Separation of Responsibility in the Operating Room: The Borrowed Servant, the Captain of the Ship, and the Scope of Surgeons' Vicarious Liability

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In a modern hospital a patient admitted for surgery is placed into the hands of a rather large number of persons, each of whom performs a function which, in varying degrees, may have an effect upon the course of, if not the result of, the surgical procedure itself. By the very fact of hospitalization, and even more so by the fact of having surgery performed, a very special set of circumstances and very important set of relationships come into being. The patient is ill and in strange surroundings; he finds himself in the unusual position of having much of the responsibility for his well-being given to others; indeed, in the operating room his life is literally in the hands of the surgical team. Because of the importance society has placed upon this setting, there has grown up an elaborate framework or structure to handle the care of the individual. With the health and safety of the patient so dependent upon this framework, there exists a fertile breeding ground for legal action whenever some aspect of care has been negligently performed. One aspect of such legal action is the vicarious liability of surgeons.

Growing primarily out of the doctrine of respondeat superior, a broader concept of vicarious liability arose in certain situations to place liability for negligently caused injuries occurring in the operating room upon the surgeon in charge of the operation. He may incur this liability despite the fact that his action was not the direct or proximate cause of the injury and despite the fact that he did not employ, in the ordinary sense, the individual whose action was the proximate cause of the injury. It has been argued in support of this result that the surgeon is the temporary employer of those persons working with him in the operating room, that they are his borrowed servants, or that his general position of being in charge of the operation makes him a “captain of the ship” and liable for the negligence of his inferiors.

In recent years this responsibility of the surgeon has been the subject of some disagreement and conflict in decisions. The purpose of this note will be to outline the nature and scope of the surgeon’s vicarious liability and to examine a theory of proper separation of responsibility within the operating room.

I. Introduction

A. Vicarious Liability Generally

The doctrine of vicarious liability has been a familiar legal concept since the days of primitive law. The principle appears, at first glance, to be a simple one: liability without fault. Because of the relationship existing between A and B, the negligence of A is charged to B, and B is liable to an injured third party, “although B has played no part in it, has done nothing whatever to aid or encourage it, or indeed has done all that he possibly can to prevent it.”1 In earlier

times the result was justified under a number of insufficient theories, including natural justice, a fiction of implied command from the master to the servant, a belief that the party who sets the force in motion initially ought to be responsible for its consequences, and the necessity for forcing upon masters the careful choice of servants. It has even been advocated because of the employer’s "deep pocket," an approach which at least de-emphasizes a search for justice.

More recently, justification for the principle of vicarious liability has been found in the control or right of control of a master over his servant. Furthermore, it is now universally accepted that the doctrine is in fact rooted in public policy.

B. Respondeat Superior and Surgeons' Liability

The most common basis for a surgeon’s liability for the negligence of another is founded upon the doctrine of respondeat superior, which holds the physician liable for the negligence of his employees. The liability stems from the master-servant relationship and most commonly concerns the action of a nurse, assistant, or technician who is on the payroll of the defendant physician. A full discussion of respondeat superior is beyond the scope of this note, and consequently, there will be only a short mention here of some of the general principles which will have a bearing upon this article’s subject matter.

To begin with, the physician will not be vicariously liable unless his employee was both directly liable for the damages and was also acting within the scope of his employment. Furthermore, the negligent party must qualify as a servant of the physician master. Here, this issue is easily resolved, assuming that there is the normal employer-employee relationship, but the matter becomes both crucial and more complicated when the concepts of "borrowed servant" and "captain of the ship" are considered. The Restatement of Agency defines a servant as follows:

A servant is a person employed to perform services in the affairs of another and who with respect to the physical conduct in the performance of the services is subject to the other's control or right to control.

One form or another of this definition is crucial to the outcome of cases seeking to hold a surgeon liable for the negligence of those with whom he works for only a short period of time in the operating room.

