The Borrowed Servant Doctrine as it Applies to Operating Surgeons

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many businesses, these imbalances would tend to be equalized.[48] Although certain difficulties mentioned above may be inherent in the suggested method it appears to be superior to the present system.

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I. Respondeat Superior and the Borrowed Servant Doctrine

The doctrine of respondeat superior is a great aid to plaintiffs in prosecuting many types of claims. The rule, succinctly stated, is that a master is liable for the torts of his servant committed within the scope of employment.[1] The employer's vicarious liability, an exception to the general law of negligence, imposes responsibility for the loss on one who was not negligent and did not participate in the injury. The legal principle of respondeat superior is firmly entrenched in Anglo-American law, but its origin is uncertain. The many explanations for its true basis range from a notion that a servant is the alter ego of his master[2] to the pragmatical idea that public policy requires that responsibility for the loss shift to the employer to better indemnify injured parties.[3] The latter basis seems to be the best justification for the rule because if claimants are to receive adequate compensation, it is usually necessary that they be able to proceed against the more affluent employer. To this end, respondeat superior is consistent with the needs of a complex civilization.[4]

Under general agency principles, a servant may have two masters

states in which large manufacturing enterprises are located, because of the vague or nonexistent methods of apportionment, are able to derive more tax revenues by attributing a larger share of the business' income to the taxing state. The method of apportionment suggested above possibly could result in some discrimination in favor of the purchasing states.

[48] The imbalances caused by discrimination against manufacturing states (*e.g.*, Michigan) might be roughly equalized by the slight discrimination in their favor in situations where they are purchasing rather than manufacturing states. An illustration of this might be found in comparing the effects on the state revenues of New York and Michigan in relation to General Motors, a Michigan based operation, and International Shoe, a New York concern.

[1] Mechem, Agency § 237 (4th ed. 1952).

[2] "[T]he use of the fiction that 'the act of the servant is the act of the master' has made it seem fair to subject the non-faulty employer to liability for the negligent . . . conduct of his servants." Restatement (Second), Agency, Intro. Notes § 219, comment on Subsection (1) at 483 (1958).

[3] "[D]amages are taken from a deep pocket." Batv. Vicarious Liability 29 (1916).

[4] See generally Mechem, Agency §§ 350-363 (4th ed. 1952).

at the same time.[5] If such a servant commits a tort, in order to apply the principles of respondeat superior, it must be determined which master is employing the servant for the purposes of that particular act.[6] The test for determining whether the servant is the employee of the general employer or the *borrowed servant* of a special employer is based upon control.[7] It is generally held that the mere right of control is of itself sufficient to create a master-servant relationship; the exercise of that right is not necessary.[8] Of course, whether or not there is a right to control and whether the right has been exercised are questions of fact for the jury.[9]

II. The Borrowed Servant Doctrine in Medicine

The broad principles of agency apply with equal efficacy to all employers. Thus, a doctor-employer is liable for the torts of his employees on the same basis and to the same extent as any other employer.[10] There is little argument with this rule. However, questions frequently arise concerning a doctor's liability for the acts of hospital personnel, who, although technically not the employees of the doctor, assist him in some manner. In this type case the borrowed servant doctrine is frequently applied to render the doctor liable for his then-servant's negligent acts according to general respondeat superior principles.[11]

The borrowed servant doctrine as applied in the field of medicine has produced some interesting results. The physician-patient cases are sui generis in the law of agency because of the unique limitations which have been placed upon a free application of the borrowed servant doctrine and the right of control test. The cases generally may be divided into two classifications—operative situations and non-operative situations. In cases involving the operating room, it is held by the great weight of authority that the surgeon is in absolute control of his assistants and nurses during the course of the operation and is responsible for their negligent acts. Such holding is not altered by the fact that these people are general employees of the hospital

[5] Dickerson v. American Sugar Ref. Co., 211 F.2d 200 (3d Cir. 1954). "A servant directed or permitted by his master to perform services for another may become the servant for such other in performing the services. He may become the other's servant as to some acts and not as to others." Restatement (Second), Agency § 227 (1958).

[6] See, *e.g.*, Denton v. Yazoo & M.V.R.R., 284 U.S. 305 (1932).

