Illinois Official Reports

Appellate Court

***Fese v. Presence Central & Suburban Hospitals Network*,**
2023 IL App (2d) 220273

Appellate Court Caption	PAMELA FESE, Individually and as Administrator of the Estate of Joseph Fese, Deceased, Plaintiff-Appellant, v. PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, d/b/a Presence Mercy Medical Center; CEP AMERICA, LLC; and DANIEL J. IRVING, Defendants (Presence Central and Suburban Hospitals Network, d/b/a Presence Mercy Medical Center, Defendant-Appellee).
District & No.	Second District No. 2-22-0273
Filed	May 1, 2023
Decision Under Review	Appeal from the Circuit Court of Kane County, No. 19-L-167; the Hon. Susan Clancy Boles, Judge, presiding.
Judgment	Affirmed in part and reversed in part. Cause remanded.
Counsel on Appeal	Michael W. Rathsack, of Park Ridge, and Charles L. Cannon III, and Daniel K. Centina, of Walsh, Knippen & Cetina Chtrd., of Wheaton, for appellant. Daniel P. Slayden, Charles A. Egner, and Steven P. Slayden, of Lewis Brisbois Bisgaard & Smith, LLP, of Chicago, for appellee.

Panel JUSTICE JORGENSEN delivered the judgment of the court, with opinion.
Justices Schostok and Kennedy concurred in the judgment and opinion.

OPINION

¶ 1 After her husband, Joseph Fese, died, plaintiff, Pamela Fese, individually and as administrator of his estate, sued defendants, Presence Central and Suburban Hospitals Network, doing business as Presence Mercy Medical Center (Presence), the hospital to which Joseph was transported after he had trouble breathing; Dr. Daniel J. Irving, the attending physician; and Dr. Irving's employer, CEP America-Illinois, PC (CEP). Pamela alleged that Dr. Irving—who diagnosed Joseph with epiglottitis, a swelling of the epiglottis that covers the opening of the trachea, which, if not resolved, cuts off the windpipe—negligently waited 52 minutes to attempt a cricothyrotomy to open an airway, the attempt was unsuccessful, Joseph died as a result. She further argued that Dr. Irving was Presence's apparent or implied actual agent and that Presence and CEP were vicariously liable for Dr. Irving's negligence. The trial court granted Presence's motion for summary judgment, and Pamela appeals, challenging aspects of the consent form she signed at the hospital and arguing that there were material factual questions concerning whether Dr. Irving was Presence's apparent or implied agent. We affirm in part, reverse in part, and remand for further proceedings.

¶ 2 I. BACKGROUND

¶ 3 On April 5, 2019, Pamela sued defendants. In an amended complaint, she alleged that, on April 9, 2017, Joseph was transported via ambulance to Presence's emergency department and treated by Dr. Irving (Presence's apparent or actual agent). During two hours of care in the emergency room, the doctor's negligent delay in diagnosing Joseph; paging an otolaryngology or ear, nose, and throat specialist (ENT); and providing proper treatment caused Joseph's epiglottis to swell and slowly close off his throat until it suffocated him. She further alleged that defendants were negligently late in attempting an emergency cricothyrotomy to open Joseph's airway, they negligently failed to establish an airway, and Joseph died as a result.

¶ 4 A. Consent Form

¶ 5 At the hospital, Pamela signed Presence's consent form, titled "Consent to Treatment and Other Acknowledgements." The two-page document addressed several topics: consent to treatment, practitioner employment status, financial agreement, assignment of insurance benefits, notification concerning out of network providers, personal possessions, patient's rights and responsibilities, use and disclosure of health information, maintenance of a safe environment, and acceptance and signature. Each of the foregoing topics was preceded by a topic header, printed in all capital letters. The paragraph addressing practitioner employment status stated:

> "I understand that all Practitioners who provide care, treatment, and other related services to me are INDEPENDENT PRACTITIONERS and not employees or agents of a Presence Health entity, except for those Practitioners who clearly and explicitly

identify themselves as facility employees by wearing an identification badge with the facility name. I understand that each Practitioner is solely and exclusively responsible for the exercise of his or her own independent medical judgment and is solely responsible for the care, treatment, and services that they order, request, direct, or provide. I acknowledge that the employment or agency status of Practitioners who treat me is not relevant to my selection of Presence Health for my care, and I neither require nor is it my expectation that any Practitioner providing me with Practitioner services be an employee of Presence Health. I also understand that I will receive, and am solely responsible for payment of, a separate bill from each of these independent Practitioners, or groups of Practitioners, for care, treatment, or services provided. By signing on the line immediately below, I acknowledge that I fully read and understood this paragraph and have had all of my questions or concerns regarding the employment status of my Practitioners satisfactorily answered by Presence Health."

¶ 6 Immediately under this paragraph was a signature line for the patient or the patient's representative. Pamela's signature appeared on this line, and she also signed at the end of the document. At the end of the document, the paragraph addressing acceptance and signature stated:

> "I represent that I have read and understand, and am duly authorized to accept and execute, these terms and conditions, and have signed the above paragraph regarding Practitioner employment status. Any questions I have had have been satisfactorily answered. I hereby accept and agree to be bound by all of the above terms and conditions and I agree that a copy of this document may be used in the place of the original in enforcing any rights hereunder."

¶ 7 B. Professional Services Agreement

¶ 8 CEP provides emergency medical and related administrative services at Presence. The terms and conditions of CEP providing these services are set forth in the professional services agreement between Presence and CEP (agreement). The agreement also provides that a practitioner's relationship with Presence is as an independent contractor and that Presence does not have control or direction over the manner or method by which CEP, through the practitioners, performs services under the agreement, provided that CEP ensures that services are performed in a manner consistent with Presence's policies, applicable law, and accreditation standards.

¶ 9 In a section addressing the removal of a practitioner, the agreement states that, within 30 days of Presence's written request to remove a practitioner from the delivery of services, CEP "will voluntarily remove, replace and thereafter no longer assign" that practitioner to provide services. Notwithstanding this provision, upon Presence's request, CEP "will immediately remove, replace, and no longer assign" a practitioner to provide services if the practitioner terminates association with CEP for any reason or no reason; fails to meet professional qualifications; dies or is permanently disabled; is charged with, indicted, or arrested for certain offenses; materially breaches patient information confidentiality; becomes uninsurable or uninsured; engages in fraudulent, unethical, or disruptive behavior; is under investigation by a regulatory agency concerning his or her provision of care; is suspended, debarred, or excluded from participation in Medicare, Medicaid, or any other government-funded health care program; acts unprofessionally toward patients or Presence personnel; places patient health or

safety in imminent and serious danger; or materially deviates from Presence's policies or applicable professional standards, including billing or ethics standards, that may result in scandal or adversely affect the identity or reputation of Presence.