3 T. Baty, Vicarious Liability 154 (1916).
4 W. Prosser, supra note 1, at 459; Laski, supra note 2, at 111;
6 If that employer is compelled to bear the burden of his servant's torts even when he himself is personally without fault, it is because in a social distribution of profit and loss, the balance of least disturbance seems thereby best to be obtained.
7 See 1 D. Louisell & H. Williams, Medical Malpractice ¶¶ 16.01 and 16.02 (1960).
8 Restatement (Second) of Agency § 251 (1958):
   A principal is subject to liability for physical harm to the person or the tangible things of another caused by the negligence of a servant or a non-servant agent:
   (a) in the performance of an act which the principal is under a duty to have performed with care;
   See W. Prosser, supra note 1, at 460-66.
7 Restatement (Second) of Agency § 220(1) (1958).
II. The Borrowed Servant and Captain of the Ship Doctrines

It is clear that the principles of vicarious liability and *respondeat superior* are not limited in their application to the common employer-employee relationship discussed above. A person need not be on the payroll in order to qualify as a servant, although salary may be evidence of a master-servant relationship. This principle is recognized by the Restatement (Second) of Agency:

Servant Lent to Another Master

A servant directed or permitted by his master to perform services for another may become the servant of such other in performing the services. He may become the other’s servant as to some acts and not as to others.

This concept has been known as the “borrowed (or loaned) servant” doctrine; it has a common application in the area of medical malpractice which stems from the working relationship between a staff physician and various employees of a hospital. It has often been found that certain hospital employees have become, in a specific task, the borrowed servants of the physician, particularly the surgeon in charge of a procedure in the operating room, whose control and authority over those employees have been likened to that of the captain of a ship over his crew. The doctrine thus serves to subject the surgeon to vicarious liability for the negligence of those hospital employees who have become his temporary or borrowed servants. The basic idea is straightforward yet there is a great deal of complexity and disagreement concerning the circumstances under which a negligent party may be considered a servant and of whom that person is a servant. Several tests or criteria have been proposed for making this determination.

A. Control: The Borrowed Servant

The basic and most commonly applied test to determine the existence of a master-servant relationship centers around the concept of control or right of control. As one court put the test: “He is to be deemed the master who has the supreme choice, control and direction of the servant and whose will the servant represents, not merely in the result of his work, but in all of its details.” In the simple employer-employee relationship, control is really presumed, and the central issue is whether the employee is acting “within the scope of his employment.” However, with regard to a borrowed servant, the issue is complicated by the existence of more than one potential master, each exercising some degree of control over the servant. This duality of control has been described as an ambiguity between short term and long term control, and the same concept...
has been found in many of the malpractice cases in a confusion over whether the test is in fact based upon actual control or rather upon simply the right to control.

It is important to remember that however one characterizes the test, the issue remains vicarious liability. The whole matter of control does not explain why vicarious liability is imposed, but rather it only serves to guide in the determination of when the master-servant relationship (a prerequisite for vicarious liability) exists. Courts that have chosen to look for actual control have used several guidelines and have ostensibly based their inquiry upon the factual circumstances of each case.

1. Presence or Absence of the Surgeon

The actual control approach to the master-servant relationship tends to focus upon the ability of the master to tell the worker what to do, how to do it, and when it should be done.4 In terms of the vicarious liability of a surgeon for the negligence of hospital employees, many decisions have turned upon the presence or absence of the surgeon, perhaps reflecting the view that the hospital employees are primarily servants of the hospital except in those cases where the surgeon has borrowed them and is with them, directing their activities.

One line of cases which clearly shows this principle has consistently denied the vicarious liability of a surgeon for the negligence of hospital employees in carrying out an order for medication or treatment. Such an order may be written on the patient's medical chart, phoned in to the hospital, or even given verbally; the point is that the order is merely that the patient is to receive something at a certain time or times of the day. Perhaps the most common example is the order for medication, where an injection is negligently given,15 the wrong medication is given,16 or the wrong dosage is given.17 In these cases the surgeon (or other physician) has not attempted, nor would he be expected, to actually supervise or direct the administering of the injection. There is no question that the physician, should he choose to do so, could come to the hospital and actually direct the hospital employee. However, he is not actually controlling the activity, regardless of any right to control, which is determinative in these cases. Vicarious liability has been denied in similar instances of the physician's absence as well.18

Many cases focusing upon actual control have found the physician vicariously liable based on his presence and supervision. One such case is *Aderhold*