[7] Restatement (Second), Agency § 220(1) (1958).

[8] See, *e.g.*, Pennsylvania Smelting & Ref. Co. v. Duffin, 363 Pa. 564, 70 A.2d 270 (1950).

[9] Restatement (Second) Agency, § 220(1), comment c, § 227, comment a (1958).

[10] Simons v. Northern Pac. Ry., 94 Mont. 355, 22 P.2d 609 (1933).

[11] See cases cited note 12 *infra*.

and receive their compensation from the hospital.[12] The surgeon-in-charge has been characterized as the "captain of the ship"[13] because in the operating room the surgeon's right of control is paramount. It is implicit in the opinions[14] that the courts consider the doctor's presence in the room as tantamount to his exercise of control over his assistants. At least such presence gives rise to an eminent ability to control and an actual opportunity to supervise. Distinctions are drawn, however, in at least two situations,[15] subjecting the surgeon's absolute control to limitation. If a nurse performs an act which is normally the function of the hospital, the surgeon's right of control is diluted; in such a case it may be held that the surgeon is not liable for the nurse's negligence in performing such ministerial duties.[16] Similarly, if the assistant possesses a professional degree of expertise, the liability of the surgeon-in-charge may be eliminated.[17] The courts which adhere to these distinctions seemingly would require actual

[12] See, *e.g.*, Ales v. Ryan, 8 Cal. 2d 82, 64 P.2d 409 (1936) (nurse left sponge in patient); Beadles v. Metayka, 135 Colo. 366, 311 P.2d 711 (1957) (nurse allowed patient to fall from table); St. Paul-Mercury Indemnity Co. v. St. Joseph's Hospital, 212 Minn. 558, 4 N.W.2d 637 (1942) (nurse burned patient with hot water); Jackson v. Joyner, 236 N.C. 259, 72 S.E.2d 589 (1952) (nurse negligently administered anesthesia); Aderhold v. Bishop, 94 Okla. 203, 221 Pac. 752 (1923) (nurse burned patient with hot water); McConnell v. Williams, 361 Pa. 355, 69 A.2d 243 (1949) (attendant damaged newborn baby's eyes with silver nitrate); Minogue v. Rutland Hospital, 119 Vt. 336, 125 A.2d 796 (1956) (attendant exerted excessive pressure on rib cage during child birth). *Contra,* Guell v. Tenney, 262 Mass. 54, 159 N.E. 451 (1928) (nurse miscounted sponges).

[13] McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949).

> Traditionally, the surgeon has been granted authority to exercise control over all activities and personnel in the operating room. All persons associated with a surgical operation are under his direct supervision. Therefore, negligent acts performed by his surgical assistants, nurses, or other personnel, *whether employed by him or not,* are imputed to him by law in most states. . . . These tenets have developed in common law out of legal and surgical necessity. For upon some one person must rest the legal responsibility to the patient. Wasmuth, Anesthesia and the Law 40 (American Lecture Series No. 448, 1961). (Emphasis added.)

[14] Cases cited note 12 *supra.*

[15] The medicinal vs. ministerial function distinction and the expertise distinction also have been used to some extent in nonoperative situations. See note 17 *infra.*

[16] Hallinan v. Prindle, 17 Cal. App. 2d 656, 62 P.2d 1075 (Dist. Ct. App. 1936) (nurse prepared wrong anesthesia, preoperative); Clary v. Christiansen, 83 N.E.2d 644 (Ohio Ct. App. 1948) (negligence of scrub nurse not attributable to surgeon, operative). For a discussion and criticism of the problems in attempting to implement this distinction see Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 4 (1957).