¶ 10 As relevant to Dr. Irving, an addendum provides that CEP will provide a physician to serve as medical director of the emergency department and that any physician assigned as medical director is subject to Presence's prior approval. The medical director must keep a record of time allocated to the performance of medical director services. The medical director's duties include participating as department representative in medical staff committees; assisting Presence in the development and implementation of its administrative policies, protocols, and procedures relating to the department's operation; providing medical supervision over and direction of special medical and technical procedures to be performed by those delivering services; supporting Presence in the delivery of quality assurance and patient care evaluation activities of the department; supporting Presence in insuring the department's professional personnel meet regulatory and accreditation requirements; conducting educational seminars; assisting Presence in developing new departmental services to meet the needs of the medical staff and patients; assisting Presence in establishing patient satisfaction standards and improvement strategies to achieve acute care targets; assisting with the preparation of annual operating and capital budgets for the department; scheduling adequate coverage in the department; and assisting in the preparation of all reports of activities from the department.

¶ 11 C. Presence's Bylaws

¶ 12 Presence's medical staff bylaws provide that Presence's medical director is, as relevant here, a physician "who is responsible for monitoring medical care provided at the Hospital, and who has general supervisory responsibility over practitioners providing medical care in a given area, Section or Department." However, in a section addressing the nature of medical staff membership and clinical privileges, the bylaws state that the membership and/or clinical privileges of practitioners engaged under a contractual agreement are subject to the terms of their contractual agreement, which governs *over* the bylaws. Further, an article addressing clinical departments and setting forth the organization of such states that each department shall have a chairperson who is responsible for overall supervision and administrative work within the department. The medical staff is organized into the following departments: internal medicine, surgery, obstetrics and gynecology, pediatrics, psychiatry, and ancillary medical services. The emergency department is not included in this list.

¶ 13 D. Depositions

¶ 14 1. Pamela

¶ 15 At her deposition, Pamela testified that she and Joseph were married for 31 years and had two children, Jessica and Joseph (Joe). Around 2015, Joseph saw a doctor for a paralyzed vocal cord and was informed that it was idiopathic and would either go away on its own or never go away. Subsequently, Joseph did not complain about issues with his vocal cords up until 2017.

¶ 16 On Saturday, April 8, 2017, Joseph woke up with a sore throat that lingered throughout the day. On Sunday morning, he was feeling a little better, but his throat was still sore. About 10 or 11 a.m., Joseph began having trouble breathing and clearing his throat. He tried sitting in different positions. Within an hour, however, he was having enough issues that Joe, who lived

with Joseph and Pamela, called 911. Joseph was still able to speak normally, but he was breathless.

¶ 17 Joseph walked to the ambulance with a paramedic. Pamela did not speak to the paramedics. She drove herself and Jessica, who had arrived at the house, to Presence. Joe drove himself. Dave, Pamela's son-in-law and a firefighter/paramedic, spoke to the paramedics.

¶ 18 When Pamela and Jessica arrived at the emergency room, they were told to sit in the waiting area because Joseph had not yet been admitted. Within a few minutes, the doors opened and someone took Pamela and Jessica to a small exam room, where Joseph was sitting on the end of a cart. Joseph reported that he had been given steroids to try to ease his breathing, but he was not feeling much better. They rang the buzzer for a nurse, and two arrived. The nurses reported that he had been looked at by a doctor. When asked if an ENT was being called, the nurses did not know and left the room. Joseph's breathing was labored, but he and Pamela were able to carry on a conversation. However, he became more agitated. According to Pamela, no one was doing anything, and Joseph was getting frantic.

¶ 19 At some point, Joseph was moved to a larger room across from the nurses' station. Someone asked Pamela for Joseph's medical history. Joe arrived while Joseph was in the larger room. Equipment was brought into the room. By now, Joseph was panicking every time someone entered the room. He stated, "I can't breathe; I can't breathe; cut me; I can't breathe." He kept stretching his neck and tried to catch his breath. People brought in towels, and Joseph pleaded, "help me; cut me; do something." When hospital personnel tried to take a chest X-ray by placing a plate behind Joseph, he could not cooperate. A woman explained that they were going to try to put a tube down his throat, but Joseph was not following directions. Pamela testified, "[s]he was talking to him but looking at me because he wasn't—he wasn't able to follow any directions. He wasn't—he couldn't acknowledge her. He was too frantic." The woman told Pamela that they would try to put the tube down Joseph's throat and, if they could not do so, they would cut his throat. Someone then pulled Pamela on her shoulder and escorted her out of the room.

¶ 20 According to Pamela, she heard "CPR sounds" from the room. A lot of people entered and left Joseph's room. Pamela and her children stood outside the curtain. At one point, a woman exited the room and Pamela asked if Joseph still had a pulse. The woman replied that someone would speak to Pamela.

¶ 21 Later, a nurse came out of the room, put her arm around Pamela's shoulder, and led her and her children to the family room. She reported that Joseph had been without a pulse for about 30 minutes. Joseph had acute epiglottitis. Pamela then spoke to Dr. Irving.

¶ 22 According to Pamela, from the time she first went back to see Joseph in the emergency room up until the time of his passing, she never spoke to anyone who identified as a doctor. When the nurse informed her and her family that Joseph had acute epiglottitis, the nurse stated that, if they had known that, they would not have tried to put a tube down his throat because his throat closed.

¶ 23 Regarding the ambulance, Pamela testified that she was not aware that she could have requested that it go anywhere but Presence, as Presence was the closest trauma center.

¶ 24 Pamela signed the consent form while in the emergency room, but she did not recall when she signed it or whether she was in the smaller room with Joseph or elsewhere. The only time she recalled anyone asking her anything was "early on" when Joseph was first taken to the

larger room. A woman asked her about Joseph's medical history and about the episode with the vocal cords. Pamela testified that it was possible that she signed the consent form as part of her interaction with the woman. She also testified that she was acting on Joseph's behalf when she signed the consent form, but that she did not recall Joseph asking her to take care of, or to sign, any documents.

