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A PHYSICIAN'S RESPONDEAT SUPERIOR LIABILITY FOR THE NEGLIGENT ACTS OF OTHER MEDICAL PROFESSIONALS—WHEN THE CAPTAIN GOES DOWN WITHOUT THE SHIP

*Lynn D. Lisk**

I. INTRODUCTION

Consider the following scenario. An auto accident victim is brought into a hospital emergency room. The treating physician orally orders a nurse[1] to obtain x-rays of the victim's head, ribs, legs, and spine. The nurse fails to request x-rays of the patient's spine when she fills out the x-ray requisition form. The patient's spinal injury is aggravated because it is not promptly diagnosed or treated. Should the physician be vicariously liable for the nurse's negligence?[2] Does it depend on whether the physician is the nurse's employer?[3] What if the physician and nurse are employees of the hospital?[4] What if the physician is in private practice and is in the hospital as a "staff physician" and the nurse is a hospital employee?[5] What if . . . the list goes on and on, but the complexity of interrelationships in the health care industry should

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The author would like to thank Mrs. Joanne Lisk, R.N., M.S.N., C.N.S., Assistant Professor of Nursing, Alcorn State University Division of Nursing, Natchez, Mississippi, for her help in answering questions about the nursing profession.

1. Nurses will be used as examples throughout this article. The intent is not to degrade, disparage, or criticize nursing as a profession in any way. However, nurses stand in a unique position, and it is only natural to think of nurses and physicians together when considering a medical malpractice suit.

2. Held "no" on similar facts in Davis v. Schneider, 182 Ind. App. 275, 395 N.E.2d 283 (1979).

3. *See* Runyan v. Goodrum, 147 Ark. 481, 228 S.W. 397 (1921.) (physician held not liable for negligence of employee x-ray technician). *See infra* notes 140-45 and accompanying text for a full discussion of *Runyan*.

4. *See* Plunkett v. Hayes, 180 Ark. 505, 21 S.W.2d 851 (1929) (clinic's doctor could be liable for negligence of clinic's nurse). *See infra* notes 152-62 and accompanying·text for a full discussion of *Plunkett*.

5. *See* Fortson v. McNamara, 508 So.2d 35 (Fla. Dist. Ct. App. 1987) *rev. denied* 520 So. 2d 584 (Fla. 1988) (surgeon not liable for negligence of hospital employed nurse anesthetist).

be apparent by now.[6]

This article explores the theories under which a physician may be liable for the negligence or malpractice of other medical professionals.[7] Understanding a physician's exposure to vicarious liability involves an analysis of basic agency law and the doctrine of respondeat superior, as well as the "borrowed servant" rules[8] and the "captain-of-the-ship" doctrine,[9] both generally and in Arkansas. Based on the analysis, this article will conclude with a discussion of proposed guidelines for the Arkansas courts to use in approaching the problem of a doctor's respondeat superior liability for the acts of other medical professionals.[10]

II. Respondeat Superior — Basic Agency Rules

Respondeat superior is a basic agency rule of liability whereby an employer, master, or principal is liable for the negligent acts of his employees, servants, or agents when those acts arise in the course and scope of their employment, service, or agency.[11] This basic rule originated in *Jones v. Hart*[12] and has survived basically unchanged.[13] As applied to the health care industry, the general rule is that a physician is "responsible for an injury done to a patient through the want of

6. For an expanded discussion of the types and nature of interrelationships see Reuter, *Toward a More Realistic and Consistent Use of Respondeat Superior in the Hospital*, 29 St. Louis U.L.J. 601, 631-37 and 651-54 (1985). *See generally* Smith & Kaluzny, The White Labyrinth (1975).

7. The term "medical professionals" includes those who commonly must meet state licensing and educational requirements in order to legally carry out certain patient care functions. This includes, but is not limited to, physicians, registered nurses, licensed practical nurses, x-ray technicians, and certified lab technicians. *See generally* Ark. Code Ann. §§ 17-80-101 to 17-100-308 (1987 & Supp. 1989) (establishing licensing requirements for various medical professions) and § 16-114-201(2) (1987) (defining "medical care provider").

8. *See infra* notes 66-116 and accompanying text. *See generally* Reuter, *supra* note 8, at 608-11; Morris, *The Negligent Nurse—The Physician and the Hospital*, 33 Baylor L. Rev. 109, 123-28 (1987).

9. *See infra* notes 117-45 and accompanying text. *See generally* Reuter, *supra* note 6, at 643-48; Morris, *supra* note 8, at 124-28.

10. *See infra* notes 192-231 and accompanying text.

11. J. Slain, C. Thompson & F. Bein, Agency, Partnership and Employment—A Transactional Approach 2-1 (1980).

12. 90 Eng. Rep. 1255 (1698). In this case a pawnbroker was found liable when his employee sold an article he was not supposed to sell. Chief Justice Holt ruled that the acts of a servant were the acts of the master when the servant acted with the master's authority.

13. The original justification for the rule has generally been discredited. Today the rule is justified by the "enterprise liability" theory. *See* Classen, *Hospital Liability for Independent Contractors: Where Do We Go From Here?*, 40 Ark. L. Rev. 469, 472-73 (1987).

proper skill and care in his assistant, apprentice, agent, or employee."[14] However, there are exceptions to the rule.[15]

First, before a physician can be held vicariously liable for the acts of another, the other person must have been negligent in some way.[16] This requirement makes sense. Without it a physician/employer would be liable for *all* injuries occasioned by acts of an employee that occur while the employee is "on the job."[17] Further, it must be remembered that an employer held liable under a respondeat superior theory has a right to seek indemnity from the employee who caused the injury.[18] In most jurisdictions the employer and tortfeasor are jointly and severally liable to the injured plaintiff.[19] It appears then, that a physician in private practice will be vicariously liable under the rule of respondeat superior when an employee negligently causes a patient to be injured.[20]

However, in the medical field a question arises as to when a physician should be liable for the negligence of other medical professionals.[21] Such instances of questionable liability include: when a nurse gives an improper medication; when a physician carries out an improper course of treatment relying on a nurse's faulty entries on a patient's chart; when an improper course of treatment results from incorrect or faulty laboratory test results; when an anesthesiologist makes an error in surgery; and when an x-ray technician injures a patient.

The reason for questioning the physician's liability is that the nurse, x-ray technician, and anesthesiologist are professionals in their own right.[22] Each professional therefore has his own duty to the patient

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14. 70 C.J.S. *Physicians and Surgeons* § 85 (1987).

15. A prime exception is found in Runyan v. Goodrum, 147 Ark. 481, 228 S.W. 397 (1921). *See supra* note 3 and *infra* notes 140-45 and accompanying text.

16. "[W]hen a master and servant are sued together for the same act of negligence, and the master's liability, if any, rests wholly upon the servant's negligence, a verdict for the servant necessarily exonerates the master." Whitfield v. Whittaker Memorial Hosp., 210 Va. 176, 183, 169 S.E.2d 563, 568 (1969). *See also* Reuter, *supra* note 6, at 605.

17. Reuter, *supra* note 6, at 606.

18. "[A]n employer held vicariously liable to a third person injured by the negligence of an employee, without negligence on the part of the employer, may seek indemnity against the employee." Fireman's Fund Am. Ins. Co. v. Turner, 260 Or. 30, 34, 488 P.2d 429, 431 (1971). *See also* RESTATEMENT (SECOND) OF AGENCY § 401 comment d (1958).

19. *Compare* RESTATEMENT (SECOND) OF AGENCY § 401 comment d (1958).

20. *Id.* Of course the employee must be working within his scope of employment at the time of the injury. *Id.*

21. This is particularly true of registered nurses.

22. *See generally* I. MURCHISON, T. NICHOLS & R. HANSON, LEGAL ACCOUNTABILITY IN THE NURSING PROCESS (2d ed. 1982) [hereinafter ACCOUNTABILITY]; H. CREIGHTON, LAW EVERY NURSE SHOULD KNOW (5th ed. 1986) [hereinafter EVERY NURSE].

which is independent from that of the treating physician. The issue is whether medical professionals should be independently liable for their own acts, or should liability be imputed to the treating physician.