17 Harlan v. Bryant, 87 F.2d 170 (7th Cir. 1936).
v. Bishop\textsuperscript{19} based on an operating room setting. The plaintiff was undergoing an operation for the removal of a goiter when she sustained burns on both feet, caused by the negligence of the operating room nurse and other hospital-employed assistants. The court held that the nurse’s negligence was imputable to the operating surgeon’s stating:

While the head nurse and her assistants were the general employees of the [hospital], they were, nevertheless, during the time required for the actual operation, under the direction and supervision of the operating surgeons, and were the servants of the operating surgeons in respect to such services as were rendered by them in the performance of the operation, and for any negligence on the part of such employees in the performance of such services the operating surgeons are liable.\textsuperscript{20}

The court went on to make it clear that actual control was what was required, stating:

\textit{The true test of the existence of the relation of master and servant in a given case does not depend upon whether the servant was in the general employ of the master, but upon whether the master actually exercises supervision and control over the servant during the time he uses such servant.}\textsuperscript{21}

An excellent illustration of the distinction between the actual control and the right to control approaches may be found in Martin v. Perth Amboy General Hospital.\textsuperscript{22} Plaintiff underwent surgery for the removal of an obstruction in his abdominal aorta. It was later discovered that during the operation a laparotomy pad (surgical sponge) had been left in the plaintiff’s abdomen. Recognizing the accepted New Jersey view that a sponge count was the duty of the nurse acting as a servant of the hospital, the court nevertheless found the surgeon vicariously liable because he had instructed the nurse to remove the ring normally attached to such sponges to facilitate locating the sponges during an operation.

Other cases have also based the vicarious liability of the surgeon upon direct control, evidenced at least in part, by his presence.\textsuperscript{23}

2. Expertise of the Servant

It should be pointed out that, as used here, the phrase, “expertise of the servant,” is a contradiction in terms. A number of cases have found that the

\begin{notes}
\textsuperscript{19} 221 P. 752 (Okla. 1923).
\textsuperscript{20} Id. at 754.
\textsuperscript{21} Id. at 755 (emphasis added).
\textsuperscript{22} 104 N.J. Super. 335, 250 A.2d 40 (1969).
\textsuperscript{23} It is important to point out that in these cases and in \textit{Martin} the directness of the surgeon’s control goes to establishing the master-servant relationship and not to establishing any direct negligence on the part of the surgeon himself.
\end{notes}
surgeon is not vicariously liable for the negligent acts of a member of the surgical team where the negligent party is acting in a sphere in which he is an expert. The two most common areas of the application of this principle are the negligence of a medical specialist to whom the patient has been referred and the negligence of an anesthesiologist in the operating room.

In *Seneris v. Haas*, an obstetrician was held not vicariously liable for the negligence of an anesthesiologist who administered a spinal anesthetic negligently where it appeared that the obstetrician was not present until the anesthetic had been given. Yet, the presence or absence of the surgeon is not determinative under this theory. In *Marvulli v. Elshire* the plaintiff was undergoing surgery when she suffered an adverse reaction (hypoxia) to the anesthetic. The surgeon was present during the mishap, and yet the court ruled that he could not be held vicariously liable for any negligence of the anesthesiologist, who was a specialist in his field.

The rationale of isolating the surgeon, although he is in one sense in charge of the operation, from vicarious liability is that each physician (the surgeon and the anesthesiologist) performs separate and distinct work independent of the other, and unless there is evidence of medical practice or custom to the contrary, the negligence of one is separate from the negligence of the other. The anesthesiologist, qualified in a specialized field of medicine, is given the entire charge of the administration of the anesthetic; his individual expertise precludes a master-servant relationship.27

The second area of concern under the “expertise” test is the negligence of a specialist to whom the patient has been referred. This issue is rather easily resolved. The vast majority of the courts hold that there is no liability without some sort of direct negligence. An example of this principle is found in *Collins v. Hand*. The plaintiff brought an action against her physician on the theory of *respondeat superior* for the negligence of members of a team administering electroshock therapy. The court found that since the doctor had not administered such treatments personally for a considerable length of time, he was seeking to have the matter handled by experts; and thus he had neither effective control nor the right to control their activities. A similar case is *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, which raised the issue of the liability of a thoracic and cardiovascular surgeon for the negligence of a hospital team in performing a specialized diagnostic procedure (an aortography). The court held that the surgeon could not be vicariously liable for acts over which he had and could have no control, noting that:

[T]o hold that the attending surgeon who does not participate ... in the procedure is liable for the acts of a competent team supplied by the hospital

would be against the best interests of patients generally. The patient by
the use of such a team gets the benefit of medical people who have become
experts in the particular procedure.\textsuperscript{31}

The defendant surgeon had arranged for the special procedure to be done by the
hospital team under the direction of a physician whose expertise was founded
on five years' experience in surgery as well as on his position of being in charge
of all special diagnostic procedures having to do with the injection of radi-
opaque or contrast material into the blood vessels.

Cases decided upon the "expertise" test often place a great deal of signif-
icance upon established medical practice or custom, giving some latitude to the
medical profession to seek better care for patients through increased special-
ization.\textsuperscript{32}

3. Medical Versus Nursing or Routine Tasks

There is a line of cases that seeks to distinguish between "medical" and
"nursing" procedures in order to determine whether control exists.\textsuperscript{33} It is a
somewhat difficult distinction to make when placed in that framework. As
mentioned above, there is indeed a line of cases giving cognizance to the indepen-
dent nature of treatment administered by floor nurses and interns in the regular
course of service furnished by a hospital. The basic point of such cases is that
the physician will not be held vicariously liable for acts negligently performed
in his absence by hospital personnel where such treatments are of the type that
are expected to be performed in a routine manner. In this sense, these cases are
analogous to the "expertise" cases, because the courts will look to recognized
medical practice and custom and will decide upon the physician's liability accord-
ing to the propriety of his having delegated the task.

However, there are a number of cases that take a similar distinction even
further, applying the test in situations where the physician is actually present
when the negligent act occurs. These cases recognize a sphere of activity for
certain hospital personnel over which the physician will not ordinarily exercise
control. Such an activity could be a sponge or instrument count during an
operation\textsuperscript{34} or the preparation of a particular machine to be used by the surgeon
during the operation.\textsuperscript{35}

This minority view seems to recognize some vague form of division of
responsibility among all members of the medical care team. However, it is sub-
ject to the criticism that it ignores the basic thrust of vicarious liability because

\textsuperscript{31} Id. at 574, 317 P.2d at 178-79.
\textsuperscript{32} See discussion in text corresponding to notes 58-76 infra.
\textsuperscript{33} See 50 Geo. L.J. 329, 332 (1961).
\textsuperscript{34} Hall v. Grosvenor, 267 Ill. App. 119 (1932); Olander v. Johnson, 258 Ill. App. 89
(1930); Grant v. Touro Infirmary, 254 La. 204, 223 So. 2d 148 (1969); Martin v. Perth
\textsuperscript{35} Clary v. Christiansen, 54 Ohio L. Abs. 254, 83 N.E.2d 644 (Ohio Ct. App. 1948);
May v. Broun, 261 Ore. 28, 492 P.2d 776 (1972). See also Nichter v. Edmistion, 81 Nev. 606,
407 P.2d 721 (1965) (application of excessive amount of disinfectant is not subject to
surgeon's direct control).
it focuses too closely upon the factual circumstances and overlooks the principle that vicarious liability is a creature of policy.\textsuperscript{36}

\section*{B. Right to Control: Captain of the Ship}

The captain of the ship doctrine had an inauspicious beginning in Pennsylvania in the case of \textit{McConnell v. Williams},\textsuperscript{37} where the court removed a non-suit in favor of an obstetrician by holding that there was a factual question for the jury, under familiar agency principles, as to whether the obstetrician could be vicariously liable for the negligence of an assisting intern. In deciding that issue the court stated:

\begin{quote}
[I]n the course of an operation in the operating room of the hospital, and until the surgeon leaves the 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 the ship over all on board.\textsuperscript{38}
\end{quote}

The decision simply applied basic agency principles to medical malpractice actions by bringing the concept of the "borrowed servant" to the setting of the operating room.\textsuperscript{39} The principle was followed in the similar case of \textit{Benedict v. Bondi},\textsuperscript{40} where the court removed a non-suit in favor of a surgeon who was supervising a nurse in a preoperative procedure when she negligently burned the patient.