¶ 25 2. Joe

¶ 26 Joe testified that, at the time of his father's passing, he lived with his parents. On Saturday, April 8, 2017, Joe arrived home in the early afternoon and noticed that his father was "off" and was coughing and sweating a lot. On Sunday, Joe awoke between 10 and 11 a.m. At some point, Pamela instructed Joe to call 911. Joe saw his father outside, sitting on the porch with his hand on his chest, trying to catch his breath. Joseph stated that it was difficult to breathe. When the ambulance arrived, Joe started walking Joseph to the ambulance; Joseph was putting a considerable amount of weight on Joe. Halfway, a paramedic took Joseph the rest of the way to the ambulance.

¶ 27 At some point, Jessica arrived at the house with her child. Dave also arrived. Pamela and Jessica were going to follow the ambulance and instructed Joe to stay home with his girlfriend. However, about 25 or 30 minutes later, Jessica called Joe and told him that the situation was serious and to come to the hospital. Joe and his girlfriend drove to the hospital.

¶ 28 At the emergency room, Joe was immediately led back to Joseph's room. He was there for about one minute before hospital personnel drew the curtain, but he saw Joseph in a gown and with a terrified look on his face. Joe also saw three hospital personnel in the room (one was taking Joseph's blood pressure), who Joe presumed were doctors, along with Pamela and Jessica. Joseph did not speak during the minute that Joe was in the room. The three family members were asked to exit the room. They stood about five feet away from the curtain. Dave arrived sometime after Joe did. Joe observed people going in and coming out of Joseph's room.

¶ 29 Dave peeked behind the curtain. Through his work, he knew people at the hospital. Dave entered Joseph's room at some point. Ultimately, Joe stopped hearing sounds from Joseph's room, and someone directed the family to the family room. In the room, a man in a white coat came and informed the family that Joseph passed away.

¶ 30 Joe testified that his family relied on the hospital to provide what was necessary and did not ask for any specific treatment or doctor. He assumed that Joseph was taken to Presence because it was the closest hospital to Joseph's home. Joe made no decisions on where Joseph would go or which individuals would provide him care.

¶ 31 3. Jessica

¶ 32 Jessica testified that, on Saturday, April 8, 2017, Jessica saw her parents at their home. It appeared to Jessica that Joseph had a cold; he was coughing a bit. On Sunday, after lunch, Jessica drove with her infant daughter to Joseph and Pamela's house. Once there, as she walked up the driveway toward the house, Pamela came out and said that an ambulance was on its way for Joseph. Joseph was sitting on the porch couch, hunched over and coughing. He looked very ill. Jessica learned that Joseph was struggling to breathe and was coughing a lot.

¶ 33 Dave arrived at some point and spoke to the paramedics. Jessica and Pamela drove separately to the hospital. When Jessica initially saw her father at the hospital, she observed

that he struggled to breathe. He appeared to be in worse condition than he was at the house. He stated to anyone who was in the room, "cut me open, I can't breathe." He was scared. Jessica tried to calm him down, and she helped lift him up and down off the bed to make him comfortable. A male and a female entered the room, and Joseph stated that he could not breathe and asked that he be cut open. Jessica asked if someone had examined her father's throat, and the male answered that they had looked at it, there was some irritation, but it did not look that bad.

¶ 34 Later, the male staffer, whom Jessica later learned was Dr. Irving (because he later spoke with the family in the family room), returned and said that Joseph was laboring too hard to breathe and that they would move him to a different room to intubate him.

¶ 35 Jessica followed her father to the larger room, as did Pamela and Dave. The family was asked to step outside when the intubation process started. A nurse named Pam was in the larger room. There was a plastic mask on Joseph's face, but he took it off and told Pamela that he loved her. The family waited outside the curtain. At some point, someone who Jessica believed was an anesthesia nurse exited Joseph's room. Pamela asked her for an update, but Jessica could not hear her response. She heard Pamela follow up, asking whether Joseph had a heartbeat. The nurse's answer was evasive. Several people went into the room.

¶ 36 The nurse, named Pam, invited Dave into Joseph's room at one point. (He did not ask if he could help.) Jessica testified that the hospital staff needed assistance because they were short-staffed. Dave performed CPR on Joseph because the person who had been performing CPR had become fatigued. Dave subsequently exited the room and shook his head when Jessica asked him if Joseph was okay. Jessica understood that her father had expired.

¶ 37 Jessica entered Joseph's room. She observed that Joseph's chest was swollen ("It looked like there was a beach ball in his chest."), his face was swollen, and he was bleeding from the throat. She blocked her mother's view, and the family was escorted to the family room. Subsequently, Dr. Irving spoke to the family, but Jessica could not recall the conversation.

¶ 38 Jessica's understanding was that medical personnel tried to intubate Joseph but were unsuccessful. Also, an incision was made in his throat to try to establish an airway.

¶ 39 Jessica could not recall someone approaching her or any family members with paperwork during the emergency room visit. The family did not ask for specific doctors or nurses at Presence. Jessica assumed that Joseph was taken to Presence because it was the closest hospital to his home.

¶ 40 When Jessica was helping Joseph become more comfortable, she noticed that he was scared. She believed that he needed to calm down and focus on his breathing. While she was unable to position him in a comfortable position, he was very agitated and started to panic.

¶ 41 4. Dr. Irving

¶ 42 Dr. Irving testified that he works for Vituity, which was formerly known as CEP. He is an emergency physician partner in the company. He has privileges at Presence. Between October 2016 and July 2018, Dr. Irving was a medical director of Presence's emergency department. In April 2017, he typically worked 30 clinical hours per week, plus two or three 8-hour administrative days.

¶ 43 As medical director, Dr. Irving created the schedules for the emergency department personnel (*i.e.*, physicians and mid-level providers—physician assistants and nurse

practitioners—not nurses). He served on the medical executive committee. He did not write or create any of the hospital's policies and procedures or rules and regulations. The emergency department had 26 beds and was a Level 2 trauma center. The hospital's rules and regulations state that the medical director is responsible for the operation of the emergency department, that is, to optimize patient flow through the department and work with ancillary departments. Equipment and supplies, for example, were not under his purview as medical director but were under that of the emergency department director, who is a nurse. On April 9, 2017, there were two physicians in the emergency department.

¶ 44 The epiglottis is a soft tissue structure that overlies the glottis, which is the opening of the trachea in the oropharynx. It is attached to the larynx. Epiglottitis is inflammation of the epiglottis. A person with this condition can develop throat pain, have pain with swallowing, and have progression of swelling that may compromise the airway. Epiglottitis can cause the airway to cut off completely. It is usually an acute occurrence and most commonly caused by a bacterial infection of the epiglottis. If a person has epiglottitis, at any time the airway could become completely shut. The signs of epiglottitis are fever, throat pain, difficulty breathing, and difficulty tolerating one's secretions and swallowing. Being immunocompromised is a risk factor for epiglottitis because one is prone to particular bacterial infections.