[17] See, *e.g.*, Thompson v. Lillehei, 164 F. Supp. 716 (D. Minn. 1958), *aff'd,* 273 F.2d 376 (8th Cir. 1959) (anesthesiologist allowed air embolism during operation); Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944) (anesthesiologist negligently administered anesthesia); Sherman v. Hartman, 137 Cal. App. 2d 589, 290 P.2d 894 (Dist. Ct. App. 1955) (anesthesiologist was negligent in giving patient transfusion); Dohr v. Smith, 104 So. 2d 29 (Fla. 1958) (doctor-anesthetist negligently administered anesthesia); Hubert v. Protestant Deaconess Hosp. Ass'n, 127 Ind. App. 565, 133 N.E.2d 864 (1956) (anesthesiologist negligently administered anesthesia); Meyer v. St. Paul-Mercury Indemnity Co., 61 So. 2d 901 (La. 1952) (doctor-anesthetist negligently administered anesthesia during oral surgery); Wiley v. Wharton, 68 Ohio App. 345, 41 N.E.2d 255 (1941) (anesthesiologist broke hypodermic needle off in patients spine). *Contra,* Voss v. Birdwell, 188 Kan. 643, 364

presence or an inclination to control before the master-servant relationship will be found to be present, because the *right* of the surgeon-in-charge to control still exists, and were this the minimum requisite, the surgeon's liability would necessarily follow.

In nonoperative situations most courts are reluctant to hold a doctor liable for the negligence of hospital employees.[18] A patient's well-being is a doctor's continuing responsibility, one that does not begin and end within the confines of the operating room. The doctor's *right* to control those who administer to his patients from admission throughout convalescense is unquestioned; but, in the nonoperative situations, the courts are unwilling to accept the right of control as being sufficient, standing alone, to give rise to a master-servant relationship. The majority of opinions which speak in terms of supervision and control imply that presence or an actual opportunity to control are prerequisite to the existence of a master-servant relationship and the resulting application of the doctrine of respondeat superior.[19] In the more liberal jurisdictions the borrowed servant doctrine has been given full play in the medical field. Even though both an employee's professional expertise and medicinal vs. ministerial function distinctions are recognized and often limit liability, doctors have been held liable in the more liberal jurisdictions in both operative and nonoperative situations under an application of respondeat superior.[20] These cases, although probably based on sound logic, represent a minority. The difficulties attending the application of the medicinal vs. ministerial function distinction to nonoperative situations make the right of control, in jurisdictions in which it is recognized independently, an exasperating fact question; and the various rationales behind the determination of which

P.2d 955 (1961) (anesthesiologist negligently administered anesthesia); Rockwell v. Stone, 404 Pa. 561, 173 A.2d 48 (1961) (hospital resident incorrectly injected anesthesia into patient).

[18] See, *e.g.*, Hohenthal v. Smith, 114 F.2d 494 (D.C. Cir. 1940) (nurse broke hypodermic needle off in patient, postoperative); Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955) (nurse negligently administered anesthesia, preoperative); Huber v. Protestant Deaconess Hosp. Ass'n, 127 Ind. App. 655, 133 N.E.2d 864 (1956) (nurse negligently administered wrong anesthesia with hypodermic needle, preoperative); Davis v. Trobough, 139 Mont. 322, 363 P.2d 727 (1961) (patient negligently burned by nurse, preoperative). *Contra,* Voss v. Birdwell, 188 Kan. 643, 364 P.2d 955 (1961) (anestheologist, a medical doctor of anesthesiology, negligently administered anesthesia, preoperative); McCowen v. Sisters of Most Precious Blood, 208 Okla. 130, 253 P.2d 830 (1953) (nurse allowed patient to fall from table, surgical preparation); Rockwell v. Stone, 404 Pa. 561, 174 A.2d 48 (1961) (hospital resident injected anesthesia incorrectly into patient, preoperative); Meadows v. Patterson, 21 Tenn. App. 283, 109 S.W.2d 417 (1937) (nurse allowed unconscious patient to injure himself, postoperative). All of the cited cases indicated by dicta that if the negligent act had occurred during the operation the surgeon would have been liable.