A few jurisdictions have recognized the validity of holding medical professionals independently liable for their own acts. In *Runyan v. Goodrum*[23] a physician was found not liable for the acts of his employee, an x-ray technician.[24] The court based its decision on the fact that the physician was a general practitioner, not a radiology specialist, and the x-ray technician had specialized training in the use of the equipment.[25] In *Thompson v. Presbyterian Hospital, Inc.*[26] a surgeon was held not liable for brain damage that occurred because the anesthesiologist was negligent in failing to obtain a medical history and to physically examine the patient before administering the anesthesia.[27] In *Thomas v. Raleigh General Hospital*[28] the court stated that an assignment of liability based on the theory of actual control was a more realistic approach[29] in light of today's increasing use of specialists.[30]

The theme throughout these cases is that a physician does not exercise "control" over other professionals' preferences for carrying out their duties.[31] The truth in this approach is apparent. Physicians routinely order x-rays to be taken, medications to be dispensed, anesthesiologists to prepare a patient for surgery, but they do not give detailed instructions as to the manner of the other professional's performance.[32] They do not "control" the other professional. They merely assign a task and rely on the other's skill and training as to how the task is to be

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23. 147 Ark. 481, 228 S.W. 397 (1921).

24. *Id.* at 499, 228 S.W. at 404.

25. *Id.* at 489, 228 S.W. at 399-400.

26. 652 P.2d 260 (Okla. 1982).

27. "Agency cannot avail here for imputing to the surgeon the anesthesiologist's allegedly negligent conduct." *Id.* at 265.

28. 358 S.E. 2d 222 (W. Va. 1987).

29. *Id.* at 225.

30. *Id.*

31. The right of control is a basic requirement of a principal-agent relationship. *See* RESTATEMENT (SECOND) OF AGENCY § 1 comment a (1958).

32. "A physician can spend only a short time at the bedside of each patient and he must therefore leave the actual fulfillment of his prescribed treatment to others . . . . If this were not the accepted practice, no person of moderate means could afford to employ [a physician]." Swigerd v. City of Ortonville, 246 Minn. 339, 343, 75 N.W.2d 217, 220 (1956). "Nursing practice includes but is not limited to administration, teaching, counseling, supervision, delegation, and evaluation of practice and execution of the medical regimen, including the administration of medications and treatments prescribed by any person authorized by state law to prescribe." EVERY NURSE, *supra* note 22, at 11.

accomplished.[33]

In order for a plaintiff to successfully sue a physician on a respondeat superior claim he must show that the tortfeasor was acting on the physician's orders and that the physician had a right of control over the tortfeasor's actions.[34] It is by the right to control the manner of performance that plaintiffs routinely prove the existence of an employee-employer relationship.[35] The cases cited above seem to indicate that, at least in the medical profession, not only should a right of control exist, but also the plaintiff should show actual control.[36] In the absence of actual control, the cases appear to say that other professionals should be treated as independent contractors in their working relationships with doctors.[37]

If other professionals are treated as independent contractors, physicians will not be liable for other professionals' negligent acts on a respondeat superior theory.[38] Physicians could still be liable in their own right for negligent hiring or supervising of other professionals,[39] but would be presumed to have no control over the manner of the other

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33. This is not to say a physician cannot or does not have a right to give detailed instructions or otherwise direct the other professional's performance. *But see* EVERY NURSE, *supra* note 22.

> The services routinely provided by the nurses . . . included, among others, the taking of history; breast and pelvic examinations; laboratory testing of [PAP] smears, gonorrhea cultures and blood serology; giving information about and providing oral contraceptives, condoms and [IUDs]; the dispensing of certain designated medications; and counseling services and community education.

Id. at 18 (citing Sermchief v. Gonzales, 660 S.W.2d 683 (Mo. 1983)). *See also* ACCOUNTABILITY, *supra* note 22. "[P]hysicians . . . cannot by fiat or policy substitute their wishes for nursing behavior for proper nursing conduct . . . they cannot substitute for the necessary educational background, the reasonable use of skill in providing nursing care, and the exercise of that informed judgement that is the hallmark of the professional nurse." *Id.* at 3.

34. *See supra* notes 11 and 14 and accompanying text. *Compare infra* notes 102-09 and accompanying text (discussing "actual control" vs. "right to control").

35. In fact, it is generally held that a *right* to control must exist for an employer-employee relationship to come into being. *See* RESTATEMENT (SECOND) OF AGENCY § 1 (1958).

36. It is logical to assume, for example, in *Runyan*, 147 Ark. 481, 228 S.W. 397 (1921), that the physician as the employer had a right of control over the x-ray technician. However, it is obvious from the case that he did not exercise "actual control." *See generally infra* notes 102-09 and accompanying text.

37. The practical effect of *Runyan*, 147 Ark. 481, 228 S.W. 397 (1921), *Thompson*, 652 P.2d 260 (Okla. 1982), and *Thomas*, 358 S.E.2d 222 (W. Va. 1987) is to do just that. *See also* EVERY NURSE, *supra* note 22, "[W]hen nurses are carrying out their professional acts concerned with patients' medical or nursing needs, i.e., following physicians' orders, they may be independent contractors." *Id.* at 110.

38. RESTATEMENT (SECOND) OF AGENCY §§ 2 comment b and 250 (1958).

39. *Id.* at § 213.

professionals' performances in carrying out their duties.[40]

Strong arguments for this approach exist in the licensing requirements,[41] statutory regulations,[42] and educational requirements[43] of most health care professionals. Also of importance to this approach are the kinds of duties performed and the professionals' range of discretion in carrying them out.[44] Finally, in support of this approach is the basic legal reasoning that every man should be responsible for his own acts.

Advocates of this approach would hold that a physician cannot be liable under a respondeat superior theory when he does not exercise actual control over tortfeasors acting within the range of their professional discretion at the time of the plaintiff's injury.[45] Under this theory, carried to its logical conclusion, a physician would not be liable for the torts of his professional employees as long as he was not exercising actual control over the employee at the time of injury.[46]

An argument against this position is that the duties owed a patient by his physician are non-delegable.[47] Under this theory, a physician is ultimately responsible for the care his patients receive and has a duty

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40. *Id.* at § 2 comment b.

41. *See* ARK. CODE ANN. §§ 17-80-101 to 17-100-308 (1987 & Supp. 1989). These statutes set forth Arkansas' general licensing requirements for various medical personnel. All other states have similar requirements with the only real differences being the types of professions which require state licensing.

42. *Id. See generally*. ARK. CODE ANN. §§ 16-114-201 to -209. (Supp. 1989). Obviously the scope of the regulations varies from state to state.

43. For example, doctors must typically have a four-year undergraduate degree and a three-year medical school degree before being eligible for licensing. Specialty certification requires two to six more years of education in the specialty field. Nurses are typically required to complete two to four years in a nursing education program before they are eligible for licensing and further education if they are to specialize. *See generally* THE NATIONAL ADVISORY COUNCIL ON VOCATIONAL EDUCATION, *The Education of Nurses: A Rising National Concern—Position Paper*, NURSING ISSUES AND NURSING STRATEGIES FOR THE EIGHTIES (1983).

44. The broader the range of discretion available to persons in performing assigned tasks, the more likely they are to be independent contractors. *Cf.* RESTATEMENT (SECOND) OF AGENCY § 2 comment b (1958). *See generally* D. JERNIGAN & A. YOUNG, STANDARDS, JOB DESCRIPTIONS, AND PERFORMANCE EVALUATIONS FOR NURSING PRACTICE (1983) (discussing and outlining the different range of duties typically ascribed to nine different types of nurses).

45. This is basically just a restatement of a principal's non-liability for the acts of independent contractors. *See generally* RESTATEMENT (SECOND) OF AGENCY § 2 comment b (1958).

46. This is exactly what occurred in Runyan v. Goodrum, 147 Ark. 481, 228 S.W. 397 (1921).

47. "Non-delegable duty" is a theory by which liability may be imposed on a principal for the acts of an independent contractor or an agent operating outside the scope of his agency. *See* RESTATEMENT (SECOND) OF AGENCY § 214 and comments (1958). *See generally* R. MORRIS & A. MORITZ, DOCTOR AND PATIENT AND THE LAW (5th ed. 1971) (discussing the obligations that attach to a doctor upon entering into a physician-patient relationship).

to assure that the care given is proper in all circumstances,[48] regardless of the training and education[49] that most medical professions require. This implies that a physician may not justifiably rely[50] on the training, skill, and experience of another in carrying out the physician's plan for treatment. For example, under the "professionals approach,"[51] if a physician ordered a nurse/employee to give a patient an injection and the nurse injured the patient in doing so, the physician would not be liable to the patient unless it was shown he was actually directing and controlling the nurse's actions as she gave the shot.[52] In contrast, under the "non-delegable duties" approach, if the nurse was acting on the physician's order, the physician is liable; whether or not he was exercising control in fact is irrelevant.[53] Under this theory, the physician has the right and duty to exercise control over the nurse's performance of the task. In truth, courts following this approach are finding that the physician was himself negligent in failing to exercise control when he had a duty to do so,[54] not that he is being held to account for the acts of another.[55]

Central to all the approaches is the issue of control.[56] Many courts, in deciding "borrowed servant"[57] and "captain-of-the-ship"[58] cases, have held specifically that in certain circumstances the physician

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48. "The law contemplates that the physician is solely responsible for the diagnosis and treatment of his patients." Mesedahl v. St. Luke's Hosp. Ass'n of Duluth, 194 Minn. 198, 206, 259 N.W. 819, 822 (1935).