¶ 45 An epiglottitis diagnosis is confirmed by visualization, either directly or indirectly using radiography or computed tomography of the epiglottis. Direct visualization can be achieved via an attempt at orotracheal intubation or the use of a fiberoptic scope. The classical teaching with epiglottitis is to minimize any manipulation of the oropharynx. Any manipulation, even by a tongue depressor, can cause additional swelling and a loss of airway. Epiglottitis is treated medically with antibiotics and steroids. Surgical management (*i.e.*, cricothyrotomy or a tracheostomy) can be required if swelling progresses to a degree where the airway is compromised.

¶ 46 It is Dr. Irving's practice not to intubate epiglottitis patients because he is concerned about manipulation of the upper airway and aggravating the condition. He either treats patients medically alone (with antibiotics and steroids) or medically and with a cricothyrotomy. Prior to April 9, 2017, he had not performed any cricothyrotomies, and he had treated seven or eight patients for epiglottitis.

¶ 47 Joseph was checked in at the hospital at 1:06 p.m. Dr. Irving saw Joseph at 1:10 p.m. He testified that Joseph's initial presentation was that he was sitting up in the bed and complaining of a sore throat, pain from swallowing, and difficulty breathing. His pain was 9 out of 10. Dr. Irving examined Joseph. He was sweating and drawing in his breaths hard. His neck was tender on the left side. By 1:15 p.m., Dr. Irving had a fairly high clinical suspicion for epiglottitis.

¶ 48 Dr. Irving ordered an X-ray, an antibiotic (Ceftriaxone), and a steroid (dexamethasone). At the time, Joseph was talking and tolerating his secretions. Dr. Irving believed there was time to start medical treatment for him and to gather more information and imaging to confirm or rule out the diagnosis. At 1:16 p.m., Dr. Irving ordered a soft tissue neck X-ray; however, it was not completed because Joseph deteriorated before it could be done. (A chest X-ray was administered to check Joseph's lungs, since he was complaining about shortness of breath, but it did not explain anything about the epiglottitis.)

¶ 49 A 1:20 p.m. nurse's respiratory assessment noted that Joseph stated he was experiencing shortness of breath, his throat felt swollen, and he was having trouble breathing and

swallowing. A nasal canula was applied (to provide supplemental oxygen) and Decadron/dexamethasone was administered.

¶ 50 At 1:45 p.m., Joseph was moved to the larger (*i.e.*, trauma) room because a nurse had informed Dr. Irving that Joseph was getting worse. A cricothyrotomy kit was retrieved and put next to his bed. A critical care process commenced. At 1:45 p.m., Joseph could still speak. He noted that he felt his throat was closing and that his symptoms were getting worse. A bag valve mask was placed over Joseph's mouth and nose. Dr. Irving testified that, if Joseph's throat was completely closed, he would not be able to speak. At this time, Dr. Irving felt that intubation would be unsuccessful and could cause the epiglottis to swell and necessitate a surgical airway. Also at 1:45 p.m., Dr. Irving decided not to perform a cricothyrotomy because Joseph was still breathing and oxygenating, and Dr. Irving paged anesthesiology for assistance because "it was becoming a critical airway" and "anesthesia" are airway experts.

¶ 51 At 1:55 p.m., Jennifer Schultz, a certified registered nurse anesthetist, arrived, and Dr. Irving informed her that he suspected epiglottitis. She agreed they should try to secure the airway in the operating room (via a tracheostomy) performed by a surgeon or, if possible, an ENT. Dr. Irving was prepared to perform a cricothyrotomy if he lost the airway. Also at 1:55 p.m., an ENT was paged. Dr. Irving did not know if an ENT or a surgeon was in the building. Also at this time, Schultz used a GlideScope to visualize Joseph's epiglottis. They were "headed towards" a surgical airway at this point, Dr. Irving believed, and a conventional intubation was worth a try.

¶ 52 The GlideScope showed epiglottitis, and it may have aggravated Joseph's epiglottitis. At 1:59 p.m., Schultz had Propofol, a sedative, administered, and she tried to intubate. The intubation attempt was unsuccessful because the airway within the epiglottis was too small to pass the endotracheal tube. It may have aggravated his epiglottitis. They bagged Joseph for a few minutes but lost the airway.

¶ 53 At 2:03 p.m., Dr. Kelanic, the ENT, called, and Dr. Irving informed him that he needed to come in as soon as possible because the patient's airway was in danger of closing. For a few minutes, oxygen was delivered via bag ventilations because Joseph still had some airway passage.

¶ 54 At 2:05 p.m., Joseph was worse than he was at 2:03 p.m. Also at 2:05 p.m., Joseph was asking hospital personnel to help him breathe. He was able to talk and communicate. When they lost the airway, Dr. Irving attempted to perform a cricothyrotomy at 2:05, which, he explained, is a very invasive procedure. However, he had difficulty and the cricothyrotomy airway did not go into the trachea but was going into the soft tissue. He made several attempts to introduce the cricothyrotomy airway into the trachea.

¶ 55 At 2:16 p.m., Joseph coded. He had no pulse, and his epiglottitis caused his airway to be completely closed off. Over the next 49 minutes, Dr. Irving made multiple attempts to secure the airway. Dr. Kelanic arrived at about 2:40 p.m., and he completed the cricothyrotomy by 2:50 p.m. However, it was likely that Joseph died at 3:05 p.m. Up until the time he coded, he was still getting oxygen through his airway.

¶ 56 Dr. Irving testified that it is possible that, if an airway had been established at some point prior to 2:16 p.m., Joseph probably would have lived but that it was not possible to say when that point was. Dr. Irving testified that he complied with the standard of care with regard to his treatment of Joseph and that he did not cause or contribute to any injury to Joseph or to his

death.

¶ 57 E. Summary Judgment Motion

¶ 58 On October 14, 2021, Presence moved for summary judgment (735 ILCS 5/2-1005 (West 2020)), arguing that there were no disputed material factual issues concerning Dr. Irving's employment status (agency or apparent agency), where he testified that he worked for CEP and where the consent form Pamela signed advised that practitioners were independent contractors and not employees or agents of Presence and that the employment or agency status of the practitioners was not relevant to the selection of Presence for care.

