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the husband's consent would have been proper under the circumstances, it was still not sufficient. He had not been advised of the true scope of the operation and consequently his consent was based on the defendant's misrepresentation. It seems likely, therefore, that the court would have accepted these circumstances to either totally vitiate the consent and hold the defendant liable for a technical battery or consider that the consent was a result of inadequate disclosure and hold the defendant liable in negligence.

WILLIAM J. JOOST

EXTENT OF THE VICARIOUS LIABILITY OF A PHYSICIAN OR SURGEON

Medical procedure usually requires the skills of many individuals. When a patient is injured by the negligent acts of an individual whose participation is required, there may be both direct and vicarious liability. It is clear that a physician or surgeon is liable for his own negligence. At issue is the extent of his liability for the negligence of others whose skills are needed.

Vicarious liability is that which is ascribed to a master, employer or principal for the tortious acts of his servant, employee or agent. This vicarious or imputed liability is grounded in the doctrine "respondeat superior." The doctrine was first enunciated by Chief Justice Holt in the case of *Jones v. Hart*, "The act of a servant is the act of his master, where he acts by authority of the master."[1]

The topic that will be discussed here is vicarious liability, or respondeat superior, as another aspect of a physician's or surgeon's liability in an action for medical malpractice.[2]

The vicarious liability of physicians and surgeons follows the general principles of agency. "A physician or surgeon is responsible for the negligent acts or omissions of his employees or agents while acting within the scope of their employment or agency."[3]

In the usual respondeat superior cases, the more frequently litigated questions are whether there is a master-servant relationship, and whether the servant was acting in the scope of his employment. In medical malprac-

1 Holt, K.B. 642, 90 Eng. Rep. 1255 (1698).

2 The reasons for imputing the negligent acts and corresponding liability of a servant to his master are varied. Thomas Baty has discussed the underlying rationale in his book *Vicarious Liability*, Clarendon Press, Oxford, England (1916). In discussing the justification for the rule, Mr. Baty reviews several arguments. Among these are the argument from profit, the argument from identification, the argument from carefulness, the argument from control, and the argument from the "deep pocket," which is based on the idea that servants are an impecunious race.

3 26 I.L.P. *Medicine and Surgery* § 34 (1957).

tice cases, the key factor is the establishment of a master-servant relationship on which vicarious liability must be founded. The decided cases in Illinois indicate that hospital employees are rarely found to be employees or agents of individual physicians or surgeons who use the hospital facilities.

In the case of *Harris v. Fall*,[4] the plaintiff underwent surgery. Dr. Harris deliberately left a strip of gauze in the plaintiff's body cavity for purposes of drainage. The gauze was to be removed as the incision healed. The trial court instructed the jury that Dr. Harris could not exonerate himself by proving that the hospital staff was solely responsible for plaintiff's injury in that they negligently performed the post operative procedure and failed to properly remove the gauze as the incision healed.

In holding that instruction to be reversible error, the court said that if the injury was the fault of the hospital staff, that fault could not be imputed to Dr. Harris. The court noted that Dr. Harris neither owned nor controlled the hospital. The hospital hired its own personnel and when these employees rendered post operative treatment, Dr. Harris in no way controlled them. In conclusion, the court said that the plaintiff contracted with the hospital for post operative care and Dr. Harris could not be charged for the fault of hospital attendants who he neither hired nor knew.

In *Funk v. Bonham*,[5] an Indiana appellate court case, a similar decision was reached. In that case, a sponge was mistakenly left in the plaintiff. The fact that the negligent act complained of occurred in the presence of the operating surgeon and in the operating room was held to be immaterial. The court said,

> It has been expressly held that a surgeon who performs an operation at a hospital, not owned and controlled by himself, and who is assisted in such operation by nurses, not his employees, but employees of such hospital, is not responsible for the mistake or[6] negligence of such nurses in failing to correctly count the sponges used in such operation, whereby a sponge is left and sewed up in the body cavity of the patient.[7]

The Illinois appellate court, in deciding *Olander v. Johnson*,[8] cited and approved the holding of the *Funk*[9] case. In *Olander*, the plaintiff underwent surgery at a charitable hospital.[10] During the operation, due to

4 177 Fed. 79 (7th Cir. 1910).

