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THE VICARIOUS LIABILITY OF A PHYSICIAN FOR THE NEGLIGENCE OF OTHER MEDICAL PROFESSIONALS —NORTH CAROLINA CHARTS A MIDDLE COURSE —THE EFFECT OF *Harris v. Miller*[1]

> "In short, just as a rule making a surgeon liable for every negligent act of every hospital employee under his [or her] control is too harsh, a rule exculpating . . . [a surgeon] for every negligent act of persons under his [or her] control simply because they are not his [or her] employees is too lenient."[2]

I. INTRODUCTION

Paramedics rush an automobile accident victim into the hospital emergency room. The treating physician quickly tells a nurse to obtain x-rays of the patient's head, ribs, leg, and spine. The nurse fails to request x-rays of the patient's spine when filling out the x-ray requisition form. As a result, the patient's spinal injury is aggravated because the injury is not promptly diagnosed.[3] Under these facts, a physician could be held vicariously liable[4] for the negligence of the nurse,[5] depending on how the jurisdiction applies the doctrine of respondeat superior.[6] In *Harris v. Miller*,[7] the North Carolina Supreme Court enunciated the standard that must be used to determine whether a physician is liable for the acts of other medical professionals.[8] Vicarious liability is imposed on a physician if the physician in fact possessed the right to control the other medical professional at the time the neg-

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1. 335 N.C. 379, 438 S.E.2d 731 (1994).
2. Foster v. Englewood Hosp. Ass'n, 313 N.E.2d 255, 261 (Ill. App. Ct. 1974).
3. Lynn D. Lisk, *A Physician's Respondeat Superior Liability For the Negligent Acts of Other Medical Professionals: When the Captain Goes Down Without the Ship*, 13 U. ARK. LITTLE ROCK L.J. 183, 183 (1991) (Lisk poses this example to highlight the complexities of the interrelationships in the health care industry.). The facts illustrated above are similar to Davis v. Schneider, 395 N.E.2d 283 (Ind. Ct. App. 1979).
4. Vicarious liability is defined as "the imposition of liability on one person for the actionable conduct of another based solely on the relationship between the two persons." BLACK'S LAW DICTIONARY 1566 (6th ed. 1990).
5. *But see Davis*, 395 N.E.2d 283 (holding physician not liable).
6. *See infra* notes 68-80 and accompanying text.
7. 335 N.C. 379, 438 S.E.2d 731 (1994).
8. *Id.* at 394, 438 S.E.2d at 740.

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ligence occurred.[9] The North Carolina Supreme Court arrived at this standard by examining the traditional test for liability under the borrowed servant rule.[10] In doing so, the supreme court overruled both *Jackson v. Joyner*,[11] which the court interpreted[12] as employing the "captain-of-the-ship" doctrine,[13] and *Starnes v. Charlotte-Mecklenburg Hospital Authority*,[14] which presumed that surgeons never enjoy the right to control a skilled specialist like an anesthetist.[15]

This Note examines the North Carolina Supreme Court's decision in *Harris v. Miller*.[16] First, the Note addresses the facts of the case. Second, it discusses the rules courts traditionally have used to impose vicarious liability under respondeat superior, the borrowed servant rule, and tests courts have established to determine whether the borrowed servant rule even applies. Next, the Note analyzes the *Harris* court's rejection of the "captain-of-the-ship" doctrine, the professionals approach,[17] and the application of the "right to control" test.[18] Finally, the Note concludes that North Carolina has charted a middle course; a course which recognizes that reality is at odds with the assumption that a surgeon has the complete right of control over all other personnel in the operating room,[19] but a course that refuses to treat specialists as independent contractors under the professionals approach.[20]

II. THE CASE

In early 1981, Mrs. Etta Harris began experiencing back pain.[21] Mrs. Harris consulted Dr. Miller, an orthopedic surgeon, who diagnosed a ruptured disk requiring surgery.[22] On

9. *Id.*
10. *See infra* notes 80-86 and accompanying text.
11. 236 N.C. 259, 72 S.E.2d 589 (1952).
12. *Harris*, 335 N.C. at 389, 438 S.E.2d at 736.
13. *See infra* notes 104-108 and accompanying text.
14. 28 N.C. App. 418, 221 S.E.2d 733 (1976).
15. *Harris*, 335 N.C. at 391-93, 438 S.E.2d at 738-39.
16. 335 N.C. 379, 438 S.E.2d 731 (1994).
17. *See* Lisk, *supra* note 3, at 189. The "professionals approach" means the general idea of treating medical professionals as independent contractors due to their skill, training, and knowledge. *Id.*
18. *See infra* notes 97-103 and accompanying text.
19. *See* William H. Payne & K. Mike Mayes, *Vicarious Liability and the Operating Room Surgeon*, 17 S. TEX. L.J. 367, 387 (1976).
20. *See supra* note 17.
21. *Harris*, 335 N.C. at 383, 438 S.E.2d at 733.
22. *Id.* at 383-84, 438 S.E.2d at 733.

June 1, 1981, Dr. Miller performed a laminectomy[23] at Beaufort County Hospital,[24] where he had staff privileges.[25] "Anesthesia was administered by Nurse Hawkes, a certified registered nurse anesthetist[26] employed by the Hospital and assigned to the case by the Hospital's Chief Anesthetist."[27] In accordance with the Hospital's Anesthesia Manual, Nurse Hawkes worked under the "responsibility and supervision" of Dr. Miller for the duration of the case because the Hospital did not employ a staff anesthesiologist.[28]

The *Harris* court concluded the operation was "doomed from the start" due to Nurse Hawkes' failure to note Mrs. Harris' heart problems during the pre-operative anesthesia evaluation.[29] Unaware of the heart problem, Nurse Hawkes administered anesthetic agents[30] "that can significantly lower blood pressure in

23. A laminectomy is defined as "the surgical removal of the posterior arch of a vertebra." WEBSTER'S THIRD NEW WORLD INTERNATIONAL DICTIONARY 1267 (1971).