¶ 59 Pamela took the position that Dr. Irving was Presence's agent because he was its emergency department's medical director, the ambulance took Joseph to Presence and he relied on Presence for complete hospital care, he could not be bound by a consent of which he had no knowledge, there was no evidence that Pamela had authority to execute the consent on Joseph's behalf, consent forms are only one factor courts consider in determining apparent agency, and the form here was ambiguous.

¶ 60 F. Trial Court's Ruling

¶ 61 On February 10, 2022, the trial court granted Presence summary judgment. First, addressing actual agency, it found that CEP appointed Dr. Irving as medical director of the emergency department and the relationship was controlled by the agreement, which set forth his independent contractor status. The agreement also provided that administrative services are separate from general patient care. Although Presence's bylaws contained policies and procedures, there was no evidence that the hospital retained the right to control Dr. Irving's patient care decisions. Addressing the agreement, the court found that its provisions did not pertain to control of Dr. Irving's patient care or decisions regarding such. Nor did Presence have the power to terminate Dr. Irving in relation to his patient care or clinical services. Accordingly, the trial court granted Presence summary judgment on the actual agency issue.

¶ 62 Next, addressing apparent agency, the court found that, in the consent form, Presence informed Pamela of Dr. Irving's independent contractor status. The court specifically noted that the practitioner employment status paragraph was the only paragraph in the form that contained its own signature line requiring consent as to the independent contractor status of the practitioners. Pamela, the court found, signed the form and, by doing so, agreed that she had no unanswered questions regarding the same. She also attested to this understanding by signing on Joseph's behalf at the end of the form, on its second page. The court further found that the form was not unclear, confusing, or ambiguous. It was short and concise, and it appropriately titled each paragraph as to its topic. The court also noted that "independent contractor/practitioner relationship" appeared in all capital letters to draw attention to the practitioners' status. The form also noted that the patient would receive a separate bill from each practitioner and, in that way, was similar to the disclaimer sufficient under case law to support summary judgment in the hospital's favor. Addressing Pamela's argument as to the timeliness of her signing the consent form and her alleged lack of authority to sign on Joseph's behalf, the court found that argument unfounded and determined that the language in the consent form was the relevant focus.

¶ 63 On May 4, 2022, the court denied plaintiff's motion to reconsider, and, on July 5, 2022, it found that there was no just reason for delaying enforcement or appeal or both of the February

10 and May 4, 2022, orders. Ill. S. Ct. R. 304(a) (eff. Mar. 8, 2016). Pamela appeals.

¶ 64 II. ANALYSIS

¶ 65 Pamela argues that the trial court erred in granting Presence summary judgment. She contends that factual issues concerning both apparent and actual agency precluded summary judgment in the hospital's favor.

¶ 66 Summary judgment is appropriate when the pleadings, depositions, and admissions on file, taken together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to a judgment as a matter of law. 735 ILCS 5/2-1005 (West 2020). The purpose of summary judgment is not to try a question of fact but to determine whether one exists. *Ray v. City of Chicago*, 19 Ill. 2d 593, 599 (1960). We construe the pleadings, depositions, admissions, and affidavits strictly against the moving party and liberally in favor of the opponent. *Purtill v. Hess*, 111 Ill. 2d 229, 240 (1986). Although summary judgment is to be encouraged as an aid in the expeditious disposition of a lawsuit, it is a drastic measure and, therefore, should be allowed only when the right of the moving party is clear and free from doubt. *Id.* We review *de novo* the trial court's grant of summary judgment. *Wallace v. Alexian Brothers Medical Center*, 389 Ill. App. 3d 1081, 1085 (2009). Furthermore, ordinarily, the question whether an agency relationship exists is a factual one. *Stewart v. Jones*, 318 Ill. App. 3d 552, 560-61 (2001). However, if there is only one conclusion to be drawn from the undisputed facts, we may decide the question as a matter of law. *James v. Ingalls Memorial Hospital*, 299 Ill. App. 3d 627, 632 (1998).

¶ 67 A. Apparent Agency

¶ 68 1. Consent Form

¶ 69 Pamela argues that the trial court erred in finding that the consent form barred apparent agency. She contends that the form was unenforceable because she did not have authority to sign on Joseph's behalf. She notes that Joseph did not say anything at the hospital about signing any documents on his behalf and that Pamela did not have, or act under, any power of attorney or other document giving her power to act on her husband's behalf. Pamela notes that their relationship as husband and wife does not create an agency relationship for one on behalf of the other.

¶ 70 "The agent's authority can only come from his [or her] principal." *Matthews Roofing Co. v. Community Bank & Trust Co. of Edgewater*, 194 Ill. App. 3d 200, 206 (1990). An agency relationship "need not depend on an express appointment but may be found in the situation of the parties, their actions, and other relevant circumstances." *Id.*

¶ 71 We conclude that the trial court erred in determining that Pamela signed the consent form as Joseph's agent because the circumstances evincing an agency relationship were not present in the record presented at summary judgment. Pamela testified that she could not recall when she signed the form or where she was when she signed it. Nor could she recall Joseph asking her to take care of, or to sign, any document. Thus, there was no evidence as to when Pamela executed the form. Nor was there any evidence that Joseph was asked about the consent form or said anything about it at any time while he was in the emergency room. Presence would have us determine that Joseph's silence constituted his acquiescence to Pamela's execution of the consent form. Considering the lack of evidence of any conduct on his part authorizing her

action, we are unable to do so. Joseph's only actions during this time—specifically, his repeated requests for treatment—did not reflect that he even knew about the form, let alone authorized Pamela to act on his behalf in signing it.

¶ 72 In *Curto v. Illini Manors, Inc.*, 405 Ill. App. 3d 888 (2010), the plaintiff wife entered into a contract with a nursing home to admit her husband, and she signed as the responsible party. She also executed an arbitration agreement, which she signed as resident representative. The plaintiff sued the defendant after her husband died, and the defendant sought to enforce the arbitration agreement. The reviewing court held that the plaintiff was not her husband's agent and, thus, the arbitration agreement was not enforceable against him. *Id.* at 895. In analyzing whether the plaintiff had actual authority, the court noted that the record did not suggest that her husband gave her express authority to make legal decisions on his behalf. *Id.* at 892-93. Also, she did not have implied authority, where no evidence indicated that her husband was present and directed her to sign the arbitration agreement as his representative, nor was there any indication that he knew she signed it and agreed to or adopted her signature as his own. *Id.* at 893. Similarly, in rejecting the defendant's apparent authority argument, the court noted that the husband never acted in a way to indicate to the defendant that the plaintiff was his apparent agent for purposes of the arbitration agreement. *Id.* at 896. It noted that no evidence showed that he was present when the plaintiff signed the agreement or that he understood she was doing so. *Id.* Nor did any words or conduct by him indicate that he consented or was asked by the nursing home to agree to the terms of the agreement. *Id.*

¶ 73 This case is similar to *Curto*. Pamela could not recall when she signed the consent form, and she could have been outside his room when she signed it. Thus, it is not clear on this record whether Joseph was present when Pamela signed it or that he was even aware of it. There was no testimony or other evidence that Joseph commented about any consent form (and he was able to speak, as he repeatedly asked for assistance and for someone to "cut [him] open") or was even asked about it. The parties' status as husband and wife did not, by itself, create an agency relationship. *Id.* at 891.

