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Physician's Liability for Torts of Hospital Employees

Irene E. Svete*

"I will prescribe regimen for the good of my patients according to my ability and my judgment, and never do harm to anyone . . . If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men in all times; but if I swerve from it, or violate it, may the reverse be my lot." Oath of Hippocrates¹

SHOULD A TREATING PHYSICIAN be held liable for negligence of hospital employees? A Federal District Court² recently held the treating physician, an obstetrician-gynecologist, liable for the negligence of the hospital employees when his patient died following childbirth. The Court held that such employees were under the control of the doctor and that he was vicariously liable for their actions.³ The decedent had been a patient of the doctor for obstetric care, remaining under his sole and exclusive care during her pregnancy, delivery and *post partum* period until her death three days after delivery.⁴

Although the defendant-physician delivered her baby, the episiotomy repairs were performed by the resident. On the day following delivery, the patient complained of severe abdominal pains, and on written order of a resident, she was given tranquilizers through that day and the next. Her condition worsened and the defendant was so informed by telephone calls from her husband and from the resident physician. However, he did not at any time order any diagnostic procedures, stating on the telephone as his opinion that she was having *post partum* cramps, as magnified by a low pain threshold. At no time did the specialist visit the patient until her condition became critical in the evening of the third day. At that time he was informed, when he telephoned the hospital, that she was in deep shock. He ordered the resident and intern to use an intravenous infusion of glucose and water with a vasopressor drug. He finally saw the patient for the first time after delivery when he came to her room about 1:15 A.M. and learned that the intravenous was unsuccessful. He made a physical examination and then ordered only such therapeutic measures as consisted of administration of oxygen, application of heat and elevation of the feet. At 3:30 A.M. the patient was declared dead. An

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¹ Wasmuth, *Law for the Physician* (1966) at 18.

² *Schuler v. Berger*, 275 F. Supp. 120 (D.C. E.D. Penna., 1967).

³ *Ibid.* at 124-125.

⁴ *Id.*

autopsy disclosed a diverticulitis of the sigmoid colon with an acute rupture of the diverticulum resulting in peritonitis and death.⁵

This malpractice action against the physician was brought by the administrator of the decedent's estate and the jury found for the plaintiff with an award of \$60,000.00. The jury had been instructed that such symptoms as noted above are obscure, and that negligence could not be found based on negligence to diagnose. Plaintiff claimed that the physician was negligent in failing to take necessary steps to detect and treat patient's peritonitis, in other words, to use the skill and care of his profession. The defendant claimed that plaintiff failed to show proximate cause, because the latter's witness had not testified that death came from cause alleged.

On appeal, however, the court found that plaintiff's expert witness did testify as to his belief that had certain therapeutic measures been taken, the patient would have survived.⁶ Citing with approval *Hicks v. United States*, the court said that proximate cause is tested and proved if "master's omission destroys the reasonable possibility of rescue."⁷

The Court, in denying motion for a new trial, found that the defendant was in control of the patient all through her pregnancy, delivery and postpartum period and had not discharged her; he delegated responsibility for her care to others and was thus liable for their actions. He and the employees had not performed blood work, or taken therapeutic measures to care for her.⁸

Why should a treating physician be held liable for any lack of treatment on the part of the hospital employees? On what basis can such a conclusion be reached? In the *Schuler* case, the *right to control*, not direct supervision, was the standard used in this vicarious liability.⁹

An agency relationship was considered as existing between the parties, making the physician liable for the actions of the hospital employees. He was the "Captain of the Ship," the one in control of the patient's treatment and care. Only he was answerable for resulting injury and death from lack of said treatment. The "Captain" will be held liable for others' negligence where the acts performed by them are under conditions where the physician could have or should have been able to prevent injurious effects and did not.¹⁰

A "Physician" has been defined as one proficient in the art of healing disease, preserving health and alleviating or remedying physical

⁵ *Id.* at 122.

⁶ *Id.* at 123.

⁷ 368 F.2d 626, 632 (4th Cir., 1966). "If there was any substantial possibility of survival and defendant has destroyed it, he is answerable."

⁸ *Supra*, note 2 at 125.

⁹ *Ibid*; *Yorston v. Pennell*, 397 Pa. 28, 153 A.2d 255, 85 A.L.R. 872 (1959).

