

Docket No. 26-338

IN THE

Shawnee Supreme Court

METROPOLITAN HEALTH SYSTEM, INC. AND CYBER-CARE SOLUTIONS, LLC,

Petitioners,

v.

EVELYN MILLER, INDIVIDUALLY AND AS SPECIAL ADMINISTRATOR FOR THE ESTATE OF
ELIAS MILLER, DECEASED,

Respondent.

ON APPEAL FROM THE SHAWNEE COURT OF APPEALS
FOR THE SECOND DISTRICT

BRIEF FOR RESPONDENT

COUNSEL FOR RESPONDENTS

Informed Dissent

Dated: October 2, 2026

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QUESTIONS PRESENTED

1. Whether MHS, a healthcare system, can be held vicariously liable under a theory of apparent agency for the diagnostic errors of Cyber MD, an autonomous AI software tool integrated into its branded telehealth platform?
2. Whether Respondent's claims fall within Shawnee's statutory exceptions to the four-year repose periods where Cyber MD continuously evaluated and monitored the same respiratory condition over several years, and where the injury-causing defect was buried behind a wall of proprietary code and medical sophistication such that an ordinary reasonably prudent person could not have discovered it within four years of delivery?

STATUTORY PROVISIONS INVOLVED

Shawnee Rev. Stat. § 12-402. Limitations of Actions: Personal Injury and Wrongful Death; Discovery Rule.

1. **Personal Injury.** Except as otherwise provided in this section, and except as provided in section 12-404 of this chapter, an action for damages for personal injury caused by the wrongful act, neglect, or default of another shall be commenced within two (2) years after the cause of action accrues.
2. **Wrongful Death.** An action for wrongful death shall be commenced within two (2) years from the date of the decedent's death.
3. **Discovery Rule Exception.** If the injury or its causal relationship to the conduct of another is not immediately discoverable through the exercise of reasonable diligence, the limitation period shall not begin to run until the claimant knows, or reasonably should have known, of the injury and the tortfeasor's identity.

Shawnee Rev. Stat. § 12-404. Limitations – Health Care Malpractice.

1. **Limitations Period.** No action for damages for injury or death against any physician, hospital, or healthcare provider arising out of patient care shall be brought more than two (2) years after the date on which the claimant knew, or through reasonable diligence should have known, of the injury or death.
2. **Repose Period.** In no event shall such action be brought more than four (4) years after the date on which occurred the act or omission or occurrence alleged to have been the cause of such injury or death. However, such period shall not bar an action where the defendant healthcare provider engaged in a continuous course of treatment of the patient for the same illness, injury, or condition that gives rise to the claim of negligence.

Shawnee Rev. Stat. § 12-410. Statute of Repose – Product Liability.

1. **Repose Period.** No product liability action based on strict liability in tort shall be commenced except within the applicable limitations period in Section 12-402, and in any event, within four (4) years from the date of first sale, lease, or delivery of possession to its initial user or consumer.
2. **Exceptions to Statute of Repose.** The four (4) year period of repose shall not apply if:
 - a. The product seller expressly warrants that its product can be utilized safely for a period longer than four (4) years;
 - b. The product seller intentionally misrepresents facts about its product, or fraudulently conceals information about it; or

c. The harm was caused by prolonged exposure to a defective product, or if the injury-causing aspect of the product that existed at the time of delivery was not discoverable by an ordinary reasonably prudent person until more than four (4) years after delivery.

OPINIONS BELOW

The opinion of the Shawnee Court of Appeals for the Second District in *Miller v. Metropolitan Health System, Inc. & Cyber-Care Solutions, LLC*, Docket No. 25-123, entered February 24, 2026, is unreported. The order of the Circuit Court of Simmons County in *Miller v. Metropolitan Health System, Inc. & Cyber-Care Solutions, LLC*, Case No. 25-L-24601, entered March 6, 2025, granting summary judgment in favor of Petitioners Metropolitan Health System, Inc. and Cyber-Care Solutions, LLC, is also unreported.

STATEMENT OF THE CASE

Elias Miller worked for thirty-five years in the maintenance department at Shawnee Steel Company, where he regularly handled asbestos-insulated machinery and frequently worked without respiratory protection. R0002. Miller, a lifelong nonsmoker and non-asthmatic with no family or documented history of respiratory disease, completed an employment-sponsored chest screening before retirement that a radiologist read as unremarkable. R0002.