[19] See authorities cited notes 12 and 18 *supra.*

[20] Cases cited following *contra* signal in note 17 *supra.*

duties are ministerial and which are medicinal confound the imagination.[21]

III. Respondeat Superior and Borrowed Servant in Texas

Generically speaking, the same agency principles exist in Texas as in the majority of jurisdictions.[22] Recently, the Texas Supreme Court, in *Newspapers, Inc. v. Love*,[23] held that "the true test for establishing a master-servant relationship in a borrowed servant situation is whether or not the alleged employer has the power (right) to control."[24] The court regarded the power to control and the right to control as being synonymous. In addition, Justice Norvell differentiated "right of control" and "exercise of control" as being two separate and distinct concepts, saying that exercise of control is evidentiary, usable to show the extent and scope of the master-servant relationship. It is clear, however, "that the 'right of control' remains the supreme test and the 'exercise of control' necessarily presupposes a right to control. . . ."[25]

The body of agency law in Texas with respect to the physician-patient cases is largely undeveloped. Doctors have been held liable for their own negligence,[26] and also for the negligence of their employees. For example, an early case indicated that a surgeon would be liable for the negligence of his employees over whose actions he had dominion and control.[27] The recent case of *Porter v. Puryear*[28] held that the doctor-owner of a hospital and the operating surgeon both were liable for the negligence of the nurse-anesthetist in administering a spinal anesthesia prior to the operation. The doctor hospital-owner's liability resulted from an application of respondeat superior while the operating surgeon's liability was based upon the theory that the two physicians were engaged in a joint venture. It is inter-

[21] See text and authorities accompanying note 16 *supra*.

[22] Western Union Tel. Co. v. Rust, 55 Tex. Civ. App. 359, 120 S.W. 249 (1909) *error ref.* This early case recognized the rule that an employee could have a general employer and a special employer at the same time and that a special employer, if he has the right of control, is liable for the servant's negligence. Interestingly, this case, although not a malpractice situation, has been cited in supreme court opinions from two other states in malpractice cases sustaining the view that the surgeon is responsible for the negligence of a borrowed nurse.

[23] Newspapers, Inc. v. Love, 380 S.W.2d 582 (Tex. 1964). It should be noted that this case was decided by a bare 5-to-4 majority, with the minority dissenting very strongly. Moreover, one of the majority has since left the court. It will be interesting to see if the court will follow its holding in *Newspapers* if the question arises again in the future.

[24] *Id.* at 585.

[25] *Id.* at 590.

[26] Moore v. Ivey, 264 S.W. 283 (Tex. Civ. App. 1924), *rev'd on other grounds*, 277 S.W. 106 (1925).

[27] Lee v. Moore, 162 S.W. 437 (Tex. Civ. App. 1913).

[28] 153 Tex. 82, 262 S.W.2d 933 (1953).

esting to note that in *Porter v. Puryear* the joint defendants attempted to relieve the doctor hospital-owner from liability by asserting that "the anesthetist, Baker, was acting under the direction and control of [the surgeon] . . . in giving the spinal anesthetic,"[29] thereby tacitly assuming that the borrowed servant principle of agency would apply to the operative situation. The court, however, did not meet the issue of control, and the borrowed servant question remained open. Although *Porter v. Puryear* involved a joint venture, it is still significant because it does indicate that common law agency principles can be applied to hold a physician liable, without negligence on his own part, for the negligent acts of assistants whom he did not hire.

IV. McKinney v. Tromly

The first Texas case to apply the borrowed servant doctrine in the surgical situation is *McKinney v. Tromley*.[30] A child died when his lungs were severely burned by an explosion caused as the electrical apparatus used by the surgeon, Doctor Tromly, came in contact with the highly explosive ether anesthesia used during the course of a routine tonsilectomy. In response to the special issues submitted, the trial jury found the nurse-anesthetist, a hospital employee, negligent in using ether because an explosion is likely to occur in better than ninety per cent of the instances when the gas is used in conjunction with an electrical apparatus. Because there was no competent medical testimony establishing the surgeon's neglect, he was exonerated. Interestingly, the surgeon's right of control was stipulated. The court of civil appeals reversed the lower court and held Tromly liable as a matter of law for the negligence of the nurse-anesthetist, saying "that the nurse, although in the general employ of the hospital, was under the facts of this case an employee of Doctor Tromly while in the operating room and under his control."[31]

The practical result reached in *McKinney* is a good one. It seems just that liability for negligent injuries to patients incurred in the operating room should fall upon the surgeon, the man who has the right to control the acts of his assistants and the man to whom the patient looks for his protection. The surgeon is truly the man in charge. Unless there are extenuating circumstances which relieve him of his responsibility, the surgeon should answer for the torts of his borrowed servants whether or not he expressly ordered the servant to perform a certain act. It would be poor public policy to allow a