¹⁰ 70 C.J.S., *Physicians and Surgeons* § 54, at 979.

defects.¹¹ He is expected to exercise a certain standard of care towards his patients, based on the ordinary care, skill, and knowledge of the profession.¹² The right to practice medicine is a constitutional right, but also a conditional one.¹³ Physicians have always been required to conform to such a reasonable standard of training as the state legislature may prescribe¹⁴ "having in mind the public health and welfare."¹⁵ Standards for Ohio are set forth in the Revised Code, as well as statutes found in the Codes of other States.¹⁶ Such legislative enactments impose a specific duty for the protection of the public.¹⁷

The physician undertakes in his treatment of the patient, by contract express or implied, to hold forth that he possesses ordinary skill and knowledge of his profession and that he will "use ordinary care and diligence in the exercise of same" to accomplish the purpose for which he was employed, that of treating the patient.¹⁸ His original and continuing obligation is to his patient. However, the contract element in this relationship is less of a factor than the matter of negligence—the omission of due care or use of skill. Common law has held him responsible for injury to the patient proximately resulting from this, or for failure to use his best judgment in manner of treatment.¹⁹ For many years, physicians were held to a community or locality standard, with an early enunciation in *Small v. Howard*, an 1880 Massachusetts case.²⁰ Modern thinking has broadened this, so far as most Courts are concerned, to take into consideration "the advances of the profession"; the "locality" rule has no present day vitality except

¹¹ 42 Ohio Jur. 2d, Physicians and Surgeons, at 521.

¹² *Beach v. Chollet*, 31 Ohio App. 8, 166 N.E. 145 (1928), wherein the standard was said to be the "present state of medical scientific knowledge at time of treatment"; Swan's Treatises, Fundamentals of Ohio Jurisprudence (1884, Rev. 1935) at 641.

¹³ 41 Am. Jur., Physician and Surgeon, at 135.

¹⁴ Ohio Rev. Code §§ 4731.34, 4731.41.

¹⁵ *State v. Garnett*, 65 Ohio St. 289, 62 N.E. 325 (1901).

¹⁶ *Ibid.*

¹⁷ *Taylor v. Webster*, 12 Ohio St. 2d 53, 231 N.E. 2d 870 (1967).

¹⁸ 42 Ohio Jur. 2d § 111, at 629. *Bowers v. Santee*, 99 Ohio St. 361, 124 N.E. 238 (1919), the "... relationship arises out of contract, express or implied."

¹⁹ *Shuman v. Drayton*, 14 Ohio C.C. 328, 80 Ohio C.D. 12 (1897). Note, 12 Vand. L. R. 595 (1959); and see, *Oleck, Damages to Persons and Property* (1961 rev. ed.) at Secs. 192, 409C, that—when a plaintiff uses reasonable care in obtaining treatment or care of his injury, aggravation of such injury by improper treatment by the physician is a reasonably possible consequence of the original wrong and makes the defendant liable for the entire injury, including the aggravated aspects of it.

²⁰ *Small v. Howard*, 128 Mass. 131 (1880), "undertaking of physician as implied by law is that he possess and will use the reasonable degree of learning, skill and experience which is ordinarily possessed by others of his profession in the community where he practices, having regard to the current state of advance of his profession . . . and that he will in cases of doubt use his best judgment as to the treatment to be given in order to produce a good result. He does not warrant a cure."

as one of the elements to determine the degree of care and skill required as a standard.²¹

*Brune v. Belinkoff*²² was a malpractice action against an anesthesiology specialist for alleged negligence in administering a spinal anesthetic, with injury resulting to the patient from an excessive dosage of pontocaine. Medical evidence showed that such dosage was customary in the city where defendant practiced his profession. The issue raised by the plaintiff was whether the defendant was to be judged by the standard of doctors residing in the community. The Court expressed the opinion, in holding the specialist liable, that *Small v. Howard* is "unsuited to present day conditions" and such holding should be overruled. A standard must be used by which consideration is given to the advances of the profession—and consider medical resources available to him as one of the circumstances in determining skill and care required in treatment of patient.²³

The Courts are thus extending this duty of physicians and requiring a still higher standard for specialists who are held to a special degree of skill and knowledge possessed by doctors who devote particular attention and study to treatment. It is, of course, based on a consideration of public policy to protect the health and lives of the people. The physician has an obligation based on his contract with the patient to render a service, that of treatment.