¶ 74 We acknowledge Pamela's testimony that she signed the consent form on Joseph's behalf. However, as she notes, the authority of an agent comes from the principal, not the agent. *Matthews Roofing*, 194 Ill. App. 3d at 206. That is, Pamela cannot attest to her status as Joseph's agent; rather, we must look to Joseph's statements or conduct to assess whether he authorized her to act on his behalf. As noted, there is no evidence that Joseph, via his words or conduct, addressed the consent form or delegated to Pamela authority to sign it on his behalf and there was no evidence that he was even present when Pamela signed the form.

¶ 75 2. "Holding Out" Factors

¶ 76 Having framed the circumstances of the consent form's execution, we turn to Pamela's argument that the trial court erred in granting Presence summary judgment on apparent agency. She argues that, under the apparent agency doctrine, Presence was vicariously liable for Dr. Irving's alleged negligence.

> " 'An agency is a fiduciary relationship in which the principal has the right to control the agent's conduct and the agent has the power to act on the principal's behalf.' *Zahl v. Krupa*, 365 Ill. App. 3d 653, 660 (2006). An agent's authority can be either actual or apparent. Actual authority can be either express or implied. Express authority occurs when a principal explicitly grants the agent authority to perform a particular act.

> *Id.* at 660-61. Implied authority is actual authority proved circumstantially by evidence of the agent's position. *Id.* at 661. *** Apparent authority occurs 'when the principal holds an agent out as possessing the authority to act on its behalf, and a reasonably prudent person, exercising diligence and discretion, would naturally assume the agent to have this authority in light of the principal's conduct.' *Zahl*, 365 Ill. App. 3d at 661." *Rasgaitis v. Waterstone Financial Group, Inc.*, 2013 IL App (2d) 111112, ¶ 48.

¶ 77 For a hospital to be vicariously liable for negligent medical treatment rendered in the hospital by an independent contractor physician under the doctrine of apparent authority, the plaintiff must establish that (1) the hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital, (2) where the acts of the agent create the appearance of authority, the hospital had knowledge of and acquiesced in them, and (3) the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence. *Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d 511, 525 (1993). The first two prongs of the *Gilbert* test are frequently grouped together and have been referred to as the "holding out" factors. *Id.*; *McIntyre v. Balagani*, 2019 IL App (3d) 140543, ¶ 109.

¶ 78 The holding out *Gilbert* factors are satisfied if the hospital holds itself out as a provider of emergency room care without informing the patient that the care is provided by independent contractors. *Gilbert*, 156 Ill. 2d at 525. Stated differently, the holding out factors are not satisfied if the evidence shows that the patient was placed on notice of the independent contractor status of the physicians. *Wallace*, 389 Ill. App. 3d at 1087.

¶ 79 A patient's signing of a consent to treatment form that contains clear and unambiguous independent contractor disclaimer language is an important factor to consider "because it is unlikely that a patient who signs such a form can reasonably believe that [the] treating physician is an employee or agent of a hospital when the form contains specific language to the contrary." *Lamb-Rosenfeldt v. Burke Medical Group, Ltd.*, 2012 IL App (1st) 101558, ¶ 27; see *Mizyed v. Palos Community Hospital*, 2016 IL App (1st) 142790, ¶ 41 (citing summary judgment cases). Such forms are "not dispositive" (*Lamb-Rosenfeldt*, 2012 IL App (1st) 101558, ¶ 27) on the holding out factors yet are significant enough to be deemed "almost conclusive" in determining whether a hospital should be held liable for an independent contractor's medical negligence (*Steele v. Provena Hospitals*, 2013 IL App (3d) 110374, ¶ 131).

¶ 80 Here, the counts in Pamela's complaint directed against Presence included claims for wrongful death (740 ILCS 180/0.01 *et seq.* (West 2020)), a claim under the Survival Act (755 ILCS 5/27-6 (West 2020)), and a claim under the family expense statute (750 ILCS 65/15 (West 2020)). Although Pamela alleged that she proceeded as to each count both individually and as the administrator of Joseph's estate, we note that wrongful death and survival actions must be brought by, and in the name of, the representative or administrator of the decedent's estate, not individually by a beneficiary. *Will v. Northwestern University*, 378 Ill. App. 3d 280, 289-90 (2007); 740 ILCS 180/2(a) (West 2020). In contrast, Pamela's claim under the family expense statute could be brought only individually. See *Janetis v. Christensen*, 200 Ill. App. 3d 581, 588 (1990) (noting that, although cause of action "is derivative, since the right of action arises out of the injury to the person of another, it is not an action for damages for injuries but is an action for damages *arising from the spouse's liability* under the family expense act" (emphasis in original)). In that count, Pamela sought medical and funeral expenses for which

she became liable on Joseph's behalf as a direct result of the alleged negligence of Presence's agents and/or employees. The trial court granted Presence summary judgment on all counts directed against it.

¶ 81 As to the wrongful death and survival claims, we conclude that the trial court erred in granting Presence summary judgment. Here, the consent form is of no import because, as discussed above, neither Joseph nor his agent executed it. This was the sole evidence, as Presence's counsel conceded at oral argument, upon which Presence relied to assert that Joseph was on notice that Dr. Irving was an independent contractor. Without any other evidence of such, Presence cannot prevail on summary judgment against the estate.

