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A Historical Sketch of Anglo-American Medical Law (With Emphasis on the Maxim of Respondeat Superior)

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(With Emphasis on the Maxim of Respondeat Superior)

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I. Introduction

IN MEDICAL JURISPRUDENCE, the medical and legal professions are united to encompass a wide range of human activity. The spectrum of medical law is so broad that a thorough consideration of its historical development would require the writing of several volumes. Consequently, this article confines itself to a discussion of the primary origins and major developments of Anglo-American medical jurisprudence. Special emphasis has been placed upon the agency concept of *respondeat superior,* since this doctrine plays a prominent role in medical law and since the doctrine has been used of late to significantly expand the potential liability of the physician.

II. Development of Respondeat Superior in England

The term *respondeat superior* first appeared in Anglo-American law during the reign of Edward I (1272-1307 A.D.).[1] The doctrine was born in that chapter of the Statute of Westminster II (1285) which regulates distresses by sheriffs or bailiffs, makes the officer disregarding its provisions answerable, and then continues, *"si hon habeat ballivus unde reddat respondeat superior suus."*[2] *Respondeat superior* was originally applicable only to public officials and not to employers generally. Furthermore, the concept was one of secondary liability which became operative only when the defendant was unable to satisfy the judgment

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[1] 2 Pollock and Maitland, *History of English Law Before the Time of Edward I,* 533 (2d Ed. 1899).

[2] *3 Selected Essays in Anglo-American Legal History* 380 (1909).

against him.[3] The enactment which gave birth to *respondeat superior* was merely one of a line of statutes dealing with the oppressive public official. Particularly distressing were the damages inflicted by the under-sheriffs. Since the underlings were often men of little substance, there was usually little prospect of enforcing judgments for damages against them.[4] *Respondeat superior* was founded on the principle that "he who expects to derive advantages from an act which is done by another for him must answer for any injuries which a third person may sustain from it."[5] Although the doctrine made action against a sheriff for the torts of the under-sheriff possible, Edward I's statutes show no "identification" of servant with master and no obvious feeling favoring "employers' liability."[6] Quoting Sir Frederick Pollock:

> Our common law when it took shape in Edward I's day did not, unless we are much misled, make masters pay for acts they had neither commanded nor ratified. Had it done so, it would have "punished" a man for an offense in which he had no part.[7]

At common law the master was not criminally liable for his servant's acts except when he commanded or approved them.[8] That *respondeat superior* was not to be used in making masters pay for acts they neither commanded nor ratified was demonstrated in *Bogo de Clare's* Case ((1290), Rot. Parl. i. 24). Pollock sketches the essentials of the case:

> Action against Bogo by a summoner of an ecclesiastical court who has been ill treated by members of Bogo's mainpast and compelled to eat certain letters of citation. Action dismissed, because plaintiff does not allege that Bogo did or commanded the wrong. Thereupon, because this wrong was done within the verge of the palace, the king takes the matter up and Bogo has to produce all his familia; but after all he is dismissed as the offenders cannot be found.[9]

Bogo had recently served a summons against the Earl of Cornwall as he was "walking up Westminster Hall to Council" and

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[3] Plucknett, *A Concise History of the Common Law* 475 (5th ed. 1956).

[4] *Ibid.*

[5] 77 C.J.S. *Respondeat Superior* § 318 (1952).

[6] 2 Pollock and Maitland, *op. cit. supra* note 1, at 532.

[7] *Id.* at 533-534.

[8] Plucknett, *op. cit. supra* note 3, at 474.

[9] 2 Pollock and Maitland, *op. cit. supra* note 1 at 534, n. 1.

had narrowly escaped having to pay a 10,000 pound claim against him by the insulted Earl. No sooner had Bogo extricated himself from this predicament, when the summoner of an ecclesiastical court attempted to serve a summons in Bogo's own house. Having recently learned that service of summons was distasteful to the King, some of Bogo's overzealous lackeys forced the apparitor to "eat his process, parchment, wax and all." [10] Bogo was thereupon forced to defend himself in an action of trespass in Parliament. As observed by Plucknett:

> His defense is an important text for our purpose, for he took the line that he was not liable for the wrong that his servants had done and demurred. The plaintiff was examined and admitted that Bogo himself neither committed nor ordered the trespass, and so Bogo had judgment.[11]

Plucknett observes that it was a common practice in some parts of England during the thirteenth century to exact judgments against the household for the torts of servants, but that in 1302 it was held "that fining the mainpast was illegal; and in 1313 Staunton, J. declared 'let those who have done wrong come to answer for their own misdeeds.'" [12] Nevertheless, quasi-criminal liability of master for servant is found alongside other rules of frankpledge as late as the time of Edward II (1307-1326).[13] By the time of Edward III (1326-1377) the applicability of *respondeat superior* was extended beyond public officers and made to embrace abbots whose wards had committed misdeeds.[14]

At its inception, *respondeat superior* had little bearing on the medical practitioner. Customarily the medieval physician or surgeon worked alone and thus was liable only for his own errors. As the performer of a deed he was responsible for its consequences whether he acted innocently or inadvertently.[15] Agency concepts, such as *respondeat superior,* would understandably be of little consequence to the physician until medicine became more sophisticated. The complexity of the modern surgical team with its delegation of responsibility still belonged to the future.

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[10] Plucknett, *op. cit. supra* note 3, at 473.

[11] *Ibid.*

[12] *Ibid.*

[13] Holmes, *Agency,* 4 Harv. L. Rev. 345 (1891).

[14] 3 Selected Essays, *op. cit. supra* note 2, at 382.

[15] Wigmore, *Responsibility for Tortious Acts,* 7 Harv. L. Rev. 316 (1894).

III. Early Medical Legislation in England

During the late fourteenth and early fifteenth centuries English surgeons and barbers began organizing themselves. The master-surgeons formed a separate guild in 1368 and recognized women physicians in 1389.[16] In 1421 a statute was passed by Parliament giving the Lords of the King's Council the power to prescribe ordinances governing the practices of physicians and surgeons.[17] Interestingly, this medical legislation followed immediately after the combination of the master surgeons and physicians in 1421. The first statute to regulate the practice of medicine in England, proposed in 1422, provided in part:

> No one shall use the mysteries of fysyk unless he hath studied in some university and is at least a bachelor in that science (the penalty being 10 £.) and every woman who shall practice physick shall suffer the same penalty.[18]

Parliament failed to enact this statute, but the age of English medical jurisprudence had nevertheless begun.

Up until the mid-fifteenth century, surgery, to a large extent, was practiced by the Guild of Barbers which, in 1461, became the Company of Barbers under charter from King Edward IV.[19] The barbers were originally trained for the purpose of bleeding and shaving monks and, just as physicians looked down upon surgeons, the highly educated master-surgeons looked down upon the barbers. The surgeons obtained a special charter to become the Guild of Surgeons in 1492.[20] Soon the emerging body of statutory law would fuse these quarrelsome factions.

What became known as the "Bishop's License" was enacted in the third year of the reign of Henry VIII (1511). This statute (3 Henry 8 c.3) prohibited the practice of medicine or surgery by any person until he had been examined and approved for that purpose by the Bishop of London or, if in the country, by the bishop of the diocese.[21] It was further provided that no one could practice medicine or surgery in London or within a radius of seven miles of it without also being "examined, approved, and

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16 Garrison, *An Introduction to the History of Medicine* 172 (1929).

17 Caldwell, *Early Legislation Regulating the Practice of Medicine*, 18 Ill. L. Rev. 225, at 229 (1924).

18 *Ibid.*

19 *Ibid.*

20 Garrison, *op. cit. supra* note 16, at 172.

21 Caldwell, *supra* note 17, at 229.

admitted" by four doctors of "physyk" or four expert surgeons.[22] A provision of the statute did, however, exempt graduates of Oxford and Cambridge.[23] The Bishop's License was superseded in 1518 when at the request of certain London physicians, Henry VIII granted an extraordinary charter which created the College of Physicians and delegated to it the power of examining and licensing candidates seeking to practice in London and its suburbs.[24] Furthermore, the charter empowered the College to govern, by statute and ordinance, all persons practicing medicine in London; to try and punish those accused of malpractice; to regulate the quality and types of medicines used; and to fine anyone practicing without a license.[25] The new charter was confirmed by Act of Parliament in 1522 (14 and 15 Henry 8 c.5). Subsequent statutes further confirmed it and enlarged the powers delegated to the College.[26]