5 151 N.E. 22 (1926).

6 The personal liability of a physician for relying on a nurse's sponge count is beyond the scope of this article, which deals only with the vicarious liability of the surgeon. The physician's personal liability when he has delegated to a nurse the duty of counting sponges is annotated at 65 A.L.R. 1026 (1930).

7 151 N.E. at 24.

8 258 Ill. App. 89 (2d Dist. 1930).

9 *Supra* note 6.

10 Today, a charitable hospital may be charged with the negligence of its employees. See Fairall v. Sisters of Third Order of St. Francis, St. Mary's Hospital, 38 Ill. App. 2d 28, 187 N.E.2d 15 (1962).

the error of the nurse who was responsible for counting sponges, a sponge was not removed from plaintiff's body cavity. The evidence showed the defendant doctor to be personally free from negligence. The court, recognizing that the existence of vicarious liability was the only issue, held that an operating surgeon was not responsible for the mistake of the nurse, since she was not his employee and the operation was performed at a hospital neither owned nor controlled by him. The court noted that the hospital provided the surgery team and the rules of procedure. The surgeon was bound to abide by its selection of personnel and to obey the reasonable rules of procedure established by it.

The decision reached in the *Olander*[11] case was reaffirmed two years later in the case of *Hall v. Grosvener*,[12] another "sponge" case. The court again indicated that a surgeon is not responsible for a nurse's mistake when the nurse is not employed—that is, not hired or paid—by the surgeon, and the operation is performed in a hospital neither owned nor controlled by the surgeon.

Not until 1937 was it suggested that the courts, in applying this rule, were perhaps overlooking some vital distinctions. In the earlier cases that had been decided, the negligence sought to be imputed to the defendant was that of an associate doctor[13] or that of a hospital employee acting out of the defendant doctor's presence.[14] The *Olander*[15] and *Hall*[16] cases were the first which squarely held that the negligence of a nurse could not be imputed to the operating surgeon though the error occurred in his presence, during the operation. The vital difference between a negligent act performed in the doctor's presence and one not performed in his presence went unrecognized.

In the case of *Harlan v. Bryant*,[17] this distinction was recognized. The case dealt with the negligence of a hospital nurse. The nurse erred in applying the Crede treatment to an infant after it had been delivered by Caesarian Section. The court held that such negligence could not be imputed to the defendant surgeon. The court said that nurses assisting in the

11 *Supra* note 8.

12 267 Ill. App. 119 (1st Dist. 1932).

13 In the case of *Morey v. Thybo*, 199 Fed. 760 (7th Cir. 1912), an Illinois case, two physicians were employed by the plaintiff, one of whom was negligent. In not imputing the negligence of one physician to the other, the court said,

> Two physicians independently engaged by the patient, and serving together by mutual consent, necessarily have the right, in the absence of contrary instructions, to make such a division of service as in their honest judgment the circumstances may require. . . . Each, in serving with the other, is rightly held answerable for his own conduct and all wrongful acts or omissions of the other as he observes and lets go on without objection, or which in the exercise of due diligence under the circumstances he should have observed. Beyond this his liability does not extend.

14 *Supra* at note 4.

15 *Supra* at note 8.

16 *Supra* at note 12.

17 87 F.2d 170 (7th Cir. 1937).

operating room at the time of delivery were agents and servants of the doctor, for they were then under his direct control and supervision and subject to his orders. However, the court felt that to say such relationship continued in all post-natal treatment administered would cast too great a burden on the surgeon. The court realized that a hospital nurse who performs a task out of the doctor's presence is no longer controlled by that doctor.

Though only dictum, the discussion in Harlan of the nurse's status while in an operating room is of significance. The court, in this dictum, did recognize the qualitative difference between a surgeon's control over hospital personnel during an operation and his lack of such control when they are out of his presence, though in both instances they are essentially employees of the hospital.

The Illinois Appellate Court for the First District appeared to see the distinction in a dictum of its own. In the case of *Graham v. St. Lukes Hosp.*,[18] the plaintiff alleged as the cause of her injury that a post operative hypodermic injection was carelessly administered by a nurse. In refusing to impute the nurse's negligence to the defendant doctor, the court said,

> . . . . It is clear that a physician is not liable for the negligence of a nurse or intern, who are employees of a hospital and not under his personal control or supervision.[19]

The key to both the *Graham* and the *Harlan* cases appears to be the presence or absence of the physician's control over the negligent individual, irrespective of whom the servant's general employer may have been. In both cases, the court decided that since there was a lack of control, there could be no master-servant relationship from which vicarious liability could arise. Though neither case found an existent master-servant relationship, both admitted the possibility.