24. *Harris*, 335 N.C. at 384, 438 S.E.2d at 733.

25. Harris v. Miller, 103 N.C. App. 312, 316, 407 S.E.2d 556, 558 (1991). Dr. Miller was in private practice. *Id.* He was neither on the hospital staff nor under contract with the hospital. *Id.* Dr. Miller had applied for and obtained privileges to use hospital facilities in the treatment of his patients. *Id.* A physician acquires the right to practice in the hospital after being screened by the hospital's credentials committee. *See* Stewart R. Reuter, *Toward a More Realistic and Consistent Use of Respondeat Superior in the Hospital*, 29 ST. LOUIS U. L.J. 601, 635 (1985). Medical staff bylaws and regulations govern the practice of the physician in the hospital. *Id.* These bylaws probably are the closest thing to an express agreement between the hospital and the physician. *Id.* An implied agreement also exists that the physician will follow the hospital rules and regulations in using the hospital facilities. *Id.*

26. *Harris*, 103 N.C. App. at 315-16, 407 S.E.2d at 558. A certified registered nurse anesthetist is a registered nurse who, in addition to the studies required to become a registered nurse, has attended a two year nurse anesthesia school and passed a written examination. *Id.* Plaintiff's expert conceded that the quality of care rendered by a certified nurse anesthetist is generally the same as the care given by an anesthesiologist. *Id.* at 319, 407 S.E.2d at 560. An anesthesiologist is a registered doctor specializing in administering anesthesia. *See* Payne & Mayes, *supra* note 19, at 375.

27. *Harris*, 335 N.C. at 384, 438 S.E.2d at 733.

28. *Id.*

29. *Id.* Nurse Hawkes interpreted Mrs. Harris' chest x-rays as "negative," even though Mrs. Harris had an enlarged heart. *Id.* Additionally, Nurse Hawkes failed to perform an electrocardiogram despite Mrs. Harris' mild obesity and history of high blood pressure. *Id.*

30. *Id.* at 384, 438 S.E.2d at 734. The anesthetic agents used by Nurse Hawkes were Demerol, Innovar, and Ethrane. *Id.*

patients with depressed cardiac functions."[31] Further, post operative x-rays revealed that the endotracheal tube was positioned improperly so the tube was ventilating only one lung.[32]

Nurse Hawkes anesthetized Mrs. Harris at seven forty-five that morning.[33] After the anesthetic was administered, Mrs. Harris' blood pressure dropped slightly[34] and then continued to drop steadly, "while her pulse rate rose dramatically."[35] Thinking that Mrs. Harris was feeling pain, Nurse Hawkes increased the anesthesia.[36] Mrs. Harris' pulse rate remained high, however, and her blood pressure did not increase because she was suffering from a lack of oxygen[37] and too much anesthesia.[38] Nurse Hawkes did not notify Dr. Miller that any problem existed.[39]

At eight forty that morning, Dr. Miller noticed an inordinate amount of bleeding and applied small packs to stem the flow of blood.[40] Because the bleeding had not stopped by nine o'clock, Dr. Miller instructed Nurse Hawkes to start giving the patient blood.[41] Nurse Hawkes did not administer blood to Mrs. Harris until approximately forty minutes later.[42] In the forty minute interim, Mrs. Harris' blood pressure dropped to a level that was "incompatible with normal brain functions,"[43] and Nurse Hawkes still did not alert Dr. Miller of Mrs. Harris' condition.[44]

At approximately ten twenty that morning, Nurse Hawkes administered a vasoconstrictor, causing Mrs. Harris' blood pressure to rise briefly.[45] Both Mrs. Harris' blood pressure and pulse rate, however, soon plummeted.[46] When Nurse Hawkes checked

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31. *Id.*
32. *Harris*, 103 N.C. App. at 317, 407 S.E.2d at 558.
33. *Harris*, 335 N.C. at 384, 438 S.E.2d at 734.
34. *Id.* A drop in blood pressure at the induction of anesthesia is a normal reaction to the anesthetic agents; "the blood pressure soon rights itself in response to the stimulation of surgery." *Id.*
35. *Id.*
36. *Id.*
37. *Id.* The lack of oxygen resulted from the misplacement of the endotracheal tube so that it was ventilating only one lung. *Id.*
38. *Harris*, 335 N.C. at 384, 438 S.E.2d at 734.
39. *Id.* at 385, 438 S.E.2d at 734.
40. *Id.*
41. *Id.*
42. *Harris*, 335 N.C. at 385, 438 S.E.2d at 734.
43. *Id.*
44. *Id.*
45. *Harris*, 335 N.C. at 386, 438 S.E.2d at 734.
46. *Id.*

Mrs. Harris' vital signs at eleven ten that morning, Mrs. Harris had no discernable blood pressure or pulse.[47] Then, for the first time, Nurse Hawkes informed Dr. Miller that Mrs. Harris was in extremis.[48] Dr. Miller ordered Nurse Hawkes to stop all anesthesia and to give Mrs. Harris one hundred percent oxygen.[49] Dr. Miller then made a partial closure of Mrs. Harris' back and began resuscitation efforts.[50]

Dr. Miller's efforts were too late to prevent Mrs. Harris' injuries; brain damage already had occurred between nine and ten forty-five that morning.[51] Mrs. Harris remained in a coma for some time, but after regaining consciousness she was able to return home.[52] Over the next five years, however, Mrs. Harris' health slowly deteriorated until she died on November 8, 1987.[53]