[29] *Id.* at 938.
[30] McKinney v. Tromly, 386 S.W.2d 564 (Tex. Civ. App. 1964).
[31] *Id.* at 565.

surgeon, by remaining silent, to avoid a liability that would be his if he exercised his right of control. A rule requiring that a doctor actually exercise his right of control in order that his liability commence would tend to encourage a doctor not to supervise his assistants properly; a doctor could never be liable for his omission unless by such omission he would be personally negligent. The result attained in *McKinney* is a logical extension of accepted agency principles into the surgical sphere. In so holding, the court wisely follows the weight of authority throughout the country on this point.

The problem in the *McKinney* case is not the result, but the court's failure to state clearly the reason for its holding. The court speaks in terms of general Texas agency law in citing a typical industrial case for the proposition that a servant may have both a general and a special employer at the same time;[32] but it is not clear if the court is also using the general agency test (right of control) in determining which employer is liable for the servant's torts,[33] or is attempting to limit right of control in borrowed servant surgical cases to the operating room. The court relied upon persuasive authority from the Supreme Courts of North Carolina,[34] Oklahoma,[35] Pennsylvania,[36] and Vermont.[37] The text of the opinion is composed primarily of excerpts from these cases, and it is somewhat difficult to determine just what the court actually is saying. Each case referred to by the court involved the operative situation, and each case conveyed the idea that the surgeon's liability would be limited to the borrowed servant's acts perpetrated during the operation and while the servant was under the control of the surgeon. Correspondingly, a possible inference might be drawn from the fact that the court selected *McConnell v. Williams*,[38] a case which apparently arbitrarily limits a doctor's liability to the physical boundaries of the operating room, rather than one of the later Pennsylvania cases which has given the borrowed servant doctrine full play in the field of medicine.[39] The question of how far a doctor's liability should

[32] Western Union Tel. Co. v. Rust, 55 Tex. Civ. App. 359, 120 S.W. 249 (1909), *error ref.*

[33] In Newspapers, Inc. v. Love, 380 S.W.2d 582 (Tex. 1964), the Texas Supreme Court set out the right of control test. See text accompanying note 23 *supra.*

[34] Jackson v. Joyner, 236 N.C. 259, 72 S.E.2d 589 (1952).

[35] Aderhold v. Bishop, 94 Okla. 203, 221 Pac. 752 (1923).

[36] McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949).

[37] Minogue v. Rutland Hospital, 119 Vt. 336, 125 A.2d 796 (1956).

[38] 361 Pa. 355, 65 A.2d 243 (1949).

[39] Pennsylvania and Kansas are "liberal" jurisdictions in that they have allowed the borrowed servant doctrine to be applied in all medical situations, both operative and non-operative. Physicians have been held liable in all situations wherein the standard measure for the master-servant relationship, right of control, existed. Presence or supervision is not required. The law is more fully developed in Pennsylvania where more cases have been

extend remains open. Possibly, an application of the *McKinney* rule would require the physician's actual presence. A sufficient right of control could exist in a borrowed servant relationship in a non-operative situation if the doctor is present. However, if a hospital-employed night nurse negligently administers prescribed medication while the doctor is not present, although a medical function is performed for the physican, there is no indication from the *McKinney* opinion that he will be held liable. A good assumption is that the application of the borrowed servant doctrine in Texas, based upon the *McKinney* opinion, should be limited to factual situations similar to those of the instant case.

V. Beyond McKinney—Problems and Policy Considerations

The doctrine of respondeat superior is a part of the body of the law of agency, but the true basis for the rule lies in public policy. The public policy considerations are even more pronounced in the physician-patient cases. The extent to which the borrowed servant doctrine will apply to physicians should not be solved by mechanical application of the principles of agency, but rather by balancing the needs of the medical profession against those of the community. There are circumstances which solicit amelioration from a consummate application of the borrowed-servant doctrine in medicine in nonoperative situations. The relationship which a doctor has with his patient is a personal one. A physician has a duty to practice his profession in the manner that best serves his patient. In this regard the physician should be free to concentrate on the patient's general well-being; he should not be hamstrung by a fear of liability, and charged with the responsibility of time-consuming rechecking of work done by supposedly competent professionals. Doubtless he is liable for the torts of his personally selected employees under respondeat superior, for implicit within that doctrine is a concept of personal selection. However, quite possibly the only personal selection a physician has if he is to perform surgery is which hospital to use for the operation, and in a small community or in emergency situations even that option may not be available to him. Nevertheless, if like his industrial counterpart, the physician is willing to benefit pecuniarily from the acts of his borrowed servants, it is certainly arguable that the same rules of agency apply in each instance.