The legality of the charter and the authority it gave to the College of Physicians was soon tested in the courts. A certain Dr. Bonham obtained the degree of Doctor of Physyk from Cambridge and then came to London where he set up practice without obtaining a license from the College of Physicians. As mentioned earlier, the Bishop's license had not required graduates of Oxford or Cambridge to obtain a license. When Bonham openly defied the College by refusing to obtain a license the College authorities had him imprisoned. Subsequently the Doctor brought an action against the College for false imprisonment. The College rested its defense upon its charter. Judgment was given for Dr. Bonham, but only because the College had failed to properly exercise its statutory powers, not because Bonham's Cambridge degree enabled him to ignore the licensing requirement. It was eventually held that all candidates, including graduates of Oxford and Cambridge, must be licensed by the College of Physicians before practicing in London.[27]

By 1540, persons licensed by the College of Physicians were authorized to practice "physyk," including surgery, anywhere

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[22] Garrison, *op. cit. supra* note 16, at 239.

[23] Caldwell, *supra* note 17, at 230.

[24] *Ibid.*

[25] *Ibid.*

[26] *Ibid.*

[27] *Id.* at 231.

within the realm (32 Hen. 8 c. 40).[28] With the mushrooming power of the College of Physicians the barbers and surgeons decided to unite before being overshadowed entirely. Thus in 1540 the burgeoning Barber Company united with the small and exclusive Guild of Surgeons to form the United Barber-Surgeon Company with the anatomist Thomas Vicary as its first Master.[29] This moment was preserved for history in a painting by Hans Holbein which depicts Henry VIII, "huge, bluff, and disdainful" in the act of handing the statute creating the United Barber-Surgeon Company to Thomas Vicary in the company of fourteen other surgeons on their knees before the monarch, who does not even condescend to look at them.[30] Thus the surgeons and barbers now had the exclusive right to practice surgery within the city of London and its suburbs. (32 Hen. 8 c. 42)[31] This union would last for some two hundred years until the barbers and surgeons were again separated into two groups by statute in 1745 (18 Geo. 2). At that time the privilege of practicing surgery would be transferred to the new Company of the Art and Science of Surgeons of London, which would also be authorized to regulate the examining and licensing of those proposing to practice surgery.[32]

Notwithstanding all the charters and licensing requirements, charlatans were still a major problem in the mid-sixteenth century. Quoting Fielding H. Garrison:

> Quackery was rampant everywhere, and in the vigorous language of the English surgeon William Clowes was practiced by "tinkers, toothdrawers, peddlers, ostlers, carters, porters, horse-gelders, and horse leeches, idiots, applesquires, broom men, bawds, witches, conjurers, soothsayers and sow gelders, rogues, set-catchers, runagates, and proctors of spittle houses." [33]

Charles Green Cumston also commented on this problem:

> In the reign of Edward 6, Grigg, a poulterer in Surrey, was put in the pillory at Croydon and again in Southwark, for cheating people out of their money by pretending to cure them by charms, or by looking at them, or by casting their water. Many other quacks (were) at various times . . . sub-

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28 *Ibid.*

29 Garrison, *op. cit. supra* note 16, at 239.

30 *Ibid.*

31 Caldwell, *supra* note 17, at 231.

32 Garrison, *op. cit. supra* note 16, at 307.

33 *Id.* at 237.