It seemed clear from these two decisions that the captain of the ship doctrine was not an extension of the borrowed servant concept, but rather a mere analogy describing the type of control which exists in a certain set of factual circumstances. Indeed, the Supreme Court of Pennsylvania, as recently as 1971, so stated.\textsuperscript{41} In using that simple analogy, \textit{McConnell} and \textit{Benedict} laid the foundation for a broadening of and a deviation from the borrowed servant doctrine. This resulted in a quite liberal approach to finding an operating surgeon vicariously liable for the negligence of those who are only tenuously subject to the surgeon's right to control.

An example of the conceptual expansion can be found in \textit{Yorston v. Pennell}.\textsuperscript{42} It was the first Pennsylvania case finding the surgeon vicariously liable for negligence occurring outside the operating room and in his absence. The defendant surgeon was found liable for the negligence of an intern who failed to record the patient's allergic sensitivity to penicillin while he was recording the patient's medical history in the emergency room. Furthermore, the actual surgical procedure was performed by a hospital resident substituting for the sur-
The Court applied the captain of the ship analogy to find the requisite control by the absent surgeon over the intern in the emergency room. From this decision it is clear that Pennsylvania's captain of the ship doctrine has a different emphasis, which reflects a different policy, from the borrowed servant cases discussed above. Yorston shows that the whole thrust of captain of the ship doctrine hinges upon an inquiry into a right to control rather than actual control or present supervision. The emphasis in McConnell upon the presence of the surgeon was no longer significant.

In Rockwell v. Kaplan and its companion case, Rockwell v. Stone, a further extension is found. In Stone the court held that the anesthesiologist was liable for the negligence of his subordinate in a pre-operative administering of the anesthetic, sodium pentothal. Although not present at the time of the mishap, Dr. Stone was the chief of the Anesthesiology Department and had ordered the resident to administer the anesthetic. Surprisingly, the court in Kaplan went on to decide that Dr. Kaplan, the surgeon, was also vicariously liable, despite the fact that it was not established that the surgeon had any authority other than to order that the administering of the anesthetic begin in preparation for surgery. It is, of course, clear that such authority is in fact a right to control in the broadest sense, but two points about this right to control are worthy of mention.

The first concerns the matter of the expertise possessed by an anesthesiologist in his specialized field. The authority of the surgeon to order the beginning or cessation of the administering of the anesthetic is in fact insufficient to establish a master-servant relationship; in reality the relationship is one of the master (the surgeon) to an independent contractor (the anesthesiologist) at least in the absence of any conduct on the part of the surgeon which would suffice to make the actions of the anesthesiologist his own.

The second point concerns policy. The attempt in the Rockwell decision to base a finding of control completely upon the facts ignores the policy behind McConnell and the cases limiting a surgeon's vicarious liability to the operating room setting. Those cases reflect a judicial concern to limit the extent of respondeat superior in order to protect the hospital during the time the surgeon is directing the operation and to protect the surgeon during the time that the patient is subject to the activities of the hospital.

Two years after the Rockwell cases the United States Court of Appeals for the Third Circuit, applying Pennsylvania law, decided two companion cases similar to Rockwell, with similar results—Mazer v. Lipschutz and Mazer v. Chodoff. The plaintiff-administrator brought a wrongful death action based upon the presence of the surgeon was no longer significant.

44 361 Pa. at 362, 65 A.2d at 246.
47 See discussion in the text corresponding to notes 24-32 supra.
48 See Laski, supra note 2, at 114: "The real problem in vicarious liability, in fact, is not so much the rectitude of its basal principles, as the degree in which they are to be applied."
49 327 F.2d 42 (3d Cir. 1963).
50 Id.
on the negligence of supplying a surgery patient with incompatible blood. Upon receiving the fresh blood in the operating room, the anesthesiologist summoned the blood bank technician to explain an apparent discrepancy in the labelling of the pack. The technician explained to the anesthesiologist that the error was merely clerical and that it was safe to administer. The court found that because of the negligence of the technician the anesthesiologist was not liable. Yet, under the captain of the ship doctrine, it found that the surgeon was vicariously liable because he was in charge of the operating room at the time of the discussion between the technician and the anesthesiologist.\footnote{53}

In both \textit{Rockwell} and \textit{Mazer} it can be seen that the captain of the ship doctrine vastly expands the liability of surgeons. In both cases the negligence occurred out of the presence of the surgeon (in \textit{Rockwell}, in the anesthesia induction room; and in \textit{Mazer}, in the laboratory) and was totally beyond his ability to control. The result appears to be unjust.