Miller lived in Cartersville, a rural community in Simmons County with severely limited access to medical care. R0002–R0003. Both local hospitals had closed, the county had no permanent diagnostic-imaging centers, and the nearest facility offering in-person radiology consultations and CT scans was approximately 190 miles away. R0003. Against that backdrop, Miller obtained diagnostic care through Metropolitan Health System’s (“MHS”) remote

telehealth platform and its integrated artificial-intelligence diagnostic system, Cyber MD. R0003–R0005.

Cyber-Care Solutions, LLC (“CCS”) developed Cyber MD as an interactive conversational artificial-intelligence diagnostic system. R0004. Cyber MD could receive patient symptoms, ask follow-up questions, compile clinical histories, generate differential diagnoses, and order and interpret diagnostic testing. R0004. CCS received FDA clearance for the system in 2017, and MHS integrated Cyber MD into its telehealth platform that same year. R0004. Cyber MD’s original algorithm trained on approximately 40,000 images from three hospital systems and achieved a reported ninety-seven-percent overall accuracy rate in classifying lung lesions. R0004. But that reported performance concealed a material weakness in the system’s treatment of asbestos-exposed patients. R0004–R0005. In 2022, CCS discovered that Cyber MD’s diagnostic accuracy fell to eighty-five percent when evaluating images of patients with prior occupational asbestos exposure because pleural shadowing could obscure underlying tumors. R0004–R0005.

Miller first consulted Cyber MD in April 2018 after experiencing shortness of breath. R0005. During that encounter, Miller disclosed his thirty-five-year history of occupational asbestos exposure. R0005. Cyber MD ordered a chest X-ray and CT scan and told Miller that, once the scans were available, it would analyze them and review the results with him. R0005. Two weeks later, Cyber MD evaluated the scans, reported “zero evidence” of malignancy, diagnosed Miller with adult-onset asthma, and recommended annual follow-up imaging. R0005.

That encounter did not end Miller’s relationship with Cyber MD. R0005. He returned for annual virtual evaluations in 2019, 2020, and 2021. R0005. At each evaluation, Cyber MD

reviewed newly obtained scans and again reported “zero evidence” of disease. R0005. Following the 2021 evaluation, Cyber MD advised Miller that annual imaging was no longer necessary. R0005. In October 2023, Miller suffered a spontaneous pneumothorax and was airlifted to MHS’s flagship hospital. R0005. Imaging revealed a 6.4-centimeter malignant mass in his left lung with extensive metastases to his pleura and spine. R0005. Retrospective expert review established that a seven-millimeter lesion had already been visible on Miller’s 2018 scans and had grown continuously thereafter. R0005. Cyber MD’s 2017 baseline coding algorithm consistently failed to identify the lesion. R0005.

Miller died on April 14, 2024. R0006. Respondent Evelyn Miller, individually and as Special Administrator of his estate, filed this action in July 2024. R0006.

Procedural History

Respondent Evelyn Miller brought claims against Metropolitan Health System, Inc. (“MHS”) and Cyber-Care Solutions, LLC (“CCS”) arising from Cyber MD’s diagnostic errors. R0001. Respondent sought to hold MHS vicariously liable under the doctrine of apparent agency and asserted strict product-liability claims against CCS based on alleged defects in Cyber MD’s software algorithm. R0001. Following discovery, MHS and CCS jointly moved for summary judgment. R0001. The Circuit Court of Simmons County granted summary judgment to both Petitioners. R0012. The court held that no genuine issue of material fact remained as to apparent agency and that Shawnee Revised Statutes §§ 12-404 and 12-410 barred Respondent’s claims under the applicable four-year statutes of repose. R0007–R0012. The court further concluded that Cyber MD’s annual evaluations did not constitute a continuous course of treatment and that

the product-liability repose exception did not preserve Respondent's claims. R0011–R0012. The court dismissed the complaint with prejudice. R0012.

The Shawnee Court of Appeals reversed. R0013, R0025. It concluded that genuine issues of material fact remained concerning apparent agency and that Respondent's claims could fall within the statutory exceptions to §§ 12-404 and 12-410. R0018–R0024. The court therefore reversed the grant of summary judgment and remanded for further proceedings. R0025. The Shawnee Supreme Court granted Petitioners leave to appeal on both issues, including whether MHS may be held vicariously liable under apparent agency and whether Respondent's claims are barred by the statutes of repose or fall within their statutory exceptions. R0026.

SUMMARY OF THE ARGUMENT

The Shawnee Court of Appeals correctly held that genuine issues of material fact exist as to whether the doctrine of apparent agency applies and, consequently, whether MHS may be held vicariously liable for the diagnostic errors of CCS's Cyber MD, which repeatedly failed to detect a growing lesion on Miller's lung. The record presents triable issues as to whether MHS held itself out as the provider of Miller's healthcare and whether Miller justifiably relied on MHS to provide that care. The record also presents a triable issue as to whether MHS's liability disclaimer adequately informed Miller of the independent relationship between MHS and CCS. Viewing the facts in the light most favorable to Respondent, this Court should affirm the Shawnee Court of Appeals.