Mrs. Harris and her husband filed a medical malpractice action on April 1, 1983, against Dr. Miller, Nurse Hawkes, and Beaufort County Hospital.[54] On October 21, 1986, Mr. and Mrs. Harris settled with Nurse Hawkes and Beaufort County Hospital, releasing them from liability.[55] After Mrs. Harris' death in November, Mr. Harris was substituted as plaintiff,[56] and the complaint was amended to allege Mrs. Harris' wrongful death.[57] The complaint alleged that Dr. Miller was negligent in both treating Mrs. Harris and supervising Nurse Hawkes, as well as vicariously liable for the negligence of Nurse Hawkes.[58]

The trial court granted Dr. Miller's motion for directed verdict on the issue of vicarious liability because there was insufficient evidence of an agency relationship between Dr. Miller and Nurse Hawkes.[59] The jury returned a verdict in favor of Dr. Miller on

47. *Id.*

48. *Id.*

49. *Harris*, 335 N.C. at 397, 438 S.E.2d at 741.

50. *Id.* at 386, 438 S.E.2d at 735.

51. *Id.*

52. *Id.* at 386, 438 S.E.2d at 735.

53. *Id.*

54. *Harris*, 103 N.C. App. at 315, 407 S.E.2d at 557.

55. *Id.*

56. *Id.* Mr. Harris was the administrator of the estate of Etta Harris. *Id.*

57. *Id.*

58. *Id.* This Note, however, will only discuss the vicarious liability allegation.

59. *Harris*, 103 N.C. App. at 315, 407 S.E.2d at 557. As an alternative ground for the directed verdict, the trial court also held the release of Nurse Hawkes in 1986 relieved Dr. Miller of any vicarious liability. *Id.*

the issue of his own negligence.[60] The North Caroliina Court of Appeals, Judge Phillips dissenting, affirmed the judgment.[61]

Plaintiff appealed to the North Carolina Supreme Court on the basis of the dissent,[62] arguing the trial court erred in granting a directed verdict on the issue of Dr. Miller's vicarious liability.[63] The supreme court reversed the court of appeals' decision and granted Plaintiff a new trial.[64] In finding for Plaintiff, the *Harris* court overruled both *Jackson v. Joyner*[65] and *Starnes v. Charlotte-Mecklenburg Hospital Authority*.[66] Chief Justice Exum, writing for the court, held that:

> [A] surgeon should not, as suggested by *Jackson*, be presumed to enjoy the authoritative control of a master merely because he is "in charge" of the operation. To the contrary, under traditional borrowed servant principles, the hospital must be presumed to retain the right of control over its operating room employees. Nor, however, should the surgeon be exempted from respondeat superior liability, as suggested by *Starnes*, merely because the negligence sought to be imputed is that of a skilled specialist. Whether a surgeon may be held vicariously liable for the negligence of one assisting in the operation depends on whether, in the particular case, the surgeon had the right to control the manner in which the assistant performed.[67]

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60. *Harris*, 103 N.C. App. at 315, 407 S.E.2d at 558.

61. *Id.* at 330, 407 S.E.2d at 566.

62. *See* N.C. GEN. STAT. § 7A-30 (1989).

63. *Harris*, 335 N.C. at 383, 438 S.E.2d at 733. Plaintiff also appealed the trial court's exclusion of testimony by the plaintiff's expert on nurse anesthesia care on the basis of Judge Phillip's dissent. *Id.* The supreme court also granted discretionary review pursuant to N.C. GEN. STAT. § 7A-31 on the trial court's ruling that the release of Nurse Hawkes extinguished the liability of Dr. Miller. *Id.*

64. *Harris*, 335 N.C. at 400, 438 S.E.2d at 743. Justice Parker did not participate in the decision. *Id.* Justice Meyer dissented on the ground that the release of Nurse Hawkes extinguished the liability of Dr. Miller. *Id.* The majority held the release did not relieve Dr. Miller of liability, basing the ruling on Yates v. New South Pizza, Ltd., 330 N.C. 790, 412 S.E.2d 666 (1992). *Harris*, 335 N.C. at 400, 438 S.E.2d at 743. The supreme court also found the trial court's exclusion of testimony by the plaintiff's expert witness reversible error. *Id.*

65. 236 N.C. 259, 72 S.E.2d 589 (1952).

66. 28 N.C. App. 418, 221 S.E.2d 733 (1976).

67. *Harris*, 335 N.C. at 395, 438 S.E.2d at 740.

Contract: The Vicarious Liability of a Physician for the Negligence of Othe

III. BACKGROUND

A. *Respondeat Superior*

Respondeat superior is a basic rule of agency[68] "whereby an employer, master,[69] or principal is liable for the negligent acts of his employees, servants,[70] or agents when those acts arise in the course and scope of their employment, service, or agency."[71] The rule originated in *Jones v. Hart*[72] under the presumption that, during the time of service, the master can exercise control over the physical activities of the servant.[73] Thus, tort liability is imposed

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68. "A master is subject to liability for the torts of his servants committed while acting in the scope of their employment." RESTATEMENT (SECOND) OF AGENCY § 219(1) (1957).

69. "A master is a principle who employs another to perform a service in his affairs and who controls or has the right to control the physical conduct of the other in the performance of the service." RESTATEMENT (SECOND) OF AGENCY § 2(1) (1957).

70. RESTATEMENT (SECOND) OF AGENCY § 220 (1957) provides:

> (1) A servant is a person employed to perform services in the affairs of another and who with respect to the physical conduct in the performance of the services is subject to the other's control or right of control.
>
> (2) In determining whether one acting for another is a servant or an independent contractor, the following matters of fact, among others, are considered:
>
> (a) the extent of control which, by the agreement, the master may exercise over the details of the work;
>
> (b) whether or not the one employed is engaged in a distinct occupation or business;
>
> (c) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision;
>
> (d) the skill required in the particular occupation;
>
> (e) whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work;
>
> (f) the length of time for which the person is employed;
>
> (g) the method of payment, whether by the time or by the job;
>
> (h) whether or not the work is part of the regular business of the employer;
>
> (i) whether or not the parties believe they are creating the relation of master and servant; and
>
> (j) whether the principal is or is not in business.