49. *See supra* notes 41-43.

50. If the physician is going to be ultimately responsible for the acts of others who assist in his patient's care, then what is the use of the licensing requirements and the statutory regulations of the other health care professions? The author is arguing that a reason for the these requirements is to allow a physician to reasonably rely on the skills of others in caring for his patients. *See* Swigerd v. City of Ortonville, 246 Minn. 339, 75 N.W.2d 217 (1956); Hallinan v. Prindle, 220 Cal. 46, 11 P.2d 426 (1936) (both discussing a physician's right to rely on the skill of others).

51. By "professionals approach" the author means the general idea of treating medical professionals in the manner of independent contractors due to their skill, training, and knowledge.

52. This is because nurses are trained in how to give an injection and without the doctor's actual control it must be presumed the nurse was exercising her professional discretion in the manner in which she proceeded. Also, if the doctor is exercising actual control over her acts, unless it is coerced, it can safely be assumed there is a true principal-agent relationship in effect.

53. It is worthy of note here that even if the nurse was not ordered to give the injection and hence acted outside the scope of her agency, the doctor could still be liable under the non-delegable duties approach. *See* RESTATEMENT (SECOND) OF AGENCY § 214 comment a (1958).

54. The author argues that this is what the court is in fact doing. *But see id.*, stating that a principal is liable under this theory without reference to his own negligence.

55. *But see id.*

56. *See* Morris, *supra* note 8, at 124.

57. *See infra* notes 65-116 and accompanying text.

58. *See infra* notes 117-36 and accompanying text.

is *presumed* to be in, or have a right of, control over the other professional's actions.[59] Proof of this presumption's preliminary fact, the right of control, is relatively easy when the physician is the professional's employer.[60] However, when the physician is not the other's employer, the preliminary fact is not so easily proved.[61] It is in this last situation that the issue of control becomes most important. In deciding this issue, the courts resort heavily to the "borrowed servant" rule.[62] The courts use this doctrine in cases where a presumption of control does not apply, or as a means to justify the presumption.[63] This doctrine is used to determine whether a master-servant relationship exists between the physician and the non-employee professional with the physician playing the role of the master.[64]

III. THE "BORROWED SERVANT" RULE

The "borrowed servant" rule holds that a "servant directed or permitted by his master to perform services for another may become the servant of such other in performing the services. He may become the other's servant as to some acts and not as to others."[65] Whether the servant of the "general employer"[66] has become the servant of the "special employer"[67] is an issue that is decided by looking to the degree of control exercised over the employee by each employer.[68]

59. In fact the "captain-of-the-ship" doctrine is a presumption that the surgeon has a right to control all surgical personnel assisting in an operation. *See* McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949). "[I]t can readily be understood . . . until the surgeon leaves . . . at the conclusion of the operation . . . he is in the same complete charge of those who are present . . . as is the captain of a ship over all on board . . . ." *Id.* at 362, 65 A.2d at 246. *See also* Reuter, *supra* note 6, at 643-46. *See generally* M. MCCAFFERTY & S. MEYER, MEDICAL MALPRACTICE BASES OF LIABILITY 122-25 (1985).

60. Obviously, unless the employee fits the definition of an independent contractor, the employer will have a *right* of control. *See* RESTATEMENT (SECOND) OF AGENCY §§ 1 & 2 (1958).

61. When there is no employer-employee relationship, the courts must rely on circumstances to determine whether the *right* of control exists. *See generally* Reuter, *supra* note 6.

62. *See infra* notes 65-116 and accompanying text.

63. For example, the Pennsylvania Supreme Court discussed the rule extensively in fashioning the "captain-of-the-ship" doctrine. *See* McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949).

64. The doctor is then, obviously, receptive to respondeat superior liability for the other professional's negligence.

65. RESTATEMENT (SECOND) OF AGENCY § 227 (1958).

66. The "general employer" is the "lending" master.

67. The "special employer" is the "borrowing" master.

68. There is a presumption that the general employer retains control, and the burden of proof is on the party seeking to impose liability on the special employer to show that control "shifted." RESTATEMENT (SECOND) OF AGENCY § 227 comment b (1958). *See also* Reuter, *supra*

Obviously, if too much control is shifted to the "special employer," the courts will find that a new contract of employment exists with the "special employer."[69] On the other hand, if the special employer's degree of control is small, the general employer, but not the special employer, will be vicariously liable.[70] The question then, in medical situations, is: When does a physician have enough control over another person to result in the physician being considered the "master" of the other person who is rendering care?[71] The classic situation in which this issue is raised occurs when a physician admits a patient to a hospital in which the physician is not a staff member, but merely has staff privileges, and the patient is injured due to the negligence of a hospital employee.[72] For this and similar situations the courts have used various tests to decide when the degree of control is enough.

These tests include the "administrative" versus "professional" acts test,[73] which holds a non-employer physician liable only for the "professional" acts of other health care professionals, and holds the hospital, or general employer, liable for their "administrative" acts.[74] The problem with this test is determining which acts are "administrative"[75] and which are "professional."[76] The courts have failed to create clear guidelines to be used in this determination.[77] Also, many of the acts

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note 6, at 614-24.

69. For example, if the right to discharge the employee, set his rate of pay, or change his hours of work is given to the special employer, it is easy to see that the employee is no longer actually employed by the general employer.

70. *See supra* note 68 and accompanying text.

71. The author feels that when the other is a medical professional in his own right, it is only when "actual control" is shown.

72. *See generally* Reuter, *supra* note 6.

73. The test originated in Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914). *See also* Beaches Hosp. v. Lee, 384 So.2d 234 (Fla. Dist. Ct. App. 1980); Swigerd v. City of Ortonville, 246 Minn. 339, 75 N.W.2d 217 (1956). *See generally* Reuter, *supra* note 6, at 639-42; 41 C.J.S. *Hospitals* § 8 (1987).

74. Reuter, *supra* note 6, at 640.

75. These have been characterized as acts which do not require the application of the specialized technique or the understanding of a skilled physician or surgeon. Swigerd v. City of Ortonville, 246 Minn. 339, 343, 75 N.W.2d 217, 222 (1956).

76. "Professional acts" are characterized as "those which require an exercise of medical skill or judgment." *Id.* at 344, 75 N.W.2d at 221.

77. Placing an improperly capped hot water bottle on a patient's body is administrative (Iacono v. New York Polyclinic Med. School & Hosp., 296 N.Y. 502, 68 N.E.2d 450), while keeping a hot water bottle too long on a patient's body is medical (Sutherland v. New York Polyclinic Med. School & Hosp., 298 N.Y. 682, 82 N.E.2d 583). Administering blood, by means of a transfusion, to the wrong patient is administrative (Necolayff v. Genesee Hosp., 296 N.Y. 936, 73 N.E.2d 117), while administering the wrong blood to the right patient is medical (Berg. v. New York Soc. for Relief of Ruptured &

regarded as "professional" by the courts are in reality such normal and routine tasks of the tortfeasors[78] that it is difficult to justify characterizing them as "professional" acts for which a physician is liable.[79] Some courts recognizing this have rejected the "administrative" versus "professional" distinction.[80]

Two tests of control used commonly in the industrial world, "scope of employment" and "whose business," have been rejected in all jurisdictions.[81] The "scope of employment" test[82] finds the special employer is in control of the tortfeasor when the task assigned falls outside the scope of the tortfeasor's employment with the general employer.[83] The obvious problem with this is that the scope of most medical professionals' employment with their general employer encompasses their acts when working at the direction of a special employer physician.[84] The "whose business" test[85] holds the special employer liable for the acts of the tortfeasor when such acts are primarily meant to advance the cause of the special employer and not those of the general employer.[86] The obvious problem with this is that the "general cause" of the special employer physician is rarely distinguishable from the general cause of the professional's general employer. Both have the goal of providing

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Crippled, 1 N.Y.2d 499, 154 N.Y.S.2d 455, 136 N.E.2d 523, reversing 286 App. Div. 783, 146 N.Y.S.2d 548). Employing an improperly sterilized needle for a hypodermic injection is administrative (Peck v. Charles B. Towns Hosp., 275 App. Div. 302, 89 N.Y.S.2d 190), while improperly administering a hypodermic injection is medical (Bryant v. Presbyterian Hosp. in City of N. Y., 304 N.Y. 538, 110 N.E.2d 391). Failing to place sideboards on a bed after a nurse decided that they were necessary is administrative (Ranelli v. Society of N. Y. Hosp., 295 N.Y. 850, 67 N.E.2d 257), while failing to decide that sideboards should be used when the need does exist is medical (Grace v. Manhattan Eye, Ear & Throat Hosp., 301 N. Y. 660, 93 N.E.2d 926).