> jected to punishment. Anthony was punished for his Annum Potabile; Dee, for advertising medicine to cure all diseases; Foster, for selling a powder for the cure of chlorosis. Tenant, a urine caster who sold pills at six pounds apiece; Aires, for selling purging sugar plums; Hunt, for putting up bills for the cure of diseased in the streets. The council in the reign of James I, dispatched a warrant to the Magistrate of London, to arrest all reputed empirics, and cause them to be examined by the Censors of the Royal College of Physicians. Several were arrested and acknowledged their ignorance.[34]

To combat quackery the Company of Barber-Surgeons obtained an extended charter in 1629 which granted it the right to examine and approve all persons practicing or wishing to practice surgery in London and Westminster and empowering those so approved to practice anywhere in England.[35]

IV. Early Medical Legislation in America

In the seventeenth century the American Colonies made their debut in the field of medical jurisprudence. Apparently the earliest Colonial attempt to regulate the practice of medicine was a Virginia statute in 1639 concerning physicians' fees.[36] Ten years later Massachusetts enacted a law forbidding "phisitians, chirurgians, midwives or others," presuming "to exercise or putt forth any act contrary to the knowne rules of arte" or exercising "any force, violence or cruelty . . . no, not in the most difficult and desperate cases,—without the advice and consent of such as are skilfull in the same arte."[37] This same law was appropriated by the Duke of York for the province of New York in 1665.[38]

To the City of New York falls the distinction of having enacted the first well-considered act regulating the practice of medicine in the Colonies. Passed on June 10, 1760, it applied only to the City of New York and, in part provided that no person would be allowed to practice (under penalty of 5 pounds and costs) medicine or surgery until he passed an approved examination.[39]

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[34] Cumston, *Laws Governing Civil Malpractice in the Middle Ages,* 15 Green Bag 413-14 (1903).

[35] Caldwell, *supra* note 17, at 232.

[36] *Id.* at 233.

[37] *Ibid.*

[38] *Ibid.*

[39] *Id.* at 234.

In 1773 New Jersey passed an act similar to that of New York City and became the first Colony to have a comprehensive medical law.[40] The Code of Virginia (1773) required every surgeon, physician and dentist to obtain a license before practicing in that colony. Failure to do so entailed a fine of $30 to $100 and deprived the practitioner of any right to collect fees owed him for his services prior to licensing.[41] A perceptive comment on Colonial medicine is Garrison's observation that:

> Under the primitive, frontier conditions, the medieval antagonisms between the physician and surgeon soon disappeared for the necessary and sufficient reason that, while midwifery was in the hands of women, the open country or backwoods doctor was liable to be called upon in any emergency, and, thrown upon his own resources, soon learned to enlarge such native skill as he had in bone-setting, treatment of arrow and bloodshot wounds, reducing hernias and the like.[42]

By the eighteenth century the traditional animosity between physician and surgeon had begun to subside in England. Coincidentally there appeared the first serious English works on medical jurisprudence. William Hunter's *Essay on the Signs of Murder in Bastard Children* (1783) was a milestone in the field of medical jurisprudence and was soon followed by the Samuel Farr's *Elements* (1788), which has been called the first substantial English work on legal medicine.[43] These two works mark the beginning of the modern period of Anglo-American medical law. Because of limitations on length, only one aspect of modern medical jurisprudence can be considered in this paper: the liability of physicians and surgeons for the acts of their subordinates.

V. Recent History of Respondeat Superior

Although the maxim of *respondeat superior* originated in the time of Edward I from cases involving the torts of inferior public officers, as late as 1685 the courts were still clinging to the medieval rule of no liability on the part of a master for the uncommanded and unratified acts of his servant.[44] In *Kingston v.*

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[40] *Ibid.*

[41] *Id.* at 235.

[42] Garrison, *op. cit. supra* note 16, at 307.

[43] *Id.* at 371.

[44] Plucknett, *op. cit. supra* note 3, at 475.

Booth, 1 Skinner 228, 90 Eng. Rep. 105 (1685), the judges gave the opinion ". . . if I commanded my servant to do what is lawful, and he misbehaved himself or do more, I shall not answer for my servant, but my servant for himself, for that it was his own act. . . ." [45] Shortly thereafter the doctrine of the master's liability in mercantile law was broadened by Lord Holt, who, in the case of *Boson v. Sandford,* 2 Salk 440, 91 Eng. Rep. 382 (1691), laid down the general rule: ". . . whoever employs another is answerable for him, and undertakes for his care to all that make use of him." [46] Plucknett feels that this rule could hardly have been possible without the prior existence of the concept of *respondeat superior.*[47]