Although a physician may not be held liable for an error of judgment, he is required to use his best judgment in the exercise of such skill and application of his knowledge, and prescribing what he thinks is best "after careful examination."²⁴

Four elements appear in a malpractice action: first, the existence of a relationship between the doctor and patient; second, the duty of the doctor to prevent injury to his patient; third, failure of doctor to

²¹ *Brune v. Belinkoff*, 235 N.E.2d 793 (Sup. Jud. Ct., Mass. 1968); Tracy, *The Doctor as a Witness* (1957) at 145; Knisely, *Modern Medico—Legal Trends*, 25 Ohio St. L. J. 362 (1964); *Pederson v. Dumouschel*, 72 Wash. 73, 431 P. 2d 973 (1967) at 978, ". . . reversible error to instruct jury that standard of (conduct) care in medical malpractice suit is the learning, skill, care and diligence ordinarily possessed in practice by others of same profession in good standing, engaged in like practice in the same locality, or a similar locality . . . has no present day vitality except as one of the elements to determine degree of care of skill." *Gaheen v. Graber*, 181 Kan. 107, 309 P. 2d 636 (1957). *Carbone v. Warburton*, 11 N.J. 418, 94 A. 2d 680 (1953) at 683 ". . . opinion of expert witness must be directed to degree of knowledge and skill, which is usual in the grade of the profession which defendant occupies and in which defendant is employed in the particular case." *Douglas v. Bussabarger*, 438 P. 2d 829 (Wash. 1968) ". . . small town doctors not entitled to different standard than similar doctors in other areas." *Hundley v. Martinez*, 158 S.E. 2d 159 (W. Va. App. 1967).

²² 235 N.E. 2d 793 (Mass., 1968).

²³ *Ibid.*

²⁴ *Pike v. Hunsinger*, 155 N.Y. 20, 49 N.E. 760 (1898). *Baggett v. Ashland Oil Co.*, 236 N.E. 2d 243 (Ohio 1968). ". . . should be held only to such a standard of care as recognizes foreseeable risk of injury."

prevent such injury; and fourth, resultant injury *i.e.*, a causal relationship between injury and failure to perform duty.²⁵

The burden of proof is on the plaintiff to establish that liability; unless gross negligence is found as a matter of law, expert medical testimony will be required.²⁶

Negligent malpractice includes those cases where there is no criminal or dishonest act—but negligence of that attention which the situation of the patient requires and “is bad or unskillful practice in a physician . . . whereby the health of the patient is injured.”²⁷

A jury hearing a malpractice action, particularly if composed in part of women, would be prone to apply the high standard in the physician's care of the patient. It is reasonable and logical to expect the obstetrician to check personally and frequently on his patient, to observe first hand her postpartum symptoms. After-birth depression is common, but more pronounced in some women than in others. For a doctor to treat and counsel the patient all through her pregnancy and then not to see her for two days following delivery would certainly raise doubts in jurors' minds, as they listen to the evidence, whether he was fulfilling his obligations to his patient. If he has the requisite skill to be an obstetrician, he certainly has the insight and judgment to determine the feasibility of looking in on the patient to analyze whether her pains are psychosomatic or physically induced, because of some complication in her condition. He can not delegate his duty to another without incurring liability for their actions. The hospital employees in Ohio are not permitted to administer any therapeutic measures without being prescribed by the physician in charge.²⁸

He has a further obligation to be in attendance during the period of hospitalization, so long as he has not discharged his patient. Too many doctors have a completely depersonalized view of their patients—so busy that they neglect to check on those under their care—not taking the time to personally treat them. When the facts of the case show that the physician is aware of the patient's condition and he ignores the symptoms, the court finds that there is liability.²⁹

²⁵ Tracy, *op. cit. supra* note 21; Regan, Doctor and Patient and the Law (3rd ed. 1956) at 29-30; Wasmuth, *op. cit. supra* note 1.

²⁶ Riggs v. Christie, 342 Mass. 402, 173 N.E. 2d 610 (1961). “Court or jury” should not retrospectively substitute its judgment for that of the person whose judgment has been sought and given until expert testimony or evidence from profession concerned is given.” Scardina v. Colletti, 63 Ill. App. 481, 211 N.E. 2d 762, 765 (1965).