In other jurisdictions, courts have found such a relationship to exist. Thus, the Supreme Court of Oklahoma, in the case of *Aderhold v. Bishop*,[20] had little difficulty in deciding that the negligence of a nurse could be imputed to the surgeon. The plaintiff was scalded due to the negligence of nurses in the operating room. A pan of hot water, needed for some of the operative procedures, had been placed between her ankles in such a careless manner that the plaintiff was burned. The hospital was a corporation and the nurses were employees of the hospital. The defendant surgeon was one of the incorporators of the hospital, but the court in its discussion did not indicate that this was a relevant fact.

The court said that the test of the existence of a master-servant rela-

18 46 Ill. App. 2d 147, 196 N.E.2d 355 (1st Dist. 1964).
19 *Id.* at 159, 196 N.E.2d at 361.
20 94 Okla. 203, 221 Pac. 752 (1923).

tionship in a given case does not depend upon whom the general employer is, but is dependent upon who actually exercises supervision and control over the servant during the time he is served by that servant. The general master may loan the service of his employee to another for a specified purpose and for a short period of time. In such instances, the borrower becomes the master and is responsible for the servant's negligent acts so long as he exercises actual supervision. The court went on to say that though the nurses were employees of the hospital, they were under the direction and supervision of the surgeon during the operation and, in respect to such services as were rendered by them during the operation, they were servants of the surgeon.

This case appears to rest on the "borrowed servant" doctrine.[21] However, it should be noted that the defendant doctor was an incorporator of the hospital and part of its directing board. Though the court disclaimed the relevance of this fact, it can be argued that the decision reached was achieved by "piercing the corporate veil." In other words, the nurses were employed by the defendant and the doctrine of respondent superior was thus clearly applicable.

A case which more clearly applies the "borrowed servant" doctrine is *Mayer v. Lipschutz.*[22] Though tried in the federal courts, Pennsylvania law controlled the decision. In that case, Professor Israel Abrams died as a result of being transfused with incompatible blood by the anesthesiologist, Dr. Chodoff. It appears that two men with the name Israel Abrams entered the hospital for treatment on the same day. Prior to the operation, one bottle of blood was placed in the operating room in case of need. It was marked 342 A Positive. Abrams needed type O, Rh Positive. During the course of the operation, blood was needed. The anesthesiologist noticed the blood type marked on the bottle and immediately sent for Mr. Kahn, the head of the Hospital Blood Bank. Mr. Kahn, placing his head inside the operating room, reported to Dr. Chodoff that the blood was compatible with the Professor's and the label was a clerical error.

The trial court told the jury that Doctor Lipschutz, the operating surgeon, could not be responsible for the negligence of the hospital employees. The appellate court found this instruction to be reversible error. In remanding for a new trial, the court said that under Pennsylvania law, the operating surgeon is "captain of the ship" and responsible for negligent acts of all parties within the operating room over whom he has control. The court reasoned that if Mr. Kahn was in any way within the operating room, his negligence might be imputed to Dr. Lipschutz. The court went on to say that the ship had but one captain, Dr. Lipschutz, and his liability

21 35 Am. Jur. *Master and Servant* § 541 (1941); 57 C.J.S. *Master and Servant* § 566 (1948); Levitan, *Loaned Employees,* 27 Wis. B. Bull 7 (1954); McNeal, *Legal Responsibility for Negligence of Borrowed Employee,* 1952 Ins. L.J. 477-87 (July 1952).

22 Mayer v. Lipschutz, 327 F.2d 42 (3rd Cir. 1964).

could not be expanded, even though it is true that the negligence of the anesthesiologist may be imputed to the operating surgeon. Thus, the conduct of Mr. Kahn could not have been imputed to Dr. Chodoff, the anesthesiologist.