Respondent's claims are not barred by Shawnee's four-year statutes of repose because both statutory exceptions apply. Cyber MD engaged in a continuous course of treatment by repeatedly evaluating the same respiratory condition, ordering and reviewing imaging, and directing annual follow-up care through 2021. Respondent's product-liability claim likewise falls

within § 12-410 because Cyber MD's defect existed in its original algorithm but remained hidden behind proprietary code and medical complexity that an ordinary reasonably prudent person could not have discovered within four years. The Court should therefore affirm the Shawnee Court of Appeals.

ARGUMENT

I. MHS is vicariously liable under the doctrine of apparent agency for the diagnostic errors of an autonomous AI software tool developed by an independent contractor integrated into its branded technology.

MHS may be held vicariously liable under the doctrine of apparent agency for the diagnostic errors of Cyber MD, the AI-driven telehealth tool created by CSS that MHS integrated into its exclusively branded patient portal. The contractual relationship between a treating physician and the hospital where treatment takes place is a determining factor of whether a patient can hold the hospital liable for medical malpractice occurring on the hospital's premises. Howard Levin, *Hospital Vicarious Liability for Negligence by Independent Contractor Physicians: A New Rule for New Times*, 2005 U. ILL. L. REV. 1291, 1292-94 (2005). Under a theory of respondeat superior, a hospital is held vicariously liable only if an agent or employee of the hospital commits malpractice while acting under the scope of his authority. *Romero v. Schulze*, 974 P.2d 959, 964 (Wyo. 1999). Under the common law, hospitals were immune from liability caused by the negligence of independent contractors. *Id.*

However, due to drastic changes in the healthcare industry, hospitals started to provide medical services through independent contractor physicians. Levin, 2005 U. ILL. L. REV. at 1292-93. Recognizing the ability of hospitals to exploit their common law immunity, courts began to hold hospitals responsible for the negligence of independent contractor physicians. *Id.* The "overwhelming majority" of states have done so through the doctrine of apparent agency.

Burless v. W. Virginia Univ. Hosps., Inc., 215 W. Va. 765, 773 (2004). Jurisdictions that have held hospitals liable for the negligence of independent contractor physicians have relied on two Restatement sections: Section 429 of the Restatement (Second) of Torts and Section 267 of the Restatement (Second of Agency). *Gilbert v. Sycamore Mun. Hosp.*, 156 Ill. 2d 511, 523 (1993). Section 429 of the Restatement (Second) of Torts provides,

“One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.”

Restatement (Second) of Torts § 429 (1965).

Section 267 of the Restatement (Second) of Agency provides,

“One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.”

Restatement (Second) of Agency § 267 (1958).

Together, these sections establish that apparent agency gives rise to liability where, because of the principal’s manifestations, a third party reasonably believes he is dealing with the principal’s agent and, in reliance of that belief, is exposed to the apparent agent’s negligence. *Gilbert*, 156 Ill. 2d at 524. The doctrine turns on what the principal communicated and what the patient reasonably believed, not on the legal status of the person or system providing care. *Id.* Here, MHS presented Cyber MD, the AI diagnostic tool developed by CCS, as part of its own branded telehealth platform. Whether Miller reasonably understood Cyber MD to be MHS’s agent is a fact question that precludes summary judgment.

A motion for summary judgment should only be granted when pleadings, depositions, and affidavits reveal that there is no genuine issue as to any material fact, and that the moving party is

entitled to judgment as a matter of law. *Balla v. Gambro, Inc.*, 145 Ill. 2d 492, 584 (1991). The purpose of summary judgment is not to try a question of fact but to determine whether one exists. *Delegatto v. Advoke. Health & Hosps.*, 2021 IL App (1st) 200484, ¶ 21. Summary judgement must be denied if fair-minded individuals could differ as to the inferences that may be drawn to the evidence. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250-51 (1986). The court must view the facts and draw all reasonable inferences in the light most favorable to the nonmoving party. *Id.* at 255. Summary judgment is a drastic measure and should only be granted when the moving party's right to judgment is "clear and free from doubt." *Williams v. Manchester*, 228 Ill. 2d 404, 417 (2008). In appeals from summary judgment rulings, the standard of review is *de novo*. *Id.*

Here, the record presents genuine disputes over whether Miller reasonably believed he was receiving care from MHS itself rather than from a system designed and controlled by an independent software developer. Because reasonable minds could draw differing inferences from the facts presented in the Record, the Shawnee Court of Appeals correctly reversed and remanded the trial court's decision granting MHS summary judgment. This Court should therefore affirm the decision of the Shawnee Court of Appeals.