In 1968 the Pennsylvania Supreme Court began to return from this extreme position in the case of \textit{Collins v. Hand}.\footnote{55} The Court implicitly overruled \textit{Rockwell} in holding that the mere right to order the beginning and end of performance was insufficient control to establish a master-servant relationship. It pointed out that:

\begin{quote}
The crucial test in determining whether an employee furnished to another becomes the servant of the one to whom he is loaned is whether he passes under the latter's right of control with regard not only to the work to be done but also as to the manner of performing it.\footnote{53}
\end{quote}

As pointed out above,\footnote{54} this view is more in keeping with the principles of general agency law and the recognition of the concept of the independent contractor.

The most recent Pennsylvania case has ostensibly brought the captain of the ship doctrine to within the confines of the "borrowed servant" concept. In \textit{Thomas v. Hutchinson}\footnote{56} the court said that "the 'captain of the ship' concept is but the adaptation of the familiar 'borrowed servant' principle in the law of agency to the operating room of a hospital."\footnote{56} The lower court had directed a verdict in favor of the plaintiff on the issue of the surgeon's vicarious liability for the negligence of the assisting residents after the surgeon had left the operating room. The two negligent physicians were surgical residents, employed and selected by the hospital to assist in this particular operation. After successfully removing a ruptured disc, the surgeon left the operating room as he allowed the residents to close the incision and to remove the remaining sponges, but one of the sponges was negligently left in the wound.

The Pennsylvania Supreme Court made two major findings. First, it held that the trial court was in error for directing the verdict on the issue of vicarious liability based solely upon the pretrial deposition of the surgeon (he had died

\footnote{51} \textit{See id.} at 49-52.  
\footnote{52} 431 Pa. 378, 246 A.2d 398 (1968).  
\footnote{53} \textit{Id.} at 394, 246 A.2d at 406.  
\footnote{54} \textit{See text corresponding to notes 28-32 supra.}  
\footnote{55} 442 Pa. 118, 275 A.2d 23 (1971).  
\footnote{56} \textit{Id.} at 125, 275 A.2d at 27.
before the trial), that the residents were his assistants, and that he was directing the operation. The master-servant relationship, the court said, was for the jury to determine. Secondly, however, the court held that this decision was for the jury to make solely on a factual basis. This view completely overlooks the nature of respondeat superior liability as a creature of policy. As such the issue of the master-servant relationship is a mixed question of law and fact, with the expectation that the court may direct a verdict when the facts are not substantially in dispute and that, otherwise, the court will provide the jury with a standard to which they may apply the facts.

This failing of the Thomas court appears to be the primary shortcoming of the captain of the ship doctrine in its present status. Although the doctrine is ostensibly limited to the operating room setting, the jury is allowed to roam too freely with respondeat superior, a doctrine of policy which would better serve both patient and physician (and, therefore, the ends of justice) were its scope to be more clearly defined.

III. Separation of Responsibility in the Operating Room

A. The Surgeon and Hospital Employees

During the course of a surgical procedure in the operating room of a hospital, the control possessed by the surgeon in charge, whether described under the captain of the ship doctrine or under the basic borrowed servant principle, is quite uniformly recognized by the law as sufficient to create a master-servant relationship between the surgeon and the employees. The corresponding vicarious liability of the surgeon for the negligence of a nurse, technician, orderly, or other assistant seems appropriate in terms of the purpose of the doctrine of respondeat superior. The surgeon is in fact in charge of the operation, giving him both the right to control and actual control of all activities associated with the procedure.

However, as was noted above, some courts have found the surgeon free from vicarious liability for negligence occurring even in his presence where it appears that the hospital employee is carrying out an activity which is more properly characterized as a hospital or nursing task. The reasoning of those cases gives little guidance; the courts seem to beg the question, finding simply that there was no control.