Holt, C. J. also originated the modern law of vicarious liability through the fiction of the implied command. He explained and supported this fiction by use of the maxim *Qui facit per alium facit per se,* which was of "ancient currency" in England, "though originally, in its application to tort, it meant no more than that a man who specifically commanded a tort was liable for it." [48] In speaking of the new doctrine of implied command Holt said: "No master is chargeable with the acts of his servant, but when he acts in execution of the authority given him by his master . . . the act of the servant is the act of the master." [49] As Oliver Wendell Holmes Jr. observed: "It is plain good sense to hold people for wrong which they have intentionally brought to pass . . ." [50] but Holt's approval of vicarious liability has puzzled at least one modern writer.[51] In any event, subsequent decisions upheld and extended Holt's concept. In *Ackworth v. Kempe,* 1 Doug. 40, 99 Eng. Rep. 204 (1788), Lord Mansfield held . . . "for all civil purposes the act of the sheriff's bailiff is the act of the sheriff." [52] And in the 1826 case of *Laugher v. Pointer,* 5 B. and C. 547, 108 Eng. Rep. 204 (1826), Littledale, J. held: ". . . Servants represent the master himself, and their acts stand upon the same

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[45] 8 Holdsworth, *A History of English Law* 473 (2 ed. 1937).

[46] Plucknett, *op. cit. supra* note 3, at 475.

[47] *Ibid.*

[48] Williams, *Vicarious Liability: Tort of the Master or of the Servant?* 72 Law Q. Rev. 523 (1956).

[49] *Ibid.*

[50] Holmes, *supra* note 13, at 347.

[51] Douglas, *Vicarious Liability and Administration of Risk,* 38 Yale L. J. 584 (1928).

[52] Williams, *supra* note 48, at 523.

footing as his own." [53] Blackstone, in his *Commentaries,* also gave the opinion that a "wrong done by the servant is looked upon in law as the wrong of the master himself." [54]

The doctrine of *respondeat superior* applies only where the relationship of master-servant, employer-employee, or principal-agent exists between the wrongdoer and the person charged for the resulting wrong.[55] The person or party being charged must stand in the relation of a superior to the wrongdoer and must be shown to have had the right to direct and supervise the wrongdoer.[56] Where such a master-servant relationship can be found to exist, the liability of a doctor for the negligent acts of his assistants may be predicated on the theory of *respondeat superior.*[57] To hold the physician liable it is necessary to show that his assistant was negligent, since the basis for liability is the misconduct of the assistant which is imputed to the physician.[58] As long as the agent acts within the scope of the master's authority, or in his employment, the master is liable to an injured third party for the torts of his agent "even though the tortious act was not commanded or expressly authorized." [59] Laski summarized the inherent difficulty of this harsh reasoning when he commented: ". . . while everyone can see that the master ought to answer for acts he has authorized, why should he be liable either where no authorization can be shown or where express prohibition of an act exists?" [60]

In truth the responsibility of public servants was traditionally greater than the responsibility of private servants and, as Oliver Wendell Holmes observed:

> (It) might be asked whether *respondeat superior* in its strict sense is not an independent principle which is rather to be deemed one of the causes of modern law, than a branch from a common stem. It certainly has furnished us with one of the inadequate reasons which have been put forward for the

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[53] *Ibid.*

[54] *Ibid.*

[55] 77 C.J.S. *Respondeat Superior* p. 319 (1952).

[56] *Ibid.*

[57] Williams, *supra* note 48, at 523.

[58] Note, 32 N. C. L. Rev. 140 (1953).

[59] 77 C.J.S. *Respondeat Superior* p. 318 (1952).