¶ 82 However, as to the family expense statute claim, the trial court did not err in granting Presence summary judgment because Pamela, individually, by virtue of signing the consent form (albeit without authority as her husband's agent), had actual notice that Dr. Irving was an independent contractor. If the plaintiff "has actual or constructive knowledge that the doctor is an independent contractor, the hospital is not vicariously liable." *Steele*, 2013 IL App (3d) 110374, ¶ 138. The same would apply to Pamela. The form's language here clearly stated that all practitioners, except those who wore certain identification badges, were independent contractors and not employees of Presence. Actual or constructive knowledge of the doctor's independent contractor status precludes a determination that the holding out factors were met. *Id.* Pamela signed the consent form, albeit not as Joseph's agent, and her *own* signature evinces her knowledge of the form's content and binds her with respect to it. *Id.* ¶ 121 ("a competent adult is charged with knowledge of and assent to a document the adult signs and *** ignorance of its contents does not avoid its effect"). Thus, the trial court properly granted Presence summary judgment on the family expense statute claim that Pamela brought against it in her individual capacity.

¶ 83 3. Justifiable/Reasonable Reliance

¶ 84 Turning to reliance—*i.e.*, the third *Gilbert* factor—a plaintiff satisfies the factor if he or she shows reliance upon the hospital to provide medical care, rather than upon a specific physician. *Gilbert*, 156 Ill. 2d at 525.

¶ 85 We address reliance only as to Pamela's wrongful death and survival claims. We need not address reliance as to the family expense statute claim because, as discussed above, Pamela failed to show that the trial court erred in concluding as a matter of law that the holding out factors were not met. See *Prutton v. Baumgart*, 2020 IL App (2d) 190346, ¶ 6.

¶ 86 Pamela testified that Presence was the closest trauma center and that she was not aware that she could have requested that the ambulance go anywhere but Presence. Similarly, Joe and Jessica testified that their family did not ask for any specific treatment or doctors at Presence, and they testified that they assumed that their father was taken to Presence because it was the closest hospital to his home.

¶ 87 The consent form states:

> "I acknowledge that the employment or agency status of Practitioners who treat me is not relevant to my selection of Presence Health for my care, and I neither require nor is it my expectation that any Practitioner providing me with Practitioner services be an employee of Presence Health."

¶ 88 In *Steele*, 2013 IL App (3d) 110374, upon which Presence relies, the court held that consent form language similar to the foregoing precluded the plaintiff from establishing the reliance factor. *Id.* ¶ 141 (reversing judgment for the plaintiff and entering judgment notwithstanding the verdict for the defendant; holding that language constituted clear disclaimer of decedent's reliance on hospital for care; statement gained more weight when taken in conjunction with additional acknowledgements that most providers were independent contractors). However, the court acknowledged that to assess this factor the sole evidence available to it was the form itself, as there was no evidence that the decedent who signed the form "made any observations or statements relative to" the doctor's relationship with the hospital. *Id.* ¶ 131.

¶ 89 Here, in contrast, Pamela, Joe, and Jessica testified that it was their understanding that Joseph was taken to Presence simply because it was the closest hospital. Further, there was no evidence that Joseph was taken to Presence to be treated by a specific provider or that he requested such. These facts sufficiently distinguish this case from *Steele*, as does the fact that, as to the estate, the consent form is not operative because Pamela was not authorized to sign it. See *Hammer v. Barth*, 2016 IL App (1st) 143066, ¶¶ 30-33 (reversing summary judgment for the defendant hospital; holding that wife, as administrator of deceased husband's estate, raised material factual questions concerning reliance factor; she gave telephonic consent for her husband's procedure but also testified that there was no specific pulmonologist she wanted her husband to see); see also *Monti*, 262 Ill. App. 3d 503, 507-08 (1994) (unconscious patient taken to nearest hospital by emergency medical personnel; persons responsible for patient "sought care from the hospital, not from a personal physician, and thus, a jury could find that they relied upon the fact that complete emergency room care *** would be provided through the hospital staff").

¶ 90 We conclude that the trial court erred in granting Presence summary judgment as to Pamela's wrongful death and survival claims.

¶ 91 B. Implied Actual Agency

¶ 92 Pamela's final argument is that the trial court erred in finding that Dr. Irving was not Presence's actual agent. Relying on the implied actual agency doctrine, Pamela argues that Dr. Irving's position as medical director, in the hospital's governing body, and his control over the emergency room created a factual question about whether he was the hospital's implied agent. We reject this argument.

¶ 93 Where a principal-agent relationship exists between a hospital and a physician accused of malpractice, the hospital may be vicariously liable for the physician's alleged negligence. *Gilbert*, 156 Ill. 2d at 518. To prevail on a claim of actual agency, or *respondeat superior*, the plaintiff must show that (1) a principal-agent relationship existed between the hospital and the physician, (2) the hospital controlled or had the right to control the physician's conduct, and (3) the alleged conduct fell within the scope of the agency. *Hammer*, 2016 IL App (1st) 143066, ¶ 15.

¶ 94 A principal is generally not liable for the acts of an independent contractor. *Id.*; *Wogelius v. Dallas*, 152 Ill. App. 3d 614, 621 (1987). However, if the principal retains sufficient control over the independent contractor's work, his or her independent contractor status is negated and the principal is vicariously liable for the contractor's tortious conduct. *Hammer*, 2016 IL App (1st) 143066, ¶ 16. This type of agency is termed implied authority or implied agency. *Id.* "An implied agency relationship is an actual agency relationship that is established through

circumstantial evidence." *Buckholtz v. MacNeal Hospital*, 337 Ill. App. 3d 163, 172 (2003) ("the decision to treat a patient in a particular manner is generally a medical question entirely within the discretion of the treating physician and not the hospital"). The cardinal consideration in deciding when a person's status as an independent contractor is negated is whether that person retains the right to control the manner of doing the work. *Petrovich v. Share Health Plan of Illinois, Inc.*, 188 Ill. 2d 17, 46 (1999). "In a hospital-physician relationship, the key issue is whether the hospital has the right to control the physician's exercise of medical judgment in delivering medical care to patients." *Hammer*, 2016 IL App (1st) 143066, ¶ 16. "[R]equiring an independent contractor to follow certain policies and procedures does not, standing alone, constitute sufficient control to create an agency relationship." *Magnini v. Centegra Health System*, 2015 IL App (1st) 133451, ¶ 33.

¶ 95 Dr. Irving, Pamela notes, was employed by CEP but was also Presence's medical director for the emergency department. In this role, he spent several hours per week on administrative responsibilities, including scheduling emergency department staffing and serving on the hospital's medical executive committee (which Presence's bylaws delegated to the hospital, not CEP). Presence's bylaws further provide, she notes, that the medical director monitors medical care provided at the emergency room, has "general supervisory authority" over those practicing there, and is subject to removal by the hospital.