Id.

71. Lisk, *supra* note 3, at 184.

72. 90 Eng. Rep. 1255 (1698).

73. RESTATEMENT (SECOND) OF AGENCY § 219 cmt. a (1957). More modern justifications for respondeat superior include the "deep pocket" theory, which

because the master controls the instrument that causes the injury.[74] Consequently, because a principal does not control the physical conduct of an independent contractor[75] in the performance of the undertaking, a principal is not vicariously liable.[76] Respondeat superior is applied to the health care industry so that a physician "is responsible for an injury done to the patient through the want of proper skill and care in his [or her] assistant, apprentice, agent, or employee."[77] While the rules of respondeat superior are relatively easy to apply when an employee serves one employer, the doctrine becomes more difficult[78] when more than one potential employer exists.[79] The borrowed servant rule has been developed to help assign liability for employee negligence to the proper employer.[80]

B. *Borrowed Servant Rule*

The most widely accepted version of the borrowed servant rule is set forth in section 227 of the Second Restatement of Agency. Section 227 states that "[a] servant directed or permitted by his master to perform services for another may become the ser-

imposes liability on the party best able to pay, and enterprise liability, which seeks to place liability with the party who is best able to spread the cost of injury throughout society as a whole, regardless of fault. *See* Reuter, *supra* note 25, at 604.

74. RESTATEMENT (SECOND) OF AGENCY § 219 cmt. a (1957).

75. *See* RESTATEMENT (SECOND) OF AGENCY § 2(3) (1957). "An independent contractor is a person who contracts with another to do something for him but who is . . . [neither] controlled by the other nor subject to the other's right of control with respect to his physical conduct in the performance of the undertaking. He may or may not be an agent." *Id.*

76. *See* RESTATEMENT (SECOND) OF AGENCY § 250 cmt. a (1957). "A principal employing another to achieve a result but not controlling or having the right to control the details of his physical movements is not responsible for incidental negligence while such person is conducting the authorized transaction." *Id.*

77. 70 C.J.S. *Physicians and Surgeons* § 85 (1987).

78. *See* Nepstad v. Lambert, 50 N.W.2d 614 (Minn. 1951). In *Nepstad* the court opined:

> Though well established, the loaned servant principle has proved troublesome in its application to individual fact situations. The criteria for determining when a worker becomes a loaned servant are not precise; as a result, the state of the law on this subject is chaotic. Respectable authority for almost any position can be found, for even within a single jurisdiction the decisions are in conflict.

Id. at 619-20.

79. *See* Reuter, *supra* note 25, at 605.

80. *Id.*

vant of such other in performing the services. He may become the other's servant as to some acts and not others."[81] In applying this rule, courts uniformly agree the employee is presumed to remain in the service of the general employer[82] in the absence of evidence to the contrary.[83] Courts focus the inquiry into which master was being served on the specific act that caused the injury.[84] The employer that is found to have been the master at the time of the act that caused the injury is vicariously liable,[85] whereas the other employer is relieved of liability.[86] Courts generally agree the determination of whether an employee has been borrowed is a question for the trier of fact.[87]

The critical inquiry then is at what point does the employee cease to be the servant of the general employer and become the servant of the special employer.[88] Jurisdictions have developed several tests to help make this determination.[89] Two tests that are commonly used in the industrial world, "scope of employment"[90] and "whose business,"[91] have been held, however, to be inapplicable to the hospital setting in all jurisdictions.[92] The obvious problem with the "scope of employment" test is the scope of most medical professionals' employment with their general employer encompasses their acts when working at the direction of

81. RESTATEMENT (SECOND) OF AGENCY § 227 (1957). Comment (a) to section 227 states "[w]hether . . . the person lent or rented becomes the servant of the one whose immediate purposes he serves depends in general upon the factors stated in § 220(2)." RESTATEMENT (SECOND) OF AGENCY § 227 cmt. (a) (1957). *See also supra* note 70.

82. The "general employer" is the lending master and the "special employer" is the borrowing master. *See* Lisk, *supra* note 3, at 190.

83. *See* Reuter, *supra* note 25, at 612.

84. *See* Reuter, *supra* note 25, at 613.

85. *Id.* An employer held liable under respondeat superior has the right to seek indemnity from the employee who caused the injury. *See* Lisk, *supra* note 3, at 185.

86. *See* Reuter, *supra* note 25, at 613.

87. *Id.*

88. *Id.* at 614.

89. *Id.*

90. *See* Lisk, *supra* note 3, at 192. "The 'scope of employment' test asks whether the negligent act falls within the scope of the servant's employment with the general employer." *Id.*

91. *See* Reuter, *supra* note 25, at 614. "The 'whose business' test asks whether the act that caused the injury was done to further the business of the general or special employer." *Id.*

92. *See* Lisk, *supra* note 3, at 192.

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the special employer physician.[93] The difficulty with the "whose business" test is the business of the special employer is rarely distinguishable from the business of the professional's general employer.[94] Courts also developed the "administrative" versus "professional" acts test, which holds a non-employer physician liable only for the "professional" acts of other health care professionals and holds the general employer liable for their "administrative" acts.[95] This test, however, has also been discarded in most jurisdictions because the distinction between the two categories is unclear.[96]

The most commonly used test is the "right to control."[97] As the court stated in *Keitz v. National Paving & Contracting Co.*, "[the] decisive test in determining whether the relation of master and servant exists is whether the employer has the *right to control and direct the servant in the performance of his work and in the manner in which the work is to be done.*"[98] The special employer has the right to be present at the time the act occurs and to give instructions as to what work is to be performed by the employee.[99] Liability does not shift unless the special employer has the right to exercise direct supervision and control over the details of the employee's negligent conduct.[100] A servant is the employee of the person who has the right of controlling the manner of the employee's performance of the work, irrespective of whether he or she actually exercises that control or not.[101] Actual control though is strong evidence of the right to control,[102] and where the parties

93. *Id.*

94. *Id.* at 191.