[60] Laski, *The Basis of Vicarious Liability,* 26 Yale L. J. 105, at 107 (1916).

law as it is,—that somebody must be held who is able to pay the damages.[61]

Physicians and surgeons are in a public calling, and that they are historically liable for their own acts has already been noted. But the growth and sophistication of medical science in the nineteenth and twentieth centuries created new problems for the courts. Take, for example, the development of the modern surgical team with its intricate and often critical divisions of responsibility. To an increasing extent a surgeon's assistants are no longer his employees. Instead they are the employees of the hospital in which the operation is performed and are only temporarily assigned to assist him. Suddenly the seeming simplicity of *respondeat superior* becomes a "veritable hornet's nest of stinging difficulties." [62] To what extent is the surgeon liable for the acts of his temporary assistants? Does his liability for their acts with his patient ever cease and if so when? What is the hospital's liability for the acts of its employees while assisting the surgeon? To what extent is the hospital liable for the surgeon's negligence? Quoting Glanville Williams on this last question:

> Perhaps the greatest difficulty with the fiction involved in the master's tort theory is to decide how far the master is to be notionally put into the position of the servant at the time of the act of negligence. . . . This must obviously be so in cases where a hospital authority is held vicariously liable for the negligence of a surgeon. It would be absurd to attribute the surgeon's act to the hospital authority, and then to ask whether such act would be negligent if performed by the authority. The answer could only be in the affirmative, for it would be negligent for the authority, not possessing surgical skill, to perform the operation at all. The only way to apply the master's tort doctrine to such a case is to decide whether the act is negligent in the surgeon before notionally transferring it to the hospital authority.[63]

As most hospitals in the late nineteenth century were charitable organizations, questions arose as to the extent which charities should be held for the negligence of their servants. One view was expressed in the 1876 case of *McDonald v. Massachusetts General Hospital,* 120 Mass. 432 (1876), where the court held:

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61 Holmes, *supra* note 13, at 357.

62 Laski, *supra* note 60, at 106.

63 Williams, *supra* note 48, at 541.

> (The) duty of a charitable hospital corporation is confined to the exercise of reasonable care in furnishing suitable accommodations and competent attendants . . . beyond the performance of these duties there is no liability of the corporation for the negligence of its servants.

Three years later a Rhode Island court held that "once the relation of servant and master is made out, a charitable corporation is liable for its servants' negligent acts. . . ." *Glavin v. R. I. Hospital,* 12 R. I. 411 (1879). In 1894 a Michigan court held: "A charitable corporation can never be held liable for the negligence of its servants." *Downs v. Harper Hospital,* 101 Mich. 555, 60 NW 42 1894). In short, the American courts at the close of the nineteenth century were not in agreement as to whether the doctrine of *respondeat superior* extended to hospitals.[64] Interestingly, the contemporary English courts refused to distinguish between charitable and business corporations in applying *respondeat superior.*[65]

The modern trend has clearly been toward increased hospital liability. In *Smith v. Duke University,* 219 N. C. 628, 14 SE 2d 643 (1941), it was determined that a hospital may be liable for negligence in recommending or selecting a physician. Subsequent cases reaffirmed this holding, so that now a hospital admitting a patient for treatment and also acting as an agent to recommend or employ the attending physician is liable in the event of negligence or malpractice.[66] Since nurses are manifestly in the service of the hospitals, it has also been argued that hospitals must respond for the acts of nurses in their employ unless it can be proven that the nurse acted under the control of a third person or in a "professional," as opposed to an "administrative," capacity.[67]

Although it has been held that the physician-patient relationship does not necessarily rest on contract (*Thaggard v. Vafes,* 119 SO 647 (Ala. 1928)), the "liability of a physician to a patient for malpractice is dependent upon the existence of a physician-patient relationship or upon a relationship based on contract." [68]

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[64] Comment, 9 Harv. L. Rev. 543.

[65] *Ibid.*

[66] Note, 29 N. C. L. Rev. 206 (1950-51).

[67] Laskin, *Case and Comment,* 16 Can. B. Rev. 568 (1938).

[68] Note, *supra* note 66, at 206.

