).