decided. Although Pennsylvania does not seem to recognize the "expertise" test, Rockwell v. Stone, 404 Pa. 574, 173 A.2d 54 (1961), apparently the medicinal vs. ministerial function distinction is acquiesced in, Yorston v. Pennell, 397 Pa. 28, 153 A.2d 255 (1959); Benedict v. Bondi, 384 Pa. 574, 122 A.2d 209 (1956). For an example of the attitude of the Kansas Court see Voss v. Birdwell, 188 Kan. 643, 364 P.2d 955 (1961).

If physicians are to be immunized from the full thrust of the borrowed servant doctrine, the patient injured by the negligence of a hospital nurse, acting within the scope of employment, may be left with no redress. The physician may not be liable; the nurse is probably neither sufficiently solvent nor insured; and the nurse's general employer, the hospital, may well be exempt as a charitable institution.[40] These considerations, however, do not inevitably compel the conclusion that reparation should be had from the doctor, although this eventuality would be better than no redress at all. A better solution might be the extirpation of the obsolete charitable immunity rule.[41]

Complicating the pure application of standard agency principles in this area is the problem that courts have in separating the surgeon's vicarious liability imposed without fault from his personal negligence. A good example of the irresistible urge to refer to the physician's personal negligence is the opinion in the *McKinney* case.[42] Although the court gave lip service to the borrowed servant doctrine and the application of respondeat superior principles, there is language in the opinion which indicates that the court is still, perhaps subconsciously, preoccupied with the physician's culpable omission.

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[40] Texas is one of the few (approximately 18) states which still adhere to the charitable immunity rule. See Southern Methodist Univ. v. Clayton, 142 Tex. 179, 176 S.W.2d 749 (1943). In this context, whether or not eradication of the charitable immunity rule would automatically end a plaintiff's problems would depend upon two additional factors: the factual determination of whether the nurse was engaged in a ministerial function or a medical function, and if a medical function, the legal determination of whether the general employer, the special employer or both would be liable for the negligent act. If the performance of a ministerial function results in the injury, the plaintiff's ability to proceed against the hospital would probably determine his recovery, because under majority holdings a physician is not liable for a borrowed servant's negligently-performed ministerial act. If a medical function is performed, possibly a plaintiff would be in no better position if there were suddenly no charitable immunity doctrine in Texas. If only the special employer (the physician) would be accountable for the borrowed servant's negligence, the public policy determination that the physician should not be held liable for his borrowed servant's torts when he is absent probably would result in the plaintiff's being unable to recover adequately, since the general employer (the hospital) undoubtedly would assert the right of control of the physician as a defense to the plaintiff's claim against him. In order for a patient injured in such a situation to recover against the hospital there must be joint liability between the special and the general employer. Elimination of the charitable immunity rule obviously would not be a complete solution to all the problems involved, but at least it would be a start in the right direction.

[41] For a discussion of the charitable immunity doctrine and its current status in hospital cases see generally Horty, *The Status of the Doctrine of Charitable Immunity in Hospital Cases*, 25 Ohio St. L.J. 343 (1964).

[42] In McKinney v. Tromly, 386 S.W.2d 564, 566 (Tex. Civ. App. 1964), toward the end of the opinion the court seems to forget that a master's vicarious liability is liability imposed without fault. The court said: "We do not believe the rule in Dallas of doctors using nurses to give anaesthetics will relieve Doctor Tromly of liability in this case." The court then quoted with approval from a case dealing with a surgeon's personal negligence. The basis of the doctor's liability in *McKinney* is the master-servant relationship; whether it is accepted practice in the community to use nurses for this purpose is irrelevant.