95. *Id.* at 192.

96. *Id.*

97. *Id.* at 193.

98. 134 A.2d 296, 301 (Md. 1957) (emphasis in original).

99. *See* Reuter, *supra* note 25, at 625.

100. *Id. See generally* 57 C.J.S. *Master and Servant* § 566; Hodge v. McGuire, 235 N.C. 132, 69 S.E.2d 227 (1952) (citing § 566 with approval); Weaver v. Bennett, 259 N.C. 16, 129 S.E.2d 610 (1963) (same). Section 566 states:

> A servant of one employer does not become the servant of another for whom the work is performed merely because the latter points out to the servant the work to be done, or supervises the performance thereof, or designates the place and time for such performance, or gives the servant signals calling him into activity, or gives him directions as to the details of the work and the manner of doing it . . . .

57 C.J.S. *Master and Servant* § 566.

101. Mature v. Angelo, 97 A.2d 59, 60 (Pa. 1953).

102. *See* Reuter, *supra* note 25, at 625.

have made an explicit agreement regarding the right to control, the agreement is dispositive.[103]

The captain-of-the-ship doctrine[104] is an extension of the borrowed servant rule.[105] This rule[106] presumes a master-servant relation ship merely from the presence of the surgeon and other operating personnel in the operating room.[107] Once the surgeon enters his ship, the operating room, he has the complete right of control over the other personnel in the operating room.[108]

C. *North Carolina Position*

North Carolina has long recognized the borrowed servant doctrine.[109] In *Weaver v. Bennett*,[110] the North Carolina Supreme Court specifically adopted section 227 of the Second Restatement of Agency, including the comments,[111] as a correct statement of the borrowed servant doctrine.[112] The supreme court also adopted

103. *Harris*, 335 N.C. at 387, 438 S.E.2d at 735.

104. *See* Lisk, *supra* note 3, at 196. The captain-of-the-ship doctrine was first set out in McConnell v. Williams, 65 A.2d 243 (Pa. 1949). In *McConnell* the court opined that "[i]n the course of an operation in the operating room of a hospital and until the surgeon leaves that room at the conclusion of the operation . . . he is in the same complete charge of those who are present and assisting him as the captain of a ship over all on board. . . ." *Id.* at 246.

105. *See* Lisk, *supra* note 3, at 196.

106. The phrase "captain-of-the-ship doctrine" is used in this Note in its expansive sense, referring to the presumption of a master-servant relationship merely from the presence of the surgeon and other operating personnel in the operating room. Some jurisdictions use the phrase in a more restrictive sense simply to refer to the borrowed servant doctrine as it applies to the surgeon in the operating room, without presuming any master-servant relation merely because of the surgeon's presence. The different usages of the "captain-of-the-ship doctrine" results from differing interpretations of *McConnell*, 65 A.2d 243. *See* Franklin v. Gupta, 567 A.2d 524, 536-37 (Md. Ct. Spec. App. 1990). This restrictive use of the phrase makes it difficult to effectively categorize the approach of various jurisdictions to the borrowed servant doctrine in list form. Such a categorization is beyond the scope of this Note.

107. *See* Payne & Mayes, *supra* note 19, at 387.

108. *Id.*

109. *See* Weaver v. Bennett, 259 N.C. 16, 129 S.E.2d 610 (1963); Leonard v. Tatum & Dalton Transfer Co., 218 N.C. 667, 12 S.E.2d 729 (1940).

110. 259 N.C. 16, 129 S.E.2d 610 (1963).

111. *See supra* note 80.

112. *Weaver*, 259 N.C. at 27, 129 S.E.2d at 617-18.

the right to control test.[113] The court reaffirmed these principles in *Harris v. Miller*.[114]

Surprisingly, North Carolina appellate courts have had only two occasions to test the liability of a surgeon for the negligence of operating room personnel under the borrowed servant rule.[115] In *Jackson v. Joyner*,[116] an eight-year-old girl died after a tonsillectomy due to anesthesia complications.[117] The girl's mother had requested that her family physician administer the anesthesia, but Dr. Joyner rejected the request, arranging for Nurse Hanson to assist instead.[118] The North Carolina Supreme Court held the trial court erred in removing the issue of respondeat superior from the jury, reasoning that "Dr. Joyner, as surgeon in charge, had full power of control over the nurses, including Nurse Hanson, so as to make him responsible for the way and manner in which the anesthetic was administered by Hanson."[119]

In *Starnes v. Charlotte-Mecklenburg Hospital Authority*,[120] a newborn was burned during a surgical procedure by a hot water bottle used to keep the infant warm during the surgery.[121] "Warming the infant during the surgery was the responsibility of the nurse anesthetist."[122] Plaintiff alleged the surgeon should be vicariously liable for the negligence of the nurse.[123] Affirming a directed verdict for the surgeon entered by the trial court, the court of appeals stated that "[a]bsent some conduct or situation that should reasonably place the surgeon on notice of negligent procedure, we think the surgeon is entitled to rely on the expertise of the anesthetist."[124]

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113. *Id.* at 28, 129 S.E.2d at 619.
114. 335 N.C. 379, 438 S.E.2d 731 (1994).
115. *Id.* at 388, 438 S.E.2d at 736.
116. 236 N.C. 259, 72 S.E.2d 589 (1952).
117. *Harris*, 103 N.C. App. at 324, 407 S.E.2d at 562.
118. *Jackson*, at 251, 72 S.E.2d at 591.
119. *Jackson*, 236 N.C. at 261, 72 S.E.2d at 591.
120. 28 N.C. App. 418, 221 S.E.2d 733 (1976).
121. *Starnes*, 28 N.C. App. at 419, 221 S.E.2d at 735.
122. *Id.* at 422, 221 S.E.2d at 737.
123. *Id.* at 424-25, 221 S.E.2d at 738.
124. *Id.* at 425, 221 S.E.2d at 738.