²⁷ Bouvier's Law Dictionary.

²⁸ Ohio Rev. Code § 4723.06 (Eff. 1-1-68) as to nurses; § 4731.291 (Eff. 12-1-67) as to residents and internes. Kinkela, Hospital Nurses and Tort Liability, 18 Clev-Mar. L. R. 58 (1969).

²⁹ Louisell and Williams, Trial of Medical Malpractice Cases, § 8.05, at 148. “Complaints, observations and remonstrances of patient must be heeded to a reasonable

(Continued on next page)

The physician has no less of a duty to call on his patient because the latter is receiving care in a reputable hospital and being seen by other doctors.³⁰ It is his right, of course, to determine by his own judgment, the frequency of his visits. But when there is cause to believe that personal attention, supervision and additional treatment are necessary, then lack of diligence in doing so, constitutes failure to exercise the skill and care of his profession. He has a duty to use and make available all diagnostic aids throughout the period of recovery.³¹

So we have two important elements of medical practice, the knowledge of basic techniques and the ability to use good judgment in fitting the whole picture of treatment into place.³²

When the physician does not personally supervise his patient, the intern, resident and nurses are his agents and are acting in behalf of the doctor. But this duty, it has been held, can not be delegated without recourse.³³ The act of the agent is deemed the act of the principal, and the latter "incurs the obligations which are the proper results of the acts of the agent done within the scope of his authority."³⁴

This doctrine of responsibility seems to turn on whether the alleged acts of negligence were "under the immediate supervision and control of the physician" when done by the hospital employees. The assistant is said to be subject to immediate control and supervision when the treating physician is the one who makes all the necessary arrangements with the hospital, business and medical, in regard to the patient.³⁵

(Continued from preceding page)

extent." Note, 12 Vand. L. R. 535 (1959) ". . . if keeping in touch by phone—must listen to complaints." *Morgan v. Sheppard*, 188 N.E. 2d 808, 816, 817 (Ohio 1963). "Usual and customary methods generally employed by physician and surgeon and the diagnosis, care and treatment of a patient, no matter how long such methods have continued to be employed, cannot avail to prove and establish as safe in law methods and conduct which are in fact negligent."

³⁰ Prosser, *Law of Torts* (3rd ed. 1964), at 218. "There must be reasonable evidence of negligence . . . But where the thing is shown to be under the management of the defendant or his servants, and accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendant that the accident arose from want of care." *Moeller v. Hauser*, 54 N.W. 2d 639 (Minn. 1952).

³¹ *Supra* note 7; Nicola, *Medical Malpractice*, 25 Ohio St. L. J. 387 (1964); Bowers v. Santee, *supra* note 18. *Gillette v. Tucker*, 67 Ohio St. 106, 65 N.E. 865, 869 (1902).

³² *Wasmuth, op. cit. supra* note 1. *Pike v. Hunsinger, supra* note 24.

³³ *Ault v. Hall*, 119 Ohio St. 422, 164 N.E. 518, 60 A.L.R. 128, 12 A.L.R. 3rd 1019n (1928).

³⁴ *Frazier v. Hurd*, 6 Mich. App. 317, 149 N.W. 2d 226 (1967), *rev'd* on other grounds 380 Mich. 291, 157 N.W. 2d 249 (1968); *Swan, op. cit. supra* note 12, at 334.

³⁵ *Ault v. Hall, supra* note 33. *Graham v. St. Luke Hospital*, 46 Ill. App. 2d 147, 196 N.E. 2d 355 (1964); *St. Paul Mercury Indemnity Company v. St. Joseph Hospital*, 212 Minn. 558, 4 N.W. 2d 637 (1942); *Aderhold v. Bishop*, 94 Okla. 203, 221 P. 752, 60 A.L.R. 137 (1923); *Lawyers Med. Cyc.* § 2.58, at 164 (curr. ed.); *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P. 2d 687, 162 A.L.R. 1258 (1944).