> From distinctions such as these there is to be deduced neither guiding principle nor clear delineation of policy . . .

Bernardi v. Community Hosp. Ass'n, 166 Colo. 280, 289, 443 P.2d 708, 712 (1968).

78. *See* Reuter, *supra* note 6, at 641.

79. *See* Plunkett v. Hayes, 180 Ark. 505, 21 S.W.2d 851 (1929) (*aff'd on other grounds*) in which the physician argued, in effect, the nurse's acts were administrative and he therefore should not have been held liable for them.

80. *See* Bernardi v. Community Hosp. Ass'n, 166 Colo. 280, 443 P.2d 708 (1968); Rice v. California Lutheran Hosp., 27 Cal.2d 296, 163 P.2d 860 (1945). *Cf.* Dickerson v. American Sugar Refining Co., 211 F.2d 200 (3rd Cir. 1954) (rejecting the test by implication).

81. *See* Reuter, *supra* note 6, at 637.

82. *Id.* at 616.

83. *Id. See also* Rogers v. Valley Outdoor Theater Co., 262 Wis. 658, 56 N.W.2d 503 (1953).

84. Reuter, *supra* note 6, at 616 n.82.

85. *Id.* at 637.

86. *Id.* at 614-16.

adequate health care.[87]

The most commonly used test is the "right to control."[88] Under this approach, if the physician in question had a *right* to control the actions of the other professional, he will be found liable on a respondeat superior theory.[89] The approach, while the most widely used, still has many problems. There is rarely an express agreement as to who has a "right of control" in what situations;[90] hence the courts have to imply the existence of the right based on circumstances.[91] Decisions on the issue are far from consistent.[92] Also, some consider the physician to have a *per se* right of control over all who aid in caring for his patients. This reasoning resembles the non-delegable duty approach.

Once a person is found to be a "servant" of the special employer, the general employer is relieved of all liability by way of respondeat superior.[93] In the situation involving non-staff physicians and negligent hospital employees, this rule determines whether the hospital or the physician will be liable for the negligent acts of hospital employees.[94]

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87. Therefore, the main problem with the "whose business" and the "scope of the employment" tests is that in the health care field they fail to establish guidelines by which a court can discriminate between a physician and another for the purposes of imposing respondeat superior liability. *Id.* at 614-17, 637.

88. *Id.* at 617 n.86.

89. "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* . . . ." Keitz v. National Paving & Contracting Co., 214 Md. 479, 491, 134 A.2d 296, 301 (1957) (emphasis in original). *See also* RESTATEMENT (SECOND) OF AGENCY § 220(1) (1957); 57 C.J.S. *Master and Servant* § 2 (1948). *See generally* Dickerson v. American Sugar Refining Co., 211 F.2d 200 (3rd Cir. 1954). "It is the power to control . . . that answers the question." *Id.* at 204; Sparger v. Worley Hosp., Inc., 547 S.W.2d 582 (Tex. 1977). "[T]he essential inquiry would be whether or not the surgeon had the *right to control* the assisting nurses . . . ." *Id.* at 583 (emphasis in original).

90. Obviously if there is a specific agreement between the general and special employer as to who has the right to control in what circumstances it will be easy to say who should be liable under a respondeat superior theory for any set of given acts by the servant. *See* Reuter *supra* note 6, at 618-19, 638.

91. *Id.* at 619.

92. For example, in McDaniel v. Sage, 419 N.E.2d 1322 (Ind. Ct. App. 1981) it was held that a nurse in the company clinic was not the agent of the physician who ordered an injection which was negligently given and caused the patient's injury. However, in Dickerson v. American Sugar Refining Co., 211 F.2d 200 (3rd Cir. 1954), the court found on almost identical facts that the nurse could have been subject to the physician's control and hence liability would not lie with the company.

93. *See* 57 C.J.S. *Master and Servant* § 566 (1948).

94. "A hospital's best chance [to avoid liability] is to allege that, at the time of the negligent act, the employee had been borrowed by . . . the attending physician." Reuter, *supra* note 6, at 608.

Since the hospital is the general employer,[95] it will be liable in the absence of proof that the physician "borrowed" its employees.[96] The weight accorded the evidence and the tests used vary from jurisdiction to jurisdiction on this issue.[97] A professional found to be the "borrowed servant" of a physician in one jurisdiction may not be considered a "borrowed servant" in another jurisdiction.[98]

It is also important to note how the involved professionals view the issue of control.[99] Typically, a non-employer physician has a right of control over a nurse only in limited, narrow circumstances such as when the physician orders the nurse to do something outside the nurse's area of expertise.[100] It is the attitude that nurses and other medical professionals are professionals in their own right[101] that brings us to the final test used by some courts to establish that a physician has "borrowed" a "servant" — the "actual control" test.

The "actual control" test[102] is an offshoot of the "right to control" test.[103] Under the "actual control" test, a showing that a physician exercised "actual control"[104] over the other professional's acts is either evidence of a right of control or presumptive proof that a right of control exists.[105] However, it is the *right* of control that gives rise to the liability.[106] As viewed by this author, and advocated in this article, the "actual control" test should stand alone as the test to be used[107] for two reasons. First, only when a physician exercises "actual control" does

95. *Id.*

96. *Id.*

97. *See generally* Reuter, *supra* note 6; Morris, *supra* note 8.

98. For example, see *supra* note 92.

99. It is important to consider their views as they will be the ones testifying in a trial, and their opinions as to who had control, or a *right* of control, will usually be the bulk of the evidence the issue is decided on.

100. Interview with Joanne Lisk, R.N., M.S.N., C.N.S., Assistant Professor of Nursing, Alcorn State University, Natchez, Mississippi.

101. *See* ACCOUNTABILITY, *supra* note 22, at 1. "[N]urses are prepared to function at a level commensurate with other health professionals." *Id. See generally* EVERY NURSE, *supra* note 22.

102. *See* Reuter, *supra* note 6, at 642-47.

103. *Id.* at 619.

104. The problem here is in determining what facts give rise to an inference of "actual control" by a physician. Some courts have said the mere *presence* of a physician gives rise to a *presumption* that the physician is in "actual control." *Id.* at 643.

105. *Id.* at 619.

106. *Id.*

107. The Oklahoma courts seem to have taken this position. *See* Aderhold v. Bishop, 94 Okla. 203, 221 P. 752 (1923) ("[T]he true test of the existence of the relation of master and servant . . . depend[s] . . . upon whether the master *actually exercises supervision and control*

the other professional lose his discretion in carrying out the task.[108] Second, when a physician exercises actual control over another's acts, unless submission to the control is coerced, it must be presumed that the other has voluntarily submitted to the control of the physician, and hence, a true "master-servant" relationship is in effect.[109] Since the decisions on the issue of control vary from jurisdiction to jurisdiction[110] and hinge on no one particular fact,[111] an attorney faced with this issue must examine previous cases in his jurisdiction to determine which factors and tests have been stressed as most important.

The importance of the "borrowed servant" rule has diminished somewhat in recent times with the abolishment of the doctrine of "charitable immunity" for hospitals.[112] This doctrine held that hospitals and other health care institutions were a public service; public policy required their immunity from suit.[113] When this doctrine applies, a plaintiff will not recover from a hospital because of an injury occasioned by the acts of negligent employees.[114] It therefore becomes more

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over the servant during the time he uses such servant." *Id.* at 206, 221 P. at 755 (emphasis added)); Randolph v. Oklahoma City General Hosp., 180 Okla. 513, 71 P.2d 607 (1937) ("[S]o long as [the nurse] was under the doctor's *immediate supervision* the hospital was not responsible for her actions." *Id.* at 514, 71 P.2d at 608 (emphasis added)).

Oregon seems to lean in this direction as well. *See* May v. Broun, 261 Or. 28, 492 P.2d 776 (1972) (When a surgeon does not "exercise direct supervision or control over [a] machine or its operation, *respondeat superior* liability does not attach to the surgeon." *Id.* at 40, 492 P.2d at 782 (emphasis in original)).