IV. ANALYSIS

A. *Captain of the Ship Doctrine Rejected*

The North Carolina Supreme Court began its analysis in *Harris* by reviewing prior North Carolina case law. The court first looked at *Jackson v. Joyner*.[125] The supreme court concluded that the *Jackson* court appears to have presumed that Dr. Joyner enjoyed the right to control from the mere fact that he was the "surgeon in charge."[126] This presumption runs contrary to the borrowed servant rule, part of which is that the lender rather than the borrower is presumed to retain the right of control.[127]

The supreme court noted that long ago hospitals may have been a mere provider of beds for the sick.[128] As such, hospitals did not control the treatment of the patient. The physician had complete control over the patient's treatment and his assistants. Thus, at the time, a presumption that the physician had the right of control was not unreasonable. Now, however, hospitals are in the business of treating the sick and injured.[129] Hospitals exercise significant control over the manner in which their employees provide treatment.[130] This control is accomplished through the use of hiring criteria, training, formal practice guidelines,[131] hierarchical supervision structures, peer review groups, and disciplinary measures.[132] Moreover, surgeons are not the only experts in the operating room.[133] Nurses, technicians, and anesthetists all have extensive training in their fields and do not rely on the surgeon to direct them.[134] In light of these realities, the supreme court held that the captain-of-the-ship doctrine—a presumption

125. 236 N.C. 259, 72 S.E.2d 589 (1952).

126. *Harris*, 335 N.C. at 389, 438 S.E.2d at 736.

127. *Id.*

128. *See* Reuter, *supra* note 25, at 632.

129. *Harris*, 335 N.C. at 389, 438 S.E.2d at 737.

130. *Id.* at 390, 438 S.E.2d at 737.

131. *Id.* These guidelines are a prerequisite to accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (formerly known as the Joint Commission on the Accreditation of Hospitals). *See* Reuter, *supra* note 25, at 633. These guidelines can have immense importance because, as in *Harris*, they can be characterized as an agreement between the surgeon and the hospital as to who has the right to control. *See Harris*, 335 N.C. at 395, 438 S.E.2d at 740.

132. *Harris*, 335 N.C. at 390, 438 S.E.2d at 737.

133. *Id.*

134. *See* Payne & Mayes, *supra* note 19, at 387-90.

that the physician has the right to control—does not apply in North Carolina and, hence, overruled *Jackson*.[135]

The overruling of *Jackson* emphasizes the depths of disfavor to which the captain-of-the-ship doctrine has fallen, and the *Harris* court's decision exemplifies this disfavor, particularly when rescinding *Jackson* was unnecessary. More specifically, the opinion in *Jackson* never explicitly adopted the captain-of-the-ship doctrine; the court only seemingly applied the doctrine by using the phrase "as surgeon in charge."[136] The *Harris* court, therefore, could have easily reconciled *Jackson* by interpreting *Jackson* as applying the right to control test, primarily because the *Jackson* court found Dr. Joyner "had full power of control over the nurses," including control over the "manner in which the anesthetic was administered;"[137] and as such, the rights to select and to discharge indicated a master-servant relationship.[138] Furthermore, Dr. Joyner did in fact arrange for Nurse Hanson to administer the anesthesia, against the express wishes of the mother,[139] which unequivocally indicates Dr. Joyner had the right to control Nurse Hanson and was therefore liable under respondeat superior. Because, however, the opinion in *Jackson* did "not sufficiently elucidate the right to control issue,"[140] the *Harris* court overruled *Jackson* in order to make the point that not only is the captain-of-the-ship doctrine dead, but courts must use the right to control analysis as well as its language.

B. Professionals Approach Rejected

The *Harris* court next looked at the "professionals approach"[141] and in doing so revisited *Starnes v. Charlotte-Mecklenburg Hospital Authority*.[142] The *Harris* court interpreted *Starnes* to stand for the proposition that where the negligence sought to be imputed is of a specialist, surgeons should be exempted altogether from respondeat superior liability on the assumption that surgeons never enjoy the right of control over an

135. *See Harris*, 335 N.C. at 391, 438 S.E.2d at 738.
136. *Jackson*, 236 N.C. at 261, 72 S.E.2d at 591.
137. *Jackson*, 236 N.C. at 261, 72 S.E.2d at 591. *See supra* note 119 and accompanying text.
138. *See Mature*, 97 A.2d at 61.
139. *Harris*, 335 N.C. at 391, 438 S.E.2d at 738.
140. *Id.* at 389, 438 S.E.2d at 736.
141. *See supra* note 17.
142. 28 N.C. App. 418, 221 S.E.2d 733 (1976).

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assisting specialist.[143] The *Harris* court summarily rejected this view.[144] While the *Harris* court acknowledged surgeons generally rely on assisting specialists to perform without supervision, the court stated that surgeons do sometimes have the right to control such assistants.[145] The surgeon may have a contractual right to control assistants, assert actual control over an inexperienced assistant, and possibly a general right to control assistants in emergency situations.[146]

The *Harris* court, however, did not discuss the policy advantages behind the rule in *Starnes*.[147] Traditionally, the primary benefit of applying respondeat superior to the surgeon was it allowed the patient, who could not recover from the hospital due to the doctrine of charitable immunity, to obtain some recovery for his or her injuries.[148] The North Carolina Supreme Court, on the other hand, has held, in *Rabon v. Rowan Memorial Hospital, Inc.*,[149] that the doctrine of charitable immunity no longer applies to hospitals and, therefore, injured patients may recover from the hospital for their injuries.