Yet the thrust of the principle raised by those decisions is sound in its attempt to recognize that a hospital, with its vast and complex framework for patient care, has some form of independent service to provide, perhaps even in the operating room. Each member of the surgical team is present in the operating room for a purpose, and the fact that the hospital employs, trains, and sets standards for the surgical activities of the nurses, technicians, and orderlies belies the fiction of exclusive control in the hands of the surgeon.

58 See discussion in text corresponding to notes 19-23 and 37-41 supra.
59 See discussion in text corresponding to notes 33-36 supra.
Furthermore, although it might be properly said that these facts of modern hospital life have no bearing upon the issue of liability without fault, it does not follow that both the surgeon and the hospital may not be vicariously liable. As can be seen by the Restatement, agency law recognizes that both masters could well be liable:

Servant Acting for Two Masters

A person may be the servant of two masters, not joint employers, at one time as to one act, if the service to one does not involve abandonment of the service to the other.60

Both the surgeon and the hospital are acting to provide care for the patient, and it is clear that the activities of the nurse serve that mutual interest of the two.61

There are perhaps two principal reasons for the failure of courts to find joint and several liability in the operating room context. The first is that, until recently, the doctrines of charitable and governmental immunity62 have had an effect upon the courts. This was recognized in Thomas v. Hutchinson63 where the Court noted that the captain of the ship doctrine,

... was announced before the decision of this Court in Flagiello v. Pennsylvania Hosp., discarding the immunity from liability in tort previously enjoyed by public hospitals. In enunciating the "captain of the ship" theory in McConnell, it was no coincidence that this Court noted, "if operating surgeons were not to be held liable for the negligent performance of the duties of those then working under them, the law would fail in large measure to afford a means of redress for preventable injuries sustained during the course of such operations."64

The present trend toward eliminating the immunities65 should relieve the courts of this concern to a great extent.

The second reason inclining the courts to look primarily to the surgeon for vicarious liability is a feeling that it would not be appropriate to hold the hospital liable where a nurse was merely following orders.66 The result in such a case should and probably would be that the following of a direct order from the surgeon would place the liability back upon him.67

60 Restatement (Second) of Agency § 226 (1958).
61 See Dickerson v. American Sugar Refining Co., 211 F.2d 200, 203-04 (3d Cir. 1954); D. Louisell & H. Williams, supra note 5, at 499.
62 See IIA Hospital Law Manual, Negligence: Immunities to Suit (1973); see generally W. Prosser, supra note 1, at §§ 131, 133.
64 Id. at 126, 275 A.2d at 27 (footnote omitted).
66 See D. Louisell & H. Williams, supra note 5, 499-500.
67 Id. The principle of joint and several liability in the borrowed servant context is proposed and defended in Skogland, supra note 14, at 317-21.
B. The Surgeon and Other Physicians

The most common situation involving multiple physicians in the same operating room is the basic surgical procedure with one surgeon and one anesthesiologist. As was pointed out above, many courts have felt that the individual expertise of the specialist in anesthesiology precludes viewing him as the servant of the surgeon.

This view is supported under a contract theory, as can be seen in Wiley v. Wharton, where the court concluded that a contract for professional services arose between the patient and the anesthesiologist, despite the fact that the anesthesiologist had been recommended by the surgeon. The result could, of course, be different if the surgeon had entered into a contract with the patient to perform the anesthesia service as well as the surgery. The view is also supported by the expectations of the patient. The anesthesiologist today makes rounds in the hospital to see his patients in much the same way as does the surgeon. In such a situation it is difficult to imagine how a patient could view the surgeon as the "ostensible owner" or master of the anesthesiologist.

The independence of the anesthesiologist is most strongly mandated by the expert nature of his specialized field under the basic agency principle of the independent contractor. The expertise of the anesthesiologist was recognized in Huber v. Protestant Deaconess Hospital Association where the court pointed out:

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

While [the surgeon] requested that the hospital furnish an anesthetist it appears to this court that there is nothing shown in the circumstances of this record, when applied to the existing rules of law, which would render . . . [the surgeon] liable for the negligent acts of this trained specialist.