During an operation the services of such employees may be loaned for a period of time to the surgeon and as such, he becomes the master and is liable for their actions while he personally supervises and has control over them.³⁶ The Courts have gone on to consider the incapacity of the patient at this time and the complete dependence on the physician during the operation and also the post operative period. The doctor is charged with the duty to see that "no preventable injury results,"³⁷ and such responsibility continues until the relationship between doctor and patient will be terminated.³⁸ If the physician no longer is going to treat his patient, he should give notice of such termination.³⁹ Therefore, so long as this relationship does exist, he retains the "Captain of the Ship" position and prescribes the treatment and therapeutic measures to be administered by the hospital employees. Thus arises the continued principal-agent position throughout the post operative period.⁴⁰

There can be no absolute liability for negligence, for a doctor cannot be an insurer of his acts; but a breach of his duty to act can be the proximate cause of injury to the patient. He must be attentive to the patient's needs and be diligent in diagnosing and treating the same. As to the amount of time and attention devoted to the patient personally, much would depend on circumstances, type of injury, custom and practice, all of which are taken in consideration by the Courts. Since he may be liable on principles of agency or master-servant, he must use utmost care in supervision and instruction of the assistants. Interns do not hold themselves out to practice medicine, nor do they have patients of their own, their chief and primary reward, it has been said, is instruction received from hospital staff physicians when assisting and watching. They, as well as nurses and residents, are limited in their duties.⁴¹ It would be unreasonable to expect the same skill and knowledge from the hospital employees as from the treating physicians. The hospitals are not in the business of treating patients, their function being the care of those admitted to the institution by the doctor in charge of the patient.

³⁶ 35 Am. Jur. Master and Servant § 3, at 445. Restatement of Agency § 226.

³⁷ Aderhold v. Bishop, *supra* note 35.

³⁸ Stewart v. Manassas, 244 Pa. 221, 90 A. 574 (1914).

³⁹ Ricks v. Bridge, 91 Utah 307, 64 P. 2d 208 (1937); Capps v. Volk, 189 Kan. 287, 369 P. 2d 238 (1962); Gillette v. Tucker, *supra* note 31.

⁴⁰ *Ibid*; Swan, *op. cit. supra* note 12.

⁴¹ Rush v. Akron General Hospital, 84 Ohio L. Abs. 392, 171 N.E.2d 378 (1958). Ohio Rev. Code § 4731.29.1 (5), (Eff. 12-1-67) ". . . practice only under supervision of attending medical staff of such hospital . . ." Ohio Rev. Code § 4723.06 (Eff. 1-1-68) practice of professional nursing defined, "acts of medical diagnosis or prescription of medical, therapeutic or corrective medical measures by a nurse are prohibited."

A landmark case in this regard is one familiar to all law school students. *Ybarra v. Spangard*⁴² is a California case in which the plaintiff had surgery with several nurses and doctors in attendance. While on the operating table, he was placed in such a position as to be resting against two hard objects below his neck. Following the operation, he had severe neck and shoulder pains, but was told that it was paralysis of traumatic origin. There was a decision for the plaintiff based on the theory that there was a special responsibility on the part of every one for his safety. Every defendant who had anything to do with his care was bound to exercise ordinary care to see that no unnecessary harm came to him and each would be liable for failure in this regard. The doctor in charge of the operation would be liable for any negligence of those who became his temporary servants for the purpose of assisting in the operation.

An oft-cited case is *Aderhold v. Bishop*,⁴³ using the *respondeat superior* theory. Here the head nurse scalded the feet of the patient while in the operating room, and again the power of the surgeon to control the situation was used as the basis of liability.⁴⁴

There is, of course, conflict in this matter as in every facet of the law. In every state, Pennsylvania,⁴⁵ Oklahoma,⁴⁶ Wyoming,⁴⁷ Massachusetts,⁴⁸ Tennessee,⁴⁹ and Ohio,⁵⁰ where physicians were not held liable in court actions of this type, the decisions seem to be based on lack of supervision or control.

On the other hand, Pennsylvania⁵¹ has been a state where several cases have found liability along with Ohio⁵² on the control theory.

⁴² *Supra* note 35.

⁴³ *Supra* note 35.

⁴⁴ *Ibid.*; *Honeywell v. Rogers*, 251 F. Supp. 841 (D.C. Pa., 1966).

⁴⁵ *Shull v. Schwartz*, 364 Pa. 554, 73 A. 2d 402 (1950); *Honeywell v. Rogers*, *supra* note 44 " . . . liability is imposed only when physician is in control and when not a surgery or post-operative matter . . . but is merely administrative and routine."