The real parties in interest in many borrowed servant cases are insurance companies, since they actually seek indemnification from another or other insurance companies.[150] If the liability for specialists assisting the surgeon was assigned to the hospital, as under the *Starnes* rule, then this would avoid the duplication of coverage and lead to lower overall insurance costs.[151] Also, under an enterprise liability theory, the hospital is in the best position to spread the costs of injuries throughout society as a whole.[152] Lastly, the hospital is in the best position to prevent the negli-

143. *Harris*, 335 N.C. at 392-93, 438 S.E.2d at 738-39.

144. *Id.* at 393, 438 S.E.2d at 739.

145. *Id.*

146. *Id.* The general right to control in emergency situations is somewhat troubling. The *Harris* court mentioned it as a possible situation where a surgeon may have the right to control, whether the surgeon actually exercises control or not, but the court gave no further clarification. The general tenor of the argument suggests in this case the right to control question could turn into a "battle of the experts."

147. The *Harris* court was aware of these arguments as the court cited to Reuter, *supra* note 25, at 665-60, in which these considerations are pointed out.

148. *See* Reuter, *supra* note 25, at 655.

149. 269 N.C. 1, 152 S.E.2d 485 (1967).

150. *See* Reuter, *supra* note 25, at 657.

151. *Id.*

152. *Id.*

gence of its employees.[153] For example, the hospital has a long-term relationship with the employee, trains the employee, and has the opportunity to monitor the employee.[154] Conversely, the physician's only contact with the employee may be during the procedure itself. Thus, imposing respondeat superior liability on the hospital would encourage the hospital to take active steps to minimize employee negligence.[155]

C. *Middle Course*

The Supreme Court of North Carolina has chosen to chart a middle course, applying the doctrine of respondeat superior in the hospital setting in the same manner as it is applied in other employment settings. Applying the borrowed servant doctrine in *Harris v. Miller*,[156] the supreme court found the plaintiff's evidence of a master-servant relationship between Nurse Hawkes and Dr. Miller was legally sufficient to be considered by the jury.[157] The court considered a provision[158] in the Hospital's Anesthesia Manual, which Dr. Miller agreed to as a condition of his staff privileges, to be persuasive[159] evidence of Dr. Miller's right to control Nurse Hawkes.[160] When read in a light most favorable to the Plaintiff, the provision manifests Dr. Miller's right to control Nurse Hawkes.[161] The *Harris* court also pointed to testimony that, in an emergency situation, the surgeon has the right to control an anesthetist's every act.[162] Further, Dr. Miller may have in fact exercised actual control when he ordered[163] Nurse Hawkes to stop all anesthesia and to give Mrs. Harris one hundred percent oxygen.[164]

153. *See* Reuter, *supra* note 25, at 658.
154. *Id.*
155. *Id.*
156. 335 N.C. 379, 438 S.E.2d 731 (1994).
157. *Id.* at 395, 438 S.E.2d at 740.
158. *See supra* note 28 and accompanying text.
159. *See supra* note 102 and accompanying text.
160. *Harris*, 335 N.C. at 395, 438 S.E.2d at 740. The court of appeals interpreted the Anesthesia Manual provision to vest "the surgeon with the right of supervision, not control: the power merely to point out the work to be done but not to direct the manner in which the work is to be performed." *Id.*
161. *Id.* at 396, 438 S.E.2d at 741.
162. *Id.*
163. *See supra* note 49 and accompanying text.
164. *Harris*, 335 N.C. at 397, 438 S.E.2d at 741.

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Other jurisdictions have also recently adopted this "middle approach." In *Franklin v. Gupta*,[165] the Court of Special Appeals of Maryland applied the traditional borrowed servant rule in determining whether the plaintiff was entitled to a jury instruction captioned "Responsibility and Liability of Surgeon—the Captain-of-the-Ship Doctrine."[166] This case involved a respondeat superior claim against a physician for the negligence of a nurse anesthetist in administering anesthesia before an operation.[167] Not only was the anesthesia ineffective, but the anesthesia caused the patient to suffer physical and emotional trauma, and the surgery was eventually cancelled.[168] After reviewing how other courts have dealt with the issue, the *Franklin* court rejected the captain-of-the-ship doctrine, stating:

> The correct doctrine to apply is the traditional "borrowed servant" rule. Where the evidence suffices to support a finding that the surgeon in fact had or exercised the right to control the details of another person's work or conduct in the operating room and the other elements of the rule are satisfied, the trier of fact may find that the surgeon was the "special employer" and is therefore liable for the negligence of the borrowed servant.[169]

The *Franklin* court found there was no evidence the physician in any way supervised or controlled, attempted to supervise or control, or had the power to supervise or control the conduct or decisions of the anesthetist.[170] The court, therefore, affirmed the denial of the instruction.[171]

The "middle approach" used in both *Harris* and *Franklin* is superior to both the captain-of-the-ship doctrine, which presumes a master-servant relation by the mere presence of the surgeon, and the professionals approach, which presumes that a surgeon never enjoys the right of control over a skilled specialist. The captain-of-the-ship doctrine has become antiquated, refusing to acknowledge that hospitals are now in the business of treating the sick and injured. The professionals approach fails to account for certain situations where a physician does have the right to control even a skilled assistant. A physician may in fact have a contrac-