Colorado also seems to be taking this approach. *See* Bernardi v. Community Hosp. Ass'n, 166 Colo. 280, 443 P.2d 708 (1968). Both the hospital and the plaintiff argued the *right* to control was the test to be used. The court seems to disagree in its statement that the doctor "not being present when the injection was given, had no opportunity to control its administration. His instructions that injections were to be given did not give rise to a master-servant relationship." *Id.* at 294, 443 P.2d at 715. *See generally* Miller v. Hood, 536 S.W.2d 278 (Tex. Civ. App. 1976, *writ ref'd n.r.e.*) (physician not liable unless hospital nurse gave medication under his supervision or control); Hallinan v. Prindle, 17 Cal. App. 2d 656 62 P.2d 1075 (1937) (physician not liable when nurse substituted formalin for novacaine on surgical tray); Annotation, *Liability of Operating Surgeon for Negligence of Nurse Assisting Him*, 12 A.L.R.3d 1017 (1967); Reuter, *supra* note 6, at 642-47; M. McCAFFERTY & S. MEYER, MEDICAL MALPRACTICE BASES OF LIABILITY 118-19 (1985).

108. *See* EVERY NURSE, *supra* note 22. "Each registered nurse is directly accountable and responsible to the *consumer* for the quality of nursing care rendered." *Id.* at 11 (emphasis added).

109. The right to control and submission to control must be voluntarily given and assumed to give rise to a master-servant relationship. RESTATEMENT (SECOND) OF AGENCY § 1 (1958).

110. *See* Reuter, *supra* note 6, at 642-43.

111. *Id.*

112. *Id.* at 634.

113. *Id.* at 606.

114. A plaintiff should not recover even if the hospital itself was negligent, as in, for example, hiring an incompetent nurse. Another theory is that the hospital *itself* did not undertake to

important to show that the physician was the "special employer" of the hospital employee who caused the injury.[115] Today, hospitals can generally be sued for their vicarious liability, and it is not necessary to sue the physician just to insure that the plaintiff has sued a non-immune defendant.[116]

IV. THE "CAPTAIN-OF-THE-SHIP" DOCTRINE

Surgery presents special problems in the use of the "borrowed servant" rule.[117] A surgical nurse is working both for the hospital and the surgeon during a surgical proceeding.[118] The problem involves determining which acts the surgeon has "borrowed" the nurse for[119] and which acts the nurse is performing for the hospital.[120] To handle this problem, the courts have fashioned the "captain-of-the-ship" doctrine. First announced in *McConnell v. Williams*,[121] this doctrine holds an operating surgeon liable *per se* for the negligent acts of all surgical personnel that occur in surgery.[122]

In "captain-of-the-ship" cases the crucial question is often at what

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provide medical treatment, but rather was merely a place where medical professionals came to render treatment. *See* Moon v. Mercy Hosp., 150 Colo. 430, 373 P.2d 944 (1962). This argument against a hospital's liability has similarly been rejected. *See* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied* 383 U.S. 946 (1966). *See generally* W. CURRAN & E. SHAPIRO, LAW, MEDICINE AND FORENSIC SCIENCE 364-90 (3rd ed. 1982).

115. Otherwise, the plaintiff was without recourse for his injury. Reuter, *supra* note 6, at 603.

116. *Id.*

117. This is because "[t]here is no doubt that a surgeon has the *right* to control the employees of the hospital . . . in the carrying out of their functions during surgery." May v. Broun, 261 Or. 28, 36, 492 P.2d 776, 780 (1972) (emphasis added). In other words, the mere fact the injury occurred in surgery gives grounds for imposing liability on the surgeon for the negligence of other surgical personnel under a pure borrowed servant "right to control" test. As would be expected, many courts are reluctant to automatically assess liability against a surgeon on this basis alone.

118. Therefore, the "whose business" test and the "scope of the employment" test are of no use in determining who should bear the brunt of liability under respondeat superior for an injury occurring in surgery.

119. A common situation involves the counting of sponges and what happens when one is left in a patient after surgery. *See* Guilbeau v. St. Paul Fire and Marine Ins. Co., 325 So.2d 395 (La. App. 1975) (holding that leaving a sponge in a patient was negligence *per se* on the part of the surgeon, and he could not escape liability by reliance on the nurse's duty to count the sponges).

120. *See* Sparger v. Worley Hosp., Inc., 547 S.W.2d 582 (Tex. 1977) (holding that the counting of sponges was a duty the nurse performed for the hospital and not the surgeon).

121. 361 Pa. 355, 65 A.2d 243 (1949).

122. Reuter, *supra* note 6, at 644; Morris, *supra* note 8, at 125-26. *See also* M. MCCAFFERTY & S. MEYER, MEDICAL MALPRACTICE BASES OF LIABILITY 122 (1985).

point did the surgeon enter the operating room.[123] Actually, the "captain-of-the-ship" doctrine is an extension of the "borrowed servant" rule[124] which states that surgery is such a specialized procedure that all involved are necessarily the "servants" of the "master" surgeon.[125] The importance of this doctrine lies in the fact that the burden of proof for a plaintiff is reduced. Once the plaintiff shows he was negligently injured in surgery,[126] the principal-agent relationship between the physician and other surgical personnel is presumed; there is no need to resolve a "right to control" issue.

Because most jurisdictions recognize to some extent the idea that surgical personnel are experts in their own right,[127] or because they feel the plaintiff should not have the benefit of the principal-agent presumption raised by the doctrine,[128] some courts have rejected the "captain-of-the-ship" doctrine outright.[129] Others have said it does not apply across the board to all personnel in a surgical setting.[130] The courts that use the rule justify its use by reference to proof problems faced by a plaintiff suing for an injury that occurred in surgery.[131]

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123. Reuter, *supra* note 6, at 644. *See also* Hallinan v. Prindle, 17 Cal. App. 2d 656, 62 P.2d 1075 (1936) (surgeon not liable for negligence in preparing a patient for surgery); Nichter v. Edmiston, 81 Nev. 606, 407 P.2d 721 (1965) (surgeon not liable under respondeat superior until surgery actually begins); May v. Broun, 261 Or. 28, 492 P.2d 776 (1972) (surgeon has control only during surgery); Hohenthal v. Smith, 114 F.2d 494 (D.C. Cir. 1940) (surgeon's control ends when he leaves after surgery is completed).

124. *See generally* M. McCafferty & S. Meyer, Medical Malpractice Bases of Liability 122-24 (1985); Reuter, *supra* note 6, at 643-45.

125. Therefore the surgeon is liable *per se* under respondeat superior for the negligent acts of others that occur in surgery.

126. *Res ipsa loquitur* and negligence *per se* are the main theories used by plaintiffs injured during surgery. *See generally* M. McCafferty & S. Meyer, Medical Malpractice Bases of Liability 122; Reuter, *supra* note 6, at 644.

127. *See* Sherman v. Hartman, 137 Cal. App. 2d 589, 290 P.2d 894 (1955) (holding a physician is entitled to rely on the skill and expertise of a nurse in giving a transfusion). *See also* cases cited in *supra* note 123. *See generally*, Every Nurse, *supra* note 22, at 109-25.

128. They generally feel it is unfair to the surgeon to give the presumption to the plaintiff. *Cf.* Sparger v. Worley Hosp., Inc., 547 S.W.2d 582 (Tex. 1977); Parker v. St. Paul Fire and Marine Ins. Co., 335 So.2d 725 (La. Ct. App. 1976).

129. *See supra* note 128. It should be noted here that the jurisdiction given credit for originating the "captain-of-the-ship" doctrine has retreated from a strict application of it, saying its discussion of it was merely an example of borrowed servant rules. *See* Thomas v. Hutchinson, 442 Pa. 118, 275 A.2d 23 (1971); Tonsic v. Wagner, 458 Pa. 246, 329 A.2d 497 (1974).

130. Reuter, *supra* note 6, at 644 n.228 and accompanying text.

131. *Cf.* Mazer v. Lipschutz, 327 F.2d 42 (3rd Cir. 1964). "If operating surgeons were not to be held liable for the negligent performance of the duties of those then working under them, the law would fail in large measure to afford a means of redress for preventable injuries sustained during the course of such operations." *Id.* at 49 (quoting *McConnell* at 364, 65 A.2d at 247, and

A major criticism of the rule is that the surgeon has no opportunity to absolve himself of liability with proof that the tortfeasor was not subject to or did not operate under his control.[132] Another criticism of the rule can be found in the fact that this doctrine, like the pure "borrowed servant" rule, will relieve a hospital of liability when an injury occurs.[133] It seems unfair to allow the burden of liability to fall on an "outside physician"[134] when the injury resulted from the acts of surgical assistants or technicians employed by the hospital.[135] Also, under the enterprise liability rule[136] it would seem that the hospital is in a better position to absorb the cost and pass it along to its customers than is the "outside physician."