In Illinois, the "borrowed servant" doctrine has not as yet found its way into the operating room. In *Harlan v. Bryant*,[23] previously discussed, the court appeared to recognize the validity of the "borrowed servant" doctrine. The court noted that of decisive importance is who actually exercised supervision and control over the servant during the time the complained of acts were performed. The court said that the identity of the servant's general employer was not controlling and that a general employer may loan the service of his employee to another "for a specified purpose and a short period of time, in which case the individual to whom such servants are let is the master, and responsible for their negligent acts so long as he exercises supervision over them."[24] However, in the factual context of the case, this apparent recognition of the validity of the borrowed servant doctrine was dictum.

While only dicta in medical malpractice cases, the validity of the "borrowed servant" doctrine has long been recognized in other areas. The case of *McCarthy v. Rorrison*[25] clearly recognized that a servant may have more than one master. In that case, a hotel doorman was instructed by defendant to park the defendant's car. While driving the car, the doorman collided with another vehicle and injured the plaintiff, who was a passenger in the other vehicle. In holding that the issue of the defendant's liability should have gone to the jury, the court said,

> [O]ne may so use the servant of another as to make him his servant in the performance of some particular act, and it has been frequently stated that no arbitrary rule can be laid down by which it can be plainly seen in every case whether a servant, in the performance of a particular act, is the servant of the general or special master and that the facts of each case must be looked into in order to reach a proper conclusion.[26]

The factors which are of importance in determining when a servant has been loaned, so that the special master becomes liable for the servant's negligence, were enumerated in *Gundlich v. Emerson-Comstock Co.*[27] There, the court said that control of the servant was the prime consideration, but control was dependent on other factors. Those factors include who has the power to hire and fire, who pays the servant, and who has the power to direct the manner in which the services are to be performed. The question of control is a fact question which ordinarily should be left to the jury.

[23] *Supra* at note 17.
[24] *Id.* at 174.
[25] 283 Ill. App. 129 (1st Dist. 1935).
[26] *Id.* at 139.
[27] 21 Ill. 2d 117, 171 N.E.2d 60 (1961).

No Illinois case has yet squarely held that a nurse, employed by a hospital, may become the servant of a physician when assisting him in surgery. Since control has been recognized as the key fact, both in ordinary cases recognizing the "borrowed servant" doctrine, and as dicta in a few malpractice cases, a change in the law may be predicted, at least as to the acts of nurses in the presence of an operating surgeon. The surgeon is in absolute control during an operation. His orders must be precisely carried out, and he may even control the manner in which they are carried out. Balanced against the construction of the surgeon as master are two factors. First, the hospital staff is hired and fired by the hospital. Second, the hospital and not the doctor pays their wages. However, these last two factors are merely elements which tend to show that the surgeon does not exercise control over a hospital nurse. But, in the context of the surgical theater, these factors lose much of their relevance. Regardless of who hires and fires or who pays wages, during the course of an operation it is the word of the operating surgeon that controls the activities of the assisting nurses. This actual control, based on both necessity and custom, results in destroying the usual presumption of control that can be drawn from the fact that it is the hospital that hires, fires, and pays the nurses. For these reasons, a change in the law can be expected should a respondeat superior case reach the appellate courts which involves a nurse who is guilty of negligent conduct during surgery in the presence of the surgeon.

MERRILL C. HOYT

SOME SPECIFIC AREAS OF MALPRACTICE

X-RAYS[1]

Liability for an injury caused by a physician's negligent use of X-rays in treating a malady rests on the same principles of duty and standard of care that exist in any instance of medical malpractice.[2] Briefly, the ordinary and reasonable care of other physicians in the use of X-rays must be followed.

A more controversial area of X-ray negligence cases is that of evidentiary requirements. The method of proof has changed as the scientific undersanding of X-rays has increased.

Originally, when the use of X-ray treatment was thought to be foolproof, res ipsa loquitur was held to be sufficient to establish a cause of action for negligence. In *Holcomb v. Magee*,[3] the plaintiff's case was based on the facts that he had X-ray burns, that the X-ray machine had been in the

1 See Annot. 13 A.L.R. 1414 (1921); supplemented 26 A.L.R. 732 (1923).
2 Simon v. Kaplan, 321 Ill. App. 203, 52 N.E.2d 832 (1st Dist. 1944).
3 217 Ill. App. 272 (2d Dist. 1920).