165. 567 A.2d 524 (Md. Ct. Spec. App.), *cert. denied*, 572 A.2d 182 (Md. 1990).
166. *Franklin*, 567 A.2d at 539.
167. *Id.* at 524.
168. *Id.*
169. *Id.* at 524.
170. *Id.*
171. *Id.*

tual right or obligation to control an assistant, or may assert actual control over an assistant, or may have a general right to control assistants during an emergency situation.[172] Neither the "deep pockets" theory, the "enterprise liability" theory, nor a judicial policy to increase a hospital's efforts to prevent employee negligence justifies a presumption by courts exculpating the physician for every negligent act of a skilled specialist under his control. If policy considerations do justify such a rule, it is the province of the legislature, not the judiciary, to sanction a departure from the traditional rules of agency.[173]

D. *Effect of Harris*

The most obvious effect of *Harris* is the decision should clear up the prevailing uncertainty which lower courts faced in applying respondeat superior to the liability of a physician[174] for the negligent acts of other medical professionals. *Jackson* and *Starnes* took two widely divergent approaches. First, *Jackson* had been interpreted by the supreme court to presume that a surgeon has the right to control those persons assisting him in the course of an operation by the surgeon's mere presence in the operating room. And second, *Starnes* had been interpreted to presume a surgeon never enjoys the right to control a skilled specialist. The apparent contradictory nature of these decisions placed lower courts in a quandary as to which rule to apply. *Harris* now provides clear guidance as to the application of respondeat superior in any setting.

Whether *Harris* generally will either increase or decrease a physician's exposure to liability is uncertain. Presently, it is unclear how much reliance lower courts placed on the contradictory opinions in *Jackson* and *Starnes*. The effect of *Harris* in this regard depends greatly on how strong the traditional presumption that the general employer retains the right of control is taken to be. Cases applying the borrowed servant rule in an industrial set-

172. *See supra* notes 145-46 and accompanying text.

173. *See* State v. Waddell, 282 N.C. 431, 476-77, 194 S.E.2d 19, 48 (1973) (Opinions of the North Carolina Supreme Court "abound with declarations that public policy is the exclusive province of the legislature . . . .") (Sharp, J., concurring).

174. Given the broad application of the traditional rules of agency, there is no reason to believe the rule in *Harris* is limited to the liability of a surgeon in an operating room. The rule in *Harris* appears to apply to any master-servant relation. It applies to physicians and surgeons inside and outside the operating room.

ting shed little light on the actual strength of the presumption.[175] Obviously, the stronger the presumption is, the less exposure the physician will have to vicarious liability.

Another effect of *Harris* generally may be to preclude a physician from obtaining a judgment as a matter of law, absent an agreement clearly allocating control over the servant to the hospital. One of the basic principles of the borrowed servant rule is the determination of whether an employee has been borrowed is generally made by the trier of fact.[176] Also, given the North Carolina Supreme Court's willingness to accept the contention that surgeons have the right to control skilled specialists during emergencies,[177] judgments as a matter of law should be rare. Already, in *Rouse v. Pitt County Memorial Hospital*,[178] the court of appeals, citing *Harris,* reversed summary judgment granted in favor of two physicians on a borrowed servant claim. Plaintiff filed suit against two attending physicians in connection with the care provided by resident physicians who actually delivered the plaintiff's child.[179] While the residents were not employees of the attending physicians and were paid salaries by Pitt Memorial Hospital, the court of appeals found that the contents of an Affiliation Agreement[180] between Pitt Memorial Hospital and the East Carolina School of Medicine, and bylaws of the hospital's medical staff[181] were sufficient to raise a genuine issue of material fact as to whether the defendants had the right to control.[182] In light of *Harris* and *Rouse*, if physicians want to obtain summary judg-

175. The North Carolina Supreme Court merely states that absent "evidence to the contrary, the original employer is presumed to retain the right of control." *Harris* 335 N.C. at 388, 438 S.E.2d at 736 (citing RESTATEMENT (SECOND) OF AGENCY § 227 cmt. b). The court gives no further guidance as to the sufficiency of the evidence necessary to overcome this presumption, other than, where the parties have an explicit agreement allocating the right to control, the agreement will be dispositive. *Harris*, 335 N.C. at 387, 438 S.E.2d at 735.

176. *See Mature*, 97 A.2d at 61.

177. *See Harris*, 335 N.C. at 393, 438 S.E.2d at 739.

178. 116 N.C. App. 241, 447 S.E.2d 505 (1994).

179. *Id.* at 243, 447 S.E.2d at 507.

180. The Affiliation Agreement provided the resident physicians "shall be responsibly involved in patient care under the supervision of the Dean and the faculty of the School of Medicine." *Rouse,* 116 N.C. App. at 248, 447 S.E.2d at 510. Attending physicians were employed by the East Carolina School of Medicine.

181. The bylaws provided residents "will only practice under the direction of the department chairman or his delegate." *Id.*

182. *Id.* at 249, 447 S.E.2d at 510.

ment, they must be keenly aware of all agreements that could possibly allocate the right of control.

V. CONCLUSION

The North Carolina Supreme Court's decision in *Harris v. Miller*[183] sets forth the standard used to determine whether a physician is liable for the negligent acts of other medical professionals. In doing so, the supreme court overruled the only two previous cases where North Carolina appellate courts have applied the borrowed servant rule to the liability of a surgeon for the negligence of operating room personnel. In applying respondeat superior to the hospital setting, the supreme court charted a middle course, holding a surgeon may be held liable under the doctrine of respondeat superior for the negligence of even a skilled assistant if the surgeon in fact possessed the right to control that assistant at the time of the assistant's negligent act. While all of the potential effects of *Harris* are uncertain, any future decisions applying the borrowed servant doctrine are certain to be more uniform than past decisions.

J. Scott Coalter

183. 335 N.C. 379, 438 S.E.2d 731 (1994).