¶ 96 An addendum to the agreement provides that the medical director supervises special medical and technical procedures, coordinates quality assurance, assures that all hospital practitioners operate in accordance with hospital policies, assists in preparing the emergency room's budget, schedules appropriate coverage in the emergency room, and participates in long-range planning for the hospital. The agreement also requires the medical director to follow Presence's policies and to enter into service contracts with all insurance programs Presence requires.

¶ 97 Pamela asserts that Presence placed Dr. Irving on its staff, had the right to discharge him, and allowed him to manage its emergency room. Dr. Irving, she argues, essentially ran Presence's emergency room. His degree of control was such that it could not be considered separate from the institution; he represents the institution, she argues, and, thus, is its implied agent.

¶ 98 We conclude that the trial court did not err in granting Presence summary judgment on the implied agency issue. The controlling document and Dr. Irving's testimony support this conclusion.

¶ 99 In a section addressing the nature of medical staff membership and clinical privileges, Presence's bylaws state that the membership and/or clinical privileges of practitioners engaged under a contractual agreement are subject to the terms of their contractual agreement, which governs *over* the bylaws. Further, in the bylaws section addressing clinical departments and including a description of the *duties* of department chairpersons (which includes responsibility for the *overall supervision* and administrative work of the department), the list of departments does *not* include the emergency department. Thus, the agreement is the relevant document.

¶ 100 The agreement provides that a practitioner's relationship with Presence is as an independent contractor and that Presence does *not* have control or direction over the manner or method by which CEP, through the practitioners, performs services under the agreement (provided CEP ensures that services are performed in a manner consistent with Presence policies, applicable law, and accreditation standards). Upon Presence's request, CEP does have

the power to "voluntarily" remove and "no longer assign" a practitioner to provide services at Presence. This contrasts with the requirement that CEP "immediately remove, replace and no longer assign" a practitioner when, among other things, he or she fails to meet qualifications, is charged with a felony, becomes uninsurable, or materially breaches patient information confidentiality.

¶ 101 Dr. Irving was appointed (pursuant to the agreement) medical director of the emergency department by CEP and was compensated by CEP, not Presence. His duties as medical director, which Pamela characterizes as being in control of the emergency department, are distinct from his primary duties and actions as a physician and are collateral thereto.

¶ 102 Indeed, Dr. Irving distinguished between his clinical work as a physician and his work as medical director. He testified that, in April 2017, he typically worked 30 clinical hours per week plus two or three 8-hour administrative days. As director, Dr. Irving created the schedules for the emergency department personnel (*i.e.*, physicians and mid-level providers, not nurses) and served on the medical executive committee. He did not write or create any of the hospital's policies and procedures or rules and regulations. The hospital's rules and regulations provided that the director is responsible for the operation of the emergency department, which Dr. Irving explained meant to optimize patient flow through the department and work with ancillary departments. Equipment and supplies, for example, were not under his purview as medical director but were under the emergency department director, who is a nurse.

¶ 103 Case law with similar facts supports our conclusion. See *id.* ¶¶ 32, 41-42 (hospital's bylaws included policies that concerned matters collateral to patient care decisions (which remained in physicians' exclusive control), did not interfere with doctors' exercise of independent medical judgment, and did not negate their independent contractor status; the medical director services agreement did not create a material factual question as to whether physician was hospital's agent via his position as its director of bariatric health services; the agreement explicitly stated that director was independent contractor and that hospital did not have control over methods by which he performed his responsibilities; nothing in any agreements or bylaws allowed hospital to terminate physician's privileges for any violation of administrative duties; and the medical director services agreement stated that director duties were distinct and separate from general patient care services he assumed); *Johnson v. Sumner*, 160 Ill. App. 3d 173, 174-76 (1987) (affirming summary judgment in hospital's favor on actual agency issue; agreement between hospital and emergency room doctor's corporate employer provided that the corporation chose a director to supervise emergency room care and services; agreement's provision that corporation was responsible for employment, retention, and supervision of emergency care physicians, such as defendant doctor, did not show that hospital controlled the medical diagnosis and treatment decision-making of emergency room physicians); see also *Hammer*, 2016 IL App (1st) 143066, ¶ 21 (affirming summary judgment for hospital on actual agency issue; professional services agreement between the physician's employer and hospital provided that physician was independent contractor and that hospital had right to terminate agreement for poor clinical patient care and retained right to terminate doctor's appointment for cause; physician was not department chief and hospital's recertification and reappointment process for staff privileges did not indicate sufficient control over physician's medical judgment in treatment of her patients but showed control over only conduct and activities of its medical staff; also, procedures and regulations required of medical staff were mostly administrative).

¶ 104 The cases upon which Pamela relies are distinguishable because they involve circumstances where the hospital could, or did, exercise significant control over the physician's work. See, *e.g.*, *Wheaton v. Suwana*, 355 Ill. App. 3d 506, 511-14 (2005) (where hospital maintained right of control over physician's work and other factors favored employment; physician was employee of county hospital; employment contract required physician to perform full-time surgical services for hospital, maintain office hours, be available for on-call surgeries, be accessible by beeper or mobile phone, and live within certain geographic range and precluded him from billing for his own services; he performed highly skilled work and hospital maintained right to discharge him; and insurance and taxes were funded or deducted by the hospital on physician's behalf; "the hospital can remain in control of an employee physician even if it does not control every medical detail of that physician's practice"); *Barbour v. South Chicago Community Hospital*, 156 Ill. App. 3d 324, 328-30 (1987) (trial court erred in dismissing complaint alleging principal-agent relationship between hospital and physician; physician was not paid by hospital but was appointed by hospital's board as chief of obstetrics and gynecology department and acted pursuant to the board of directors' orders, and thus, the clear inference was that hospital's board had control over him, for he could have been removed from position if he failed to properly perform his duties; also, changes in policy had to be implemented by board through the physician).

¶ 105 In summary, the trial court did not err in granting Presence summary judgment on the implied agency issue.

¶ 106 III. CONCLUSION

¶ 107 On the apparent agency issue, the trial court erred in granting Presence summary judgment on the claims where Pamela proceeded as administrator of Joseph's estate. The court did not err in granting Presence summary judgment on the family expense statute claim (where Pamela proceeded individually) because, by virtue of signing the consent form, Pamela had actual notice of Dr. Irving's independent contractor status. On the implied agency issue, the trial court did not err in granting Presence summary judgment. Thus, for the reasons stated, we affirm in part and reverse in part the judgment of the circuit court of Kane County and remand for further proceedings.

¶ 108 Affirmed in part and reversed in part.

¶ 109 Cause remanded.