Certainly the signing of a permission slip before an operation is a consensual gesture which dates back to the written guarantees of release in medieval times. With few exceptions an operation performed without the consent of the patient automatically constitutes an assault for which damages are recoverable.[69] In the absence of a special contract to the contrary, the physician-patient relationship begins upon acceptance of the patient for treatment and terminates upon mutual agreement, the patient's dismissal of the physician, or determination by the physician that his services are no longer needed.[70] It is fairly well established that where no specific contract exists to the contrary, the physician does not guarantee to effect a cure and is not obliged to stay with a case until his services are no longer needed; *Davis v. Pittman,* 212 N.C. 680, 194 S.E. 97 (1937). However, a physician is bound to use reasonable care in terminating his treatment, and terminating his services without giving the patient ample opportunity to secure other medical attendance is tantamount to abandonment; for this the physician becomes liable for damages.[71] In other words, a physician or surgeon who takes a patient for treatment can be discharged by the patient without notice, but he cannot discharge the patient without notice.[72]

With the remarkable growth of medical and surgical specialization in the last forty years has come the problem of "shifting responsibility" in cases involving *respondeat superior*; *Funk v. Bonham,* 204 Ind., 170, 183 N. C. 312 (1932). Can a physician or surgeon relieve himself of liability for the negligent acts of a substitute physician or surgeon? If so, under what circumstances? In the light of such questions the following safeguards have been suggested:

> (To relieve himself of liability, for the negligence of a substitute, a physician or surgeon should make certain that:) (1) he is under no contract which would create a greater liability than that which rises out of the mere physician and patient relationship, (2) due care is exercised in selecting such substitute (and) (3) by the relations actually existing among the parties under their agreements or acts, agency between the physicians in fact does not exist.[73]

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[69] Cline, *Professional Liability,* 35 Neb. L. Rev. 549 (1956).

[70] Note, *supra* note 66, at 207.

[71] Cline, *supra* note 69, at 548.

[72] *Ibid.*

[73] *Supra* note 66, at 210.

Whether or not fees were received by the assigning physician is of no consequence in cases of shifting responsibility. A physician cannot escape liability by refusing to charge for his services.[74]

Liability of a physician for the acts of his assistants usually exists in one of two situations: (1) where the physician himself was negligent in allowing the assistant to injure the patient or (2) where the assistant's negligence is imputed to the physician under the principles of agency.[75] As to the first situation, it has long been held that a doctor's liability is dependent, in part, on his presence at the time of the negligent act. *Perionowski v. Freeman,* 4 Fost. & F. 977, 176 Eng. Rep. 873 (1886). The courts usually consider a physician or surgeon to be in "control" when he is in charge of treatment and is present in the room with the patient and assistant during the administration of treatment.[76] Obviously a doctor's "control" of a treatment is governed in part by his authority to give directions. *Emerson v. Chapman,* 138 Okla. 270, 280 P. 820E (1929).

A physician may be held personally liable for "employing, retaining, or using an incompetent assistant" as, for example, engaging a layman to administer anesthetic.[77] It is the doctor's legal duty to see that treatments administered to his patient are carried out correctly. However, the physician may delegate simple tasks to properly trained assistants and thereby relieve himself of legal responsibility.[78] A notable exception lies in the matter of counting gauzes or sponges used in a surgical operation. Here many courts hold to a rule of strict liability and will not allow the physician to escape responsibility by assigning this task to an assistant.[79] Finally, the physician is also liable for negligently instructing or supervising his assistant, and some courts have absolved the assistant of liability when, in performance of his legal duty, he has administered the treatment under the specific, but erroneous, instructions of the physician in charge.[80]

In the second situation of physician responsibility agency principles play a more prominent role. In the landmark case of

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74 McClean, *Doctor versus Law,* 13 Green Bag, 352 (1901).

75 Note, *supra* note 58, at 138.

76 *Id.* p. 140.

77 *Id.* p. 138.

78 *Ibid.*

79 *Id.* p. 139.

80 *Ibid.*

Ybara v. Spangard, 25 Cal. 2d 486, 154 P. 2d 687 (1945), it was held that the doctor in charge of the operation is liable for the negligence of those who become his temporary servants for the purpose of assisting in the operation. The older rule was that a physician or surgeon might be liable for the malpractice of his partner but not for the negligence of interns, nurses, or hospital employees unless he owns or controls the hospital.[81] In the case of *Harlan v. Bryant,* 87 F. 2d 170 (Ill. 1936), a nurse placed a 30% silver nitrate solution (normal strength 1%) in a new-born infant's eyes and seriously damaged the child's vision. An action was brought against the surgeon who attended the child at birth in an effort to hold him responsible for the nurse's negligence on the basis of *respondeat superior.* In defense it was shown that the nurse was not in the employ of the surgeon and that the surgeon was not present when she administered the solution. Furthermore it was demonstrated that use of a silver nitrate solution was unnecessary. After losing below, the surgeon appealed and judgment was reversed and remanded. In finding for the surgeon the court held that where no duty exists to perform the service out of which the injury arises and where the party performing it is not the surgeon's servant, the surgeon is not liable for the party's negligence.