V. THE ARKANSAS APPROACH

In Arkansas, respondeat superior and the "borrowed servant" rule are alive and well.[137] However, the Arkansas appellate courts have never addressed the "captain-of-the-ship" doctrine. Likewise, the courts have never applied the "borrowed servant" rule in a medical setting in Arkansas.[138] Most Arkansas cases proceed on the theory that the physician was negligent in some way.[139] There are, however, a few

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Rockwell v. Kaplan, 404 Pa. 574, 579, 173 A.2d 54, 56 (1961)). While use of *res ipsa loquitur* allows a plaintiff to prove a compensable injury, it does not reveal who should do the compensating.

132. The defendant in *Mazer* did argue this, but his arguments were to no avail due to the application of the doctrine.

133. *See supra* note 93 and accompanying text.

134. By "outside physician" the author means a surgeon who is not a hospital employee.

135. Most operations require, in addition to the actual surgeon, an anesthesiologist, a surgical assistant (who may or may not be another doctor), a scrub nurse and a surgical or "floating" nurse.

136. *See* Reuter, *supra* note 6, at 656-58.

137. *See* Billings v. Gipson, 297 Ark. 510, 763 S.W.2d 85 (1989) (finding objection to jury instruction on borrowed servant rule meritless when servant was not negligent to begin with); George's, Inc. v. Otwell, 282 Ark. 152, 666 S.W.2d 406 (1984). "[T]he most significant question regarding a loaned employee is [who] has direction and control of the employee." *Id.* at 154, 666 S.W.2d at 407.

138. The issues of control inherent in a borrowed servant analysis have, however, been discussed. The court has not *expressly* based a ruling on this doctrine in a medical situation though. *See infra* notes 140-72 and accompanying text.

139. *See* Garst v. Cullum, 291 Ark. 512, 726 S.W.2d 271 (1987) (The court held that both physicians involved in the treatment were negligent in their own right.); Kelley v. Wiggins, 291 Ark. 280, 724 S.W.2d 443 (1987) (The court found both the clinic and the physician liable for negligent treatment of a patient who died. The court expressly found the physician's negligence was not an "intervening cause" so as to relieve the clinic of liability. There was also evidence a nurse failed to inform the doctor that the patient was having seizures. But, no holding was based

interesting cases—the two most noteworthy of which are *Runyan v. Goodrum*[140] and *Gray v. McLaughlin*.[141]

In *Runyan* the Arkansas Supreme Court held that a general practitioner was not liable for the acts of the x-ray technician he employed.[142] The court based its ruling on the fact that the x-ray technician had specialized training in the use of the x-ray equipment, whereas his employer, the physician who told him to use it, had none.[143] The court took a step toward the "professionals approach"[144] with this case. It expressly found an x-ray technician *could not* be an agent of his employer when the employer did not have the same special training and skills as the alleged agent.[145]

A few years later in *Gray*, the court retreated from its earlier ruling and held on virtually identical facts that the employer was liable.[146] What makes the ruling most noteworthy is the fact that the court distinguished *Runyan* because the physician/employer was a general practitioner,[147] and in *Gray* he was a radiologist.[148] The rules are fairly clear as to radiologists as a result of *Gray*. If the radiologist employs an x-ray technician, he will be liable for the x-ray technician's acts.[149] If, on the other hand, an "ignorant"[150] physician hires an x-ray technician, the physician will not be liable.[151] However, as to nurses and other medical professionals, the Arkansas courts have not been so clear.

In *Plunkett v. Hays*[152] the court was faced with the issue of a physician's respondeat superior liability for the acts of a nurse.[153] The

on this evidence.); White v. Mitchell, 263 Ark. 787, 568 S.W.2d 216 (1978) (The court found the treating physician negligent, but dismissed the claim against the attending physician who, it seems from the facts, could have prevented the plaintiff's injury.)

140. 147 Ark. 481, 228 S.W. 397 (1921).

141. 207 Ark. 191, 179 S.W.2d 686 (1944).

142. *Runyan*, 147 Ark. at 499, 228 S.W. at 404.

143. *Id.* at 489-90, 228 S.W. at 400.

144. *See supra* note 51 (defining "professionals approach").

145. 147 Ark. at 490, 228 S.W. at 400.

146. 207 Ark. at 196, 179 S.W.2d at 688.

147. 147 Ark. at 483, 228 S.W. at 397.

148. 207 Ark. at 193, 179 S.W.2d at 687.

149. *Id.* at 196, 179 S.W.2d at 688. This is the holding in *Gray*. *See also* Door v. Fike, 177 Ark. 907, 9 S.W.2d 318 (1928); Dorr, Gray & Johnson v. Headstream, 173 Ark. 1104, 295 S.W. 16 (1927). Both of these cases involved a partnership of which Dr. Gray was a member. The issue of agency was not discussed in these cases as the negligent party was an actual partner, not just an employee, and hence all partners were liable.

150. By "ignorant" the author means a physician without expertise in the field.

151. This is the holding in *Runyan*.

152. 180 Ark. 505, 21 S.W. 2d 851 (1929).

153. *Id.* at 506, 21 S.W.2d at 852. It should be noted here that both the physician and the

nurse, acting on the physician's orders, gave an injection to a five year old girl who later died.[154] Evidence at trial indicated that the nurse had injected a toxic substance into the victim.[155] The defendant argued that he should not be liable because he was not present at the time the shot was given,[156] nor did he designate which of the available nurses was to give the shot.[157] He also, and most notably, argued: "[T]he act [can] be performed by the nurse as well as by a physician . . . ."[158] The physician cited *Runyan* in support of his position.[159] The court, however, did not decide the case on the issues raised by his arguments.[160] It instead based its ruling[161] on the facts that the defendant physician would not reveal the identity of the nurse who gave the shot and that he expressly avowed his responsibility for her acts.[162]

Also worthy of note at this point are the *Arkansas Code Annotated* sections that lay out the licensing requirements for nurse and lay midwives.[163] Most interesting is the section stating, "A nurse midwife . . . shall *not* be deemed an agent or employee of the consulting physician[164] solely on the basis of a consulting physician agreement . . . ."[165] No similar provision exists in the statutes dealing with lay midwives.[166] Obviously, the Arkansas General Assembly feels that a physician's exposure to respondeat superior liability for the acts of registered nurses

nurse were apparently employed by the clinic with the doctor playing the role of clinic supervisor. *Id.*

154. *Id.*

155. *Id.* at 508-09, 21 S.W.2d at 853.

156. *Id.* at 510, 21 S.W.2d at 853.

157. *Id.*

158. *Id.* at 509, 21 S.W.2d at 853. This could possibly be viewed as an argument that the act was "administrative" as opposed to "professional." *See supra* notes 73-80 and accompanying text.

159. *Plunkett*, 180 Ark. at 509, 21 S.W.2d at 853.

160. *Id.* at 510, 21 S.W.2d at 853. Besides the possible "administrative" vs. "professional" acts issue, the author here argues the physician raised the issue of "actual control" and the "professionals approach" by his testimony that he was not present, that he did not select the nurse, and that a nurse is as qualified to give an injection as a physician. *See supra* note 158.

161. Their actual ruling reversed a directed verdict in the doctor's favor. 180 Ark. at 510, 21 S.W.2d at 853.

162. Id. at 507, 510, 21 S.W.2d at 852, 853.

163. ARK. CODE ANN. §§ 17-86-501 to -507 (1987) (nurse midwives) and §§ 17-85-101 to -107 (Supp. 1989) (lay midwives).

164. *See* ARK. CODE ANN. § 17-86-506 (1987) (requiring a nurse midwife to have a consulting physician agreement with a doctor who has obstetrical privileges in a hospital as a prerequisite to practicing midwifery).

165. ARK. CODE ANN. § 17-86-507 (1987) (emphasis added).

166. However, lay midwives must practice under a physician's supervision. ARK. CODE ANN. § 17-85-107(b) (Supp. 1989).

acting as midwives should be limited.