That is, permeating the court opinions in this area is the unexpressed idea that the surgeon's liability results from his failure to properly supervise his assistants. In rationalizing this dilemma the courts translate their engrossment with the physician's duty into agency terms, saying that the right of control exists in the operating room, when the physician is present, but may not exist when the surgeon is not present.[43] Thus, although the courts speak in terms of agency, they apparently think in terms of personal liability. If a nurse is functioning for a physician, it is no more logical, applying strict agency principles, to say that his right to control exists when that nurse acts within his presence than when the physician is absent. His presence can add nothing to the agency relationship. "The control test, rather, is merely a judicial tool, . . . [a]s such, it is flexible enough to support any policy a court wishes to pursue."[44] This is not to say that the results reached are not good, but it does seem clear that the courts do not follow strict agency principles in physician-patient cases.[45]

VI. CONCLUSION

It is generally beneficial to public welfare, and particularly to an individual plaintiff, that a victim of medical negligence be compensated for his loss. Moreover, it seems equitable that responsibility for the loss lie upon the person or entity who is responsible for the well-being of the patient at the time of the mishap. The proof problems

[43] Exemplifying the courts' confusion of supervisory duties with an agency relationship is this statement from Davis v. Trobough, 139 Mont. 322, 363 P.2d 727, 729 (1961): "Certainly the surgeon has exclusive control of the nurses in surgery and *while he is there.* The same is true while the nurses are with the patient *in his presence.* But, distinguishing between that case and the instant cause, the nurses become the temporary servants . . . of the surgeon in *charge* while the operation is in progress." (Emphasis added.)

[44] Note, 50 Geo. L.J. 329, 331 (1962).

[45] Partially accountable for this confusion are the built-in problems confronted in attempting to prove negligence upon a doctor. The standard of care to which doctors are held somewhat approximates the conduct expected from a reasonably prudent doctor under similar circumstances. The doctor's deviation from that standard can generally be proven only by competent medical testimony, given by his professional peers within the community. See Bowles v. Bourdon, 213 S.W.2d 713, 715 (Tex. Civ. App. 1948), *aff'd*, 219 S.W.2d 779 (1949). Unfortunately the rule does not always work the way it was intended; doctors comprise a homogeneous group and a plaintiff's counsel has a difficult time finding a "reasonably prudent" doctor who will testify "for the record," except to the rankest sort of negligent conduct. Rarely is a doctor found personally negligent for his omission. Some jurisdictions partially remedy this shortcoming by using the doctrine of *res ipsa loquitur* to aid injured patients in proving negligence, thereby shifting to the surgeon the problem of eliciting expert testimony indicating conformity to the standard of care required. See, *e.g.*, Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944); Frost v. Des Moines Still College of Osteopathy & Surgery, 248 Iowa 294, 79 N.W.2d 306 (1956); Jensen v. Linner, 260 Minn. 22, 108 N.W.2d 705 (1961); Foxton v. Woodhouse, 236 Ore. 271, 386 P.2d 659 (1963). For a discussion of the more recent developments in this area, see Brophy, *Highlights on Res Ipsa Loquitur in Medical Malpractice Cases*, 1964 Ins. L.J. 645.

inherent in the medical standard of care and the charitable immunity doctrine interlock to erect a formidable barrier to a plaintiff. It seems clear that in operating or treatment rooms the physician is completely in control and should be charged with a duty of supervising his borrowed servants; and even absent his personal negligence, the physician should be held liable, vicariously, for the negligent acts of such servants. In nonoperative situations, when the physician is not present, it seems better public policy to allow physicians to assume that hospital personnel will function competently regardless of whether such a result would conform to usual agency rules. A physician's time is a valuable community resource and it must be conserved. In order for a physician to use his time to best advantage he should be relieved from worry about possible personal liability occasioned by the acts of hospital personnel while he is away. In the medical profession there is a personal relationship not to be found in industry. Perhaps the special needs of this unique relationship warrant the application of specialized rules. Therefore, any extension of the rule of the *McKinney* case should come only after careful evaluation of the policy considerations involved. If a patient, injured by the negligence of hospital personnel, is left without a financially responsible defendant, it is probably the charitable immunity rule that is to blame and not an unwarranted limitation of agency principles as applied to physicians.

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