⁴⁶ *Clary v. Christensen*, 54 Ohio L. Abs. 254, 83 N.E. 2d 644 (1948) surgeon had no responsibility to direct activities in re preparation of operating room.

⁴⁷ *Wright v. Conway*, 34 Wyo. 1, 241 P. 369, 242 P. 1107 (1925).

⁴⁸ *Baker v. Wentworth*, 155 Mass. 338, 29 N.E. 589 (1892).

⁴⁹ *Meadows v. Patterson*, 21 Tenn. App. 283, 109 S.W. 2d 417 (1937) physician cannot be liable unless it appears that he had continued control.

⁵⁰ *Oberlin v. Friedman*, 5 Ohio St. 2d 1, 213 N.E. 2d 168 (1965) administration by anesthetist held to be the responsibility of the hospital; *Klema v. St. Elizabeth Hospital*, 170 Ohio St. 519, 166 N.E. 2d 765 (1960).

⁵¹ *Mazur v. Lipshulz*, 360 A. 2d 275 (3d Cir. Pa., 1966); *McConnell v. Williams*, 361 Pa. 355, 65 A. 2d 243 (1949).

⁵² *Ault v. Hall*, *supra* note 33; *Shannon v. Joller*, 6 Ohio App. 2d 206, 217 N.E. 2d 234 (1966); *Morgan v. Sheppard*, *supra* note 29.

Courts of England,⁵³ Missouri,⁵⁴ Oklahoma,⁵⁵ Idaho,⁵⁶ Louisiana,⁵⁷ Minnesota,⁵⁸ District of Columbia,⁵⁹ Michigan,⁶⁰ Kansas,⁶¹ Tennessee,⁶² Illinois,⁶³ Vermont,⁶⁴ and California⁶⁵ have all held the treating physician liable.

In analyzing the decisions reached in the various jurisdictions, we can see that in determining the matter of liability, the Courts have prominently brought into play this "Captain of the Ship" doctrine and used it as a guiding principle. When the Courts have found him not liable, they have held, "no control."⁶⁶

Some early cases denied relief to the plaintiff where there was no reasonable anticipation of injury and the nurses were under the supervision of the hospital.⁶⁷

However, a 1909 English case⁶⁸ followed the rule of vicarious liability, where the hospital had been found to have exercised care in selection of its agents, and not liable for their negligence, such agents being under the orders of the operating surgeon. The same result was reached in a 1911 Ohio case.⁶⁹

Courts have held that such employees can be servants of two masters at one time,⁷⁰ and when lent to a second master, he becomes liable for their actions. When having been lent, the principal is silent as to the acts of his agents, he is ratifying such act and is liable.⁷¹

⁵³ Hillyer v. Governor of St. Bartholomew Hospital, 2 K.B. 820 (1909).

⁵⁴ Longan v. Williams, 79 S.W. 655 (Mo. 1904).

⁵⁵ Aderhold v. Bishop, *supra* note 35.

⁵⁶ Davis v. Potter et al., 2 P. 2d 318 (Idaho 1931).

⁵⁷ Messina v. Societe Francaise de Bienfaisance, 170 S. 801 (La. App. 1936).

⁵⁸ St. Paul v. St. Jos. Hospital, *supra* note 35.

⁵⁹ Hohenthal v. Smith, 72 App. D. C. 345, 114 F. 2d 494 (1940).

⁶⁰ Winchester v. Meade, 372 Mich. 593, 127 N.W. 2d 337 (1964). Frazier v. Hurd, *supra* note 34, physician held liable for negligence of doctor assisting him, the latter becoming the agent of the former, according to the Court.

⁶¹ Voss v. Bridwell, 188 Kans. 643, 364 P. 2d 955 (1961). Capps v. Volk, *supra* note 39.

⁶² Harrison v. Wilkerson, 405 S.W. 2d 649 (Tenn. 1966).

⁶³ Lundahl v. Rockford Memorial Hospital, 235 N.E. 2d 671 (Ill. 1968) court held that treatment is responsibility of physician, and hospital not liable.

⁶⁴ Minoque v. Rutland Hospital, 119 Vt. 336, 125 A. 2d 796 (1956) hospital not liable because physician was held to be the one with right to control; the employees were temporary servants of the doctor in charge.

⁶⁵ Ybarra v. Spangard, *supra* note 35.