A number of other cases have found this reasoning compelling and have been led by the facts of modern medicine to reach a similar conclusion. 

68 See discussion in text corresponding to notes 24-27 supra.
69 68 Ohio App. 345, 41 N.E.2d 255 (1941).
70 "Ostensible owner" is an agency principle holding one liable for the negligence of another if he allows himself to appear to be the master of the other; see Santise v. Martins Inc., 258 App. Div. 663, 17 N.Y.S.2d 741 (1940); see also Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 496 (1972).
71 See RESTATEMENT (SECOND) OF AGENCY § 220(2) (1958), for a list of factors to be considered in distinguishing between a servant and an independent contractor.
73 Id. at 576-77, 133 N.E.2d at 869-70.
74 Dohr v. Smith, 104 So. 2d 29, 32 (Fla. 1958).

[It is clear to us that he [the surgeon] and the anesthetist were working in highly expert fields peculiar to each and that despite the common goal, the successful repair of the patient's ulcer, their responsibilities were not inextricably bound together.


And even assuming that Lillehei was "surgeon-in-charge" or "Captain of the Ship," as urged, does it follow that he is responsible for the negligence, if any, of an anesthesiologist such as Dr. X, assigned to the case by his own superior, exercising his own independent special medical knowledge in performing his duties without any specific directions from Lillehei? I don't think so. . . .
In addition to the anesthesiologist there will likely be found a greater number of other specialists in the operating room as surgeons' medical practice broadens and as more particular specialization arises to cope with the wider scope. In a complicated surgical procedure with more than one specialist operating, the division of responsibility among the surgeons themselves is a difficult issue. As stated by Professors Louisell and Williams:

> While definite allocation of responsibility between anesthesiologist and surgeon is relatively easy to effect on a sensible basis, uncritical extension of the policy of such allocation to other relationships is fraught with danger to the patient... [S]ome situations in modern surgery appear so complex, particularly when... an unusually large number of people participate, that there should be one person, ... charged with the coordination and supervision of all procedures.\(^7\)

Any dispute over the propriety or degree of division of responsibilities in the operating room must focus primarily upon the benefit to be given to the patient. To begin with it is axiomatic that the patient will gain from the increased medical knowledge and talents of surgeons who choose to study in more specialized fields. What remains unclear is whether the legal response to the increased specialization should be a blind reflection of the separation of medical expertise or whether it should ignore the fact of medical progress and adhere to a doctrine that may be both obsolete and unjust in light of the realities of modern medicine.

A step in the right direction, however, would be an acceptance of legal reality and an abandoning of troublesome legal fictions like the captain of the ship doctrine. "Like most of its kind... [it]... is simply a stumbling block in the pathway of juristic progress. It is one of those dangerous generalizations which shivers into untruth upon the approach of fact."\(^7\) Liability without fault should be recognized and approached as a principle of policy.

The policy, that underlying respondeat superior, is substantially designed for the benefit of innocent plaintiffs, and yet it is artificially limited by its own terms. Indeed, this artificiality gives the principle one of its greatest advantages: stability. Once it is accepted that there is a division of responsibility between the surgeon and the anesthesiologist, there arises a need for the law to allocate, in whatever proportion, the responsibility among the other possible participants in an operation. When there are multiple surgical specialists working on the same operation, each owes the same high degree of care to the helpless patient. Each should be directly liable to the patient, therefore, to the degree that he exercises his independent judgement. When a hospital employee is involved the hospital

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\(^7\) To extend the doctrine of respondeat superior to a situation such as that reflected in the evidence would be to strain the doctrine beyond the basis for its creation. Brossard v. Koop, 200 Minn. 410, 274 N.W. 241 (1937); see also Morey v. Thybo, 199 F. 760 (7th Cir. 1912).


\(^76\) Laski, supra note 2, at 107.
should be subject to vicarious liability, and the surgeon using his services should be jointly liable.

A properly delineated separation of responsibility would serve the medical profession by providing a stable legal principle and the patient by assuring him that the law will provide him with a means of recourse against whoever might be deriving profit from this particular aspect of society's growing complexity.

J. Talbot Young, Jr.