The court has addressed the liability of a doctor for the negligent acts of another doctor. In *Norton v. Hefner*[167] a physician from Lake Village, Arkansas, left his patient in the care of another physician[168] in Little Rock after surgery. Allegedly, this other physician's negligence caused the plaintiff's injury.[169] The court held that absent proof that the defendant-physician was negligent in his selection of the other physician, he could not be held liable.[170]

The *Norton* case is cited for support by the dissent in *Chicago R.I. & P.R.R. v. Britt*.[171] Here a nurse assisting in surgery was injured due to the surgeon's negligence.[172] What makes the case interesting for our purposes is the fact the railroad company that had a contract for the surgeon's and nurse's services along with the use of the hospital's facilities was held liable to the nurse on a respondeat superior theory.[173] In his dissent,[174] Justice McHaney, quoting an earlier case which held a railroad *not* liable to a *patient* for the malpractice of a company physician,[175] stated:

> A physician cannot be regarded as an agent or servant in the usual sense of the term, since he is not and necessarily cannot be directed in the diagnosing of diseases and injuries and prescribing treatment therefor, his office being to exercise his best skill and judgment in such matters, without control from those by whom he is called or his fees are paid.[176]

Another interesting case along these lines is *Black v. Bearden*.[177] In this case the plaintiff alleged that the defendant, a dentist, had overcharged him and was guilty of malpractice.[178] The court remanded the case for a new trial because it could not tell which of the claims the

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167. 132 Ark. 18, 198 S.W. 97 (1917).
168. The other doctor was an intern at the hospital. *Id.* at 21, 198 S.W. at 98.
169. *Id.*
170. *Id.* at 22, 198 S.W. at 99. "[T]he doctrine of *respondeat superior* . . . does not apply to a physician . . . who, when employed, acts upon his own initiative and without direction from others." *Id.* at 23, 198 S.W. at 98 (emphasis in original). The doctrine applies to a "servant who acts under the direction and control of the master." *Id.*
171. 189 Ark. 571, 74 S.W.2d 398 (1934).
172. *Id.* at 576-77, 74 S.W.2d at 398.
173. *Id.* at 584, 74 S.W.2d at 403-04.
174. *Id.* at 584-92, 75 S.W.2d at 404-07.
175. *See* Arkansas Midland R.R. Co. v. Pearson, 98 Ark. 399, 135 S.W. 917 (1911).
176. *Britt*, 189 Ark. at 586, 74 S.W.2d at 405 (McHaney, J., dissenting).
177. 167 Ark. 455, 268 S.W. 27 (1925).
178. *Id.* at 456, 268 S.W. at 27.

jury based its verdict on, and the claim for overcharging could not be sustained on the evidence.[179] What is important to our discussion is that the defendant's assistant, himself a dentist, was apparently the actual tortfeasor.[180] Unfortunately, the court never reached any of the agency issues.[181]

The issue of respondeat superior was also apparent, but not discussed, in the cases of *Napier v. Northrum*[182] and *Dunman v. Raney*.[183] In *Napier* the issue was avoided by a ruling that the acts of an anesthesiologist were not negligent.[184] In *Dunman* the defendant physician was, in effect, an assistant to the actual treating physician.[185] He assumed care of the patient when the physician who set the patient's broken leg left.[186] The defendant later returned the patient to the original treating physician's care.[187] The evidence was conflicting, but the original physician who set the leg testified the leg was dislocated when he saw the plaintiff twelve days after setting it.[188] He also stated it was not setting right when he took complete control of the case some two months later.[189] However, the defendant-physician was found liable with no real discussion of the other physician's responsibility or any respondeat superior theory for shifting liability from one physician to another.[190]

VI. CONCLUSION

While the Arkansas courts have rarely faced the issue of a physician's respondeat superior liability for the acts of other professionals,[191]

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179. *Id.* at 459-60, 268 S.W. at 28-29.

180. *Id.* at 456-57, 268 S.W. at 27.

181. The court had no need to discuss the issue of agency in light of the actual holding. Under a *Gray*-type analysis liability would be imposed anyway. *See supra* note 141. *See infra* notes 220 to 233 and accompanying text.

182. 264 Ark. 406, 572 S.W.2d 153 (1978).

183. 118 Ark. 337, 176 S.W. 339 (1915).

184. 264 Ark. 406, 409-10, 572 S.W.2d 153, 155.

185. 118 Ark. 337, 341-42, 176 S.W. 339, 340-41.

186. *Id.* at 339, 176 S.W. at 341. It is not absolutely clear from the opinion, but it appears that the plaintiff initially sought treatment from the defendant who in turn called in the physician who actually set the leg.

187. *Id.* at 342, 176 S.W. at 341. It is not clear why the defendant left or turned the patient over to the other doctor.

188. *Id.* at 341-42, 176 S.W. at 341.

189. *Id.* at 342, 176 S.W. at 341. He further testified the defendant had rendered proper care in the case.

190. *Id.*

191. *See supra* note 7 (defining "medical professionals").

it is obvious they will eventually face the issue again. It is hoped that at that time they will continue the commendable approach begun in *Runyan* and *Norton.*[192]

The holdings in these cases recognize that doctors give orders but rely on other professionals to carry them out.[193] Further, it is hoped that Arkansas will reject the "captain-of-the-ship"[194] doctrine and treat surgery as any other medical setting.[195] Finally, the author hopes the Arkansas courts will apply the "actual control" test[196] to situations involving both employees of the physician and his "borrowed servants."[197] A requirement that "actual control" be shown before respondeat superior will attach liability to the physician recognizes the discretion various medical professionals have in the manner of performing their tasks.[198] Only when a physician is actually directing the other professional's acts has he gained sufficient control over that professional's discretion to qualify himself as a "principal" and the professional as his "agent."[199]

To fully implement the "actual control" test consistently for all medical professionals, without overruling *Runyan* or *Gray*, the Arkansas courts must distinguish *Gray*. The distinction should be based on the physician/employer's expertise in the field.[200] In other words, Arkansas should recognize a "*Gray*" exception to the "actual control" test for physicians acting as employers.[201] This exception would find respondeat superior liability when a physician is the employer of the actual

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192. *See supra* notes 142-45 and 167-70 and accompanying text. *See also* notes 171-76 and accompanying text.

193. *Supra* note 33 and accompanying text.

194. *Supra* notes 117-36 and accompanying text.

195. That is, by use of regular agency rules without the "captain-of-the-ship" doctrine or similar presumptions.

196. *Supra* notes 102-09 and accompanying text.

197. While the test is discussed generally in situations involving borrowed servants, the ruling in *Runyan* makes it possible to logically apply it to employment situations.

198. *See* D. JERNIGAN & A. YOUNG, STANDARDS, JOB DESCRIPTIONS, AND PERFORMANCE EVALUATIONS FOR NURSING PRACTICE (1983) (outlining typical duties and discretions of different types of nurses). *See generally* EVERY NURSE, *supra* note 22.

199. This is the author's position. Obviously, some take the position that a mere *right* of control gives rise to a master-servant relationship between professionals. *See supra* notes 88-92 and accompanying text. The problem with this view is that a physician always has a *right* of control over others who render treatment to the physician's patients. *See supra* note 117.

200. This is the basis on which the Arkansas Supreme Court distinguished *Gray* from *Runyan. See supra* notes 147-48 and accompanying text.

201. That is, when they act as employers of professionals with an expertise in the same field as the physician/employer.

tortfeasor *and* both the tortfeasor and the physician have an expertise in the same specialty.[202] For example, a surgeon would be liable for the acts of a surgical nurse in his employ, but not liable, absent a showing of "actual control," for the acts of an emergency room nurse in his employ.[203] Or, as in *Gray*, a radiologist would be liable for the negligence of an x-ray technician in his employ, but not for the negligence of a general practitioner he employed.[204]

It seems more appropriate to find a specialist in a field liable for the acts of his professional staff who have a similar expertise.[205] As a specialist, the physician should be more aware of the other professional's range of function within the field.[206] As an employer, he is more likely to exercise "actual control" over the acts of professional employees working in the same specialty as himself than he is over other professional employees.[207]

The above approach will leave the court's decision in *Gray* intact while at the same time recognizing the "professionals approach."[208] Under this modified "actual control" procedure, a general practitioner would not be liable for the acts of an employee-professional with expertise in a specialty whose characteristic manner of performance is something the physician is familiar with only generally[209] unless it is shown he was exercising "actual control."[210] This seems only fair and appears to be the logic at work in *Runyan.*

By the same token, and in keeping with *Gray*, the general practitioner would not be liable, without a showing of "actual control," for

202. Both of these factors were present in *Gray* and were cited as the reason for the decision. 207 Ark. 191, 196, 179 S.W.2d 686, 688 (1944).

203. This is because a surgeon is not an expert in emergency care. *See generally* D. JERNIGAN & A. YOUNG, STANDARDS, JOB DESCRIPTIONS, AND PERFORMANCE EVALUATIONS FOR NURSING PRACTICE (1983) (outlining the difference in duties of a surgical nurse and an emergency care nurse).