⁶⁶ *Supra* note 48.

⁶⁷ *Supra* notes 38, 47.

⁶⁸ *Supra* note 53.

⁶⁹ Taylor v. Protestant Hospital Association, 85 Ohio St. 90, 96 N.E. 1089 (1911).

⁷⁰ McConnell v. Williams, *supra* note 51.

⁷¹ Manufacturers Casualty Insurance Co. v. Martin Libreton Insurance Co., 242 F. 2d 951 (5th Cir., 1957).

However, in *Harlan v. Bryant*,⁷² where a nurse administered drops to a new born infant's eyes, causing damage, the Court held that he had not ordered such treatment, and the nurse had acted of her own volition, and the physician was not liable. In the *Hohenthal v. Smith*⁷³ case, however, where an intern gave an injection and the needle broke off in the patient, the physician who ordered the injection was liable, as the intern was "performing the duty of the hospital to the patient when carrying out the instructions of the physician." When the physician's orders to the hospital employees were incomplete and injury to the patient resulted, the doctor was liable.⁷⁴ In *Capps v. Volk*,⁷⁵ when defendant physician attended patient throughout post operative care, his implied contract continued, carrying continuing liability for injury, which resulted when an intern was negligent in removing a drain tube from the incision. The physician's duty was held to extend to this aftercare. *Shannon v. Joller*⁷⁶ required of the physician an explanation of the resultant injury, he being the one in control.

Sponges left in incisions are common occurrences and the courts hold surgeons accountable on principle of *respondeat superior*.⁷⁷ Even when the surgeon leaves the operating room, he may be held liable for the actions of the attendants.⁷⁸ When a technician administered the wrong type of blood, his negligence was attributed to the surgeon,⁷⁹ the treatment of the patient being the responsibility of the physician.⁸⁰

With this particular type of case, the Courts continue to hold that the hospital cannot be liable since they cannot practice medicine and these borrowed servants are the responsibility of the treating physician.⁸¹

As we consider the development of this theory of liability, it becomes apparent that it is not new. There may be some trend toward abandoning the "Captain of the Ship" doctrine because of the fall of hospital "charitable immunity,"⁸² but it is not reflected in the cases

⁷² 87 F. 2d 170 (7th Cir., 1936).

⁷³ 72 App. D. C. 345, 114 F. 2d 494 (1940).

⁷⁴ *Winchester v. Meade*, *supra* note 60.

⁷⁵ 189 Kan. 287, 369 P. 2d 238 (1962).

⁷⁶ 6 Ohio App. 2d 206, 217 N.E. 2d 234 (1966).

⁷⁷ *Supra* note 62.

⁷⁸ *Harrison v. Wilkerson*, *supra* note 62.

⁷⁹ *Mazur v. Lipshulz*, *supra* note 51.

⁸⁰ *Supra* note 63.

⁸¹ Note, 12 Vand. L. R. 598 (1959); *op. cit. supra* note 29. *St. Paul Mercury Indemnity Co. v. St. Joseph Hospital*, *supra* note 35; *Aderhold v. Bishop*, *supra* note 35; *Minoque v. Rutland Hospital*, *supra* note 64.

⁸² *Avellone v. St. John Hospital*, 165 Ohio St. 467, 135 N.E. 2d 410 (1956); *Klema v. St. Elizabeth Hospital*, 170 Ohio St. 519, 166 N. E. 2d 765 (1960).

discussed here. The "enterprise theory" or "deep pocket" theory in re the physician⁸³ still seems to have impact.

Other than to suggest that the possibility that malpractice actions are certain to proliferate, it is impossible to hazard a guess as to whether this trend of holding the treating physician liable for the torts of the hospital employees will continue. The medical practitioners must make fewer mistakes, take a more personal view of their patients, and restrict their case loads to provide more individual attention, and maintain a high degree of care, skill and knowledge.

The public cannot at the present time rely on the legislature to discipline the medical profession for its flagrant mistakes, and a malpractice suit is the only alternative for a person who has been injured, because of medical negligence. The physician must not be allowed to shift the responsibility for his tortious acts of omission or commission to the hospital employees.⁸⁴

⁸³ Capps v. Volk, *supra* note 39.

⁸⁴ Averbach and Belli, II Tort and Medical Yearbook (1962) at 392.