Perhaps the most spectacular medical malpractice case involving *respondeat superior* in recent times is that of *McConnel v. Williams,* 361 Pa. 355, 65 A. 2d 243 (1949). Here the defendant-obstetrician was employed by the plaintiff to attend his wife during pregnancy. At the time of delivery it was determined that a Caesarean operation would be necessary. To aid in this operation the defendant directed an intern to assist him by taking care of the baby after delivery. The plaintiff alleged the intern negligently administered silver nitrate to the infant's eyes after birth. Evidence was introduced to show that silver nitrate is a caustic solution requiring careful dosage and that the "usual technique required is to apply one or two drops in each eye with immediate irrigation." [82] Testimony revealed that the intern applied an excess of the solution and failed to irrigate immediately. The result of the intern's negligence was the loss of the child's right eye, which ultimately had to be excised and replaced by

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[81] Cline, *supra* note 69, at 548.

[82] Waters, *A Caveat to Surgeons,* 14 Ins. L. J. 796 (1949).

a prosthesis, and permanent damage to her left eye as the result of scarring. Suit was instituted by the child's father in his own right and on her behalf against the obstetrician alone without naming as defendants either the intern directly responsible for the negligent act or the hospital in which the operation was performed. The plaintiff did not charge that the obstetrician was personally guilty of negligence but, under the doctrine of *respondeat superior,* sought to hold him for the negligence of the intern. The trial court directed a verdict for the doctor from which the plaintiff appealed.

The principal question before the Appellate Court was whether, in the light of the intern's negligence, the doctrine of *respondeat superior* applied to the obstetrician. Was the intern, in the view of the law, the servant, agent, or employee of the obstetrician for the course of the operation which necessarily included attention to the newborn infant? The essential test in determining whether a person is a servant, agent, or employee of another is whether or not he is subject to the control or right of control of the other who is deemed his superior during performance of the duties in question.[83] Under cross examination the obstetrician admitted that all persons in the operating room were under his control or were subject to his control in the performance of their duties.

A second question in the case was whether the intern, as an employee of the hospital, could actually become the obstetrician's servant, agent, or employee at the same time. Determination of defendant's responsibility was found to be a question for the jury, but the court held (p. 248):

> In determining whether the intern was the defendant's servant at that time, the mere fact that he was then in the general employ of the hospital would not prevent the jury from finding that he was also at the same time the servant of the defendant if he was then subject to the defendant's orders in respect to the treatment of the child's eyes with the silver nitrate solution.

Ultimately the final judgment for the plaintiff in the *McConnel* case was based upon the surgeon's right to control the acts of his subordinates during an operation. To argue that a physician is in "control" it is necessary to establish his presence in

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[83] *Ibid.*

the room during the operation or treatment.[84] Once the physician leaves his patient, as in the post operative situation, the courts generally will cease to hold him liable under *respondeat superior* for the negligence of others attending the patient.[85] The major contribution of the *McConnel* case to contemporary medical law is its ultimate conclusion that, in cases of wanton negligence, the physician in control should be required to explain the cause of injury. Furthermore, he must prove that he exercised reasonable skill and care in supervising the activities of his subordinates, for failure to do so will raise the presumption of his own negligence.[86] *Respondeat superior* today is viewed as a just but harsh rule capable of considerable abuse.[87] The current trend in the law indicates that our courts are quickly approaching a position where physicians and surgeons will be responsible not only for their own acts but also for the acts of those who assist them.[88]

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[84] Davis, *supra* note 58, at 140.

[85] *Ibid.*

[86] Waters, *supra* note 82, at 797.

[87] 77 C.J.S., *Respondeat Superior* § 318 (1952).

[88] Waters, *supra* note 82, at 798.