204. *Cf.* Norton v. Hefner, 132 Ark. 18, 198 S.W. 97 (1917).

205. *Cf. Gray*, 207 Ark. 191, 179 S.W.2d 686 (1944).

206. The court pointed this out in *Gray* as a justification for their holding and seeming departure from the *Runyan* ruling. *Id.* at 196, 179 S.W.2d at 688.

207. Obviously, as an employer a physician is likely to exercise "actual control" over all his employees. However, he is *more likely* to exercise such control over professionals whose duties he is familiar with due to his similar expertise than he is over other professional employees.

208. *Supra* note 51 and accompanying text.

209. *E.g. Runyan*-type situations.

210. Admittedly, it will be easier to show "actual control" over an employee than a non-employee. However, the author maintains such a showing should be required before respondeat superior can be used to impose liability on a physician for the negligence of another medical professional.

the acts of a general nurse in his employ as neither of them are "specialists" in any one field.[211] Also, a specialist, while vicariously liable for the acts of his similarly specialized employees, would not be liable for the acts of non-specialized professional employees or employees with a specialty in another field. This final rule is necessary to keep with the "professionals approach"[212] of insulating physicians from respondeat superior liability for the discretionary acts of other professionals. It also will keep the "*Gray*" exception within the narrow confines of cases involving specialists and their similarly specialized employees.[213] The final result then, will be that a physician is not liable on a respondeat superior theory for the acts of other professionals (in his employ or not) without a showing of "actual control" unless the physician is a specialist in a field and the injury was caused by a professional employee with a similar specialty.[214]

In proving "actual control" the issue of the other professional's training and general duties will become crucial.[215] When it is shown

211. Some might argue they are both specialists in the practice of general medicine and hence under *Gray* the physician should be liable for the nurse's acts as she is a similarly specialized employee. However, this view would seem to defeat the logic in the distinction made by the court between general practioners in *Runyan* and specialists in *Gray*. 207 Ark. 191, 179 S.W.2d 686 (1944).

212. *See supra* note 51 and accompanying text.

213. In other words, it is *only* when the tortfeasor is a specialized *employee* of a similarly specialized physician that the *presumption* of "actual control" created by the "*Gray*" exception should apply. In *all* other instances the plaintiff should have to *prove* "actual control."

214. If the similarly specialized professional is not an employee of the physician then *Gray* would not apply, and a finding of "actual control" would be required to show the physician in question "borrowed" the other professional. Therefore, the author advocates that for a physician to be liable on a respondeat superior basis for the acts of another medical professional the plaintiff must show the physician was exercising "actual control" over the professional. The only exception to the rule would be that "actual control" is presumed to exist when the physician and the other professional are in an employer-employee relationship *and* they both have similar expertise in a specialized field of practice such as in *Gray*, 207 Ark. 191, 179 S.W.2d 686 (1944) (radiologist and x-ray technician).

215. Admittedly this may bear a resemblance to a "scope of the employment" test analysis. However, instead of saying the professional was acting outside the scope of his duties with the general employer, and hence the "special employer" is liable for the acts, the "actual control" view of the issue is that any proof that the professional was working outside his usual scope of duties with the "general employer" is not conclusive proof he has become the servant of the special employer physician, it is merely evidence of such. If, for example, a physician requests a nurse to do something she has been trained for, but has never actually been required to do for the hospital, it is evidence she is subject to the doctor's "actual control." However, the fact she has been trained in the performance of the requested task cuts against a finding of "actual control" and is evidence to be weighed in determining the issue. On the other hand, a "scope of the employment" analysis will easily find the doctor liable for the acts due to the fact that the acts are not within the nurse's regular duties for the hospital. *See generally* D. JERNIGAN & A. YOUNG,

the other professional is operating outside the sphere of his training and/or usual duties it is much more likely that the physician is exercising "actual control" over his performance.[216] Also of importance in proving "actual control" is the physical location of the physician at the time the negligent act occurred.[217] If he is present at the time of injury, there is a much greater likelihood that he was in "actual control."[218] Care must be taken, however, not to let the mere presence of the physician be conclusive proof of "actual control."[219]

Finally, of importance in proving actual control is the specificity with which the physician gives his instructions.[220] If, for example, a physician ordered a shot of ten milligrams of Valium in the right arm of the patient and, in the physician's presence, the nurse negligently injures the patient when she injects twenty milligrams in the left arm, there is greater evidence of the physician's "actual control" over the procedure than if he had merely ordered the nurse to give the patient a tranquilizer and then left.[221] Ultimately, whether the physician was exercising "actual control" is a matter of fact to be decided by the jury.

Some will criticize this approach by saying it will leave innocent plaintiffs without redress for injuries suffered at the hands of negligent, judgment-proof professionals.[222] They will in particular object to this approach when the negligent professional is the physician's employee.[223] The claim will be that this approach is too strict a limitation

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STANDARDS, JOB DESCRIPTIONS, AND PERFORMANCE EVALUATIONS FOR NURSING PRACTICE (1983) (outlining the different duties performed by different types of medical professionals).

216. It is important to note that a medical professional may be working outside his usual scope of duties with one employer, but may still be acting within the range of his professional discretion and training.

217. *See* Reuter, *supra* note 6, at 643-44. The "captain-of-the-ship" doctrine is premised on the idea that a surgeon is in control by the mere fact of his presence.

218. *Cf.* Norton v. Hefner, 132 Ark. 18, 198 S.W. 97 (1917). *Compare* Plunkett v. Hays, 180 Ark. 505, 21 S.W.2d 851 (1929) (doctor liable for negligent injection given outside his presence) *with* Bernardi v. Community Hosp. Ass'n, 166 Colo. 280, 443 P.2d 708 (1968) (doctor not liable for injection given outside his presence).

219. This is the flaw in the "captain-of-the ship" doctrine.

220. Of course, whether or not the physician is the other's employer is also an important factor to look at in deciding the issue of "actual control."

221. Applying *Gray* we could easily find liability in either situation if the physician was a psychiatrist and the nurse was a psychiatric nurse practitioner in his employ.

222. This was the original reason the "borrowed servant" rule and other methods of finding vicarious liability on the part of a physician were so important in the past. *See* Reuter, *supra* note 6, at 603. *See supra* notes 114-16 and accompanying text.

223. *But see* Runyan v. Goodrum, 147 Ark. 481, 228 S.W. 397 (1921). The author was unable to locate any critism by a court of the decision in *Runyan*.

of the traditional respondeat superior theory of liability.[224] The answer to this is that most employers of medical professionals have liability insurance to cover claims against the professionals so employed.[225] Also, personal liability insurance is available to those professionals who are not covered by their employers.[226] The plaintiffs will not be without recourse. What is suggested is that the physician himself should not be answerable in damages for the acts of other professionals unless he was in "actual control."

Finally, in further support of the approach being advocated here, is the argument that nurses, x-ray technicians, and others similarly situated are professionals in their own right.[227] They carry out their duties, usually, with a broad range of discretion[228] and expertise.[229] Their relationship with a physician is more akin to that of an independent contractor.[230] Usually the physician assigns a task to be accomplished, but does not direct the other professional in the manner of its performance.[231] The professional directs himself. It is only when the physician is exercising "actual control" that it can be said a true principal-agent relationship has come about whereby respondeat superior may be used to hold the physician liable for the negligence of other medical professionals.

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224. The traditional approach focus is on the *right* to control. However, as pointed out in this article, doctors *always* have a *right* to control the treatment of their patients.

225. For example, ARK. CODE ANN. § 23-79-210 (1987) authorizes action directly against a liability insurance carrier.

226. *See* Reuter, *supra* note 6, at 605-06.

227. "[N]urses are prepared to function at a level commensurate with other health professionals." ACCOUNTABILITY, *supra* note 22, at 1.

228. *See generally* EVERY NURSE, *supra* note 22, at 11-18.

229. *See supra* notes 41-43 and accompanying text.

230. "Each registered nurse is directly accountable and responsible to the consumer for the quality of nursing care rendered." EVERY NURSE, *supra* note 22, at 11. "Surgeons no longer 'borrow' hospital employees; instead, the hospital is supplying certain services directly to the patient . . . ." *Id.* at 68. "[W]hen nurses are carrying out their professional acts concerned with patients' medical or nursing needs, i.e., following physicians' orders, they may be independent contractors." *Id.* at 110. *See generally* ACCOUNTABILITY, *supra* note 22.

231. He may have a *right* to control the performance, but he should not he held liable unless he actually does so.