A. The doctrine of apparent agency does not shield MHS from liability because MHS held itself out as the sole provider of Miller's care, and Miller relied on MHS to provide such care.

1. Through its exclusive branding of the Cyber MD platform, MHS created the appearance that Cyber MD was its own agent.

The doctrine of apparent agency prevents MHS from disclaiming liability for the errors of CSS's Cyber MD software in diagnosing a lesion on Miller's lung. As established above, agency law has increasingly extended into the healthcare context to account for the reality that hospitals frequently deliver care through independent contractors rather than employees. Levin, 2005 U. ILL. L. REV. at 1292-93. A seminal case in this development is *Gilbert v. Sycamore Municipal*

Hospital, where the Illinois Supreme Court abrogated common law hospital immunity and held that hospitals could be vicariously liable for the negligence of independent contractor physicians. Under *Gilbert*, a hospital can be held vicariously liable for the negligent acts of a physician providing care at the hospital, regardless of whether the physician is an independent contractor, unless the patient knows, or should have known, that the physician is an independent contractor.” *Gilbert*, 156 Ill. 2d at 511.

Although *Gilbert* addressed apparent agency in the context of emergency-room physicians, courts have not confined its framework to the emergency-room setting. *Prutton v. Baumgart*, 2020 IL App (2d) 190346, ¶ 26. That principle is significant here because Miller sought care after experiencing shortness of breath, not for an emergency condition. R0017. Courts have extended *Gilbert*’s apparent agency principles to diagnostic specialists whose relationships with patients may be more attenuated than those of treating physicians, including radiologists. *See, e.g., Roessler v. Novak*, 858 So. 2d 1158, 1162 (Fla. Dist. Ct. App. 2003) (finding a genuine dispute of material fact as to whether the hospital’s conduct represented a radiologist as its apparent agent); *Gunther v. Staten Island Hosp.*, 640 N.Y.S.2d 601, 602 (App. Div. 1996) (holding that a question of fact existed where a patient reasonably believed a radiologist providing care at the hospital was a hospital employee despite the radiologist’s independent contractor status).

In applying the doctrine of apparent authority, the *Gilbert* court established a three-part test that is central to determining when a patient may hold a hospital liable for the malpractice of an independent contractor:

- (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 plaintiff must also prove that 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, 156 Ill. 2d 511 at 525.

The first two elements are often grouped together and referred to as “holding out.” *Delegatto*, 2021 IL App (1st), ¶ 27. Holding out is satisfied when a hospital holds itself out as a provider of care without informing the patient that the care is being provided by independent contractors. *Gilbert*, 156 Ill. 2d at 525. The inquiry focuses on what the patient knew or reasonably should have known. *Id.* Courts look to the hospital’s affirmative conduct which often includes marketing campaigns portraying physicians as hospital employees and discharge instructions using first-person language. *Brayboy v. Advoc. Health & Hosp. Corp.*, 2024 IL App (1st) 221846, ¶ 37.

The holding-out inquiry focuses on the overall impression created by the hospital’s conduct and whether, under the totality of the circumstances, that conduct could lead a reasonable patient to believe the provider was acting on the hospital’s behalf. *Id.* ¶ 33. A principal that creates an appearance of authority through its manifestations and representations cannot then deny the resulting agency relationship to the prejudice of a party who reasonably relied on that appearance. *Gilbert*, 156 Ill. 2d at 795. (holding whether a person is put aware or should be aware of the independent contractor status due to the circumstances is a question of fact).

Recently in *Brayboy*, the Illinois Appellate Court, applying *Gilbert*, reversed summary judgment in favor of Advocate Hospital largely due to Advocate’s branding and marketing representations that created the appearance that Advocate was the provider of patient care. 2024 IL App (1st) 221846, ¶ 40. This marketing campaign included advertisements that referred to physicians using possessive or employment-related language, including “Advocate Good

Samaritan Hospital associates and physicians,” “our top doctors,” and “Find an Advocate physician...” *Id.* ¶ 38. The advertisements also prominently associated physicians with Advocate’s various medical groups and specialties, including pictures of physicians wearing clothing or lab coats that read “Advocate Heart Institute,” “Advocate Healthcare,” and “AMG neurosurgery.” *Id.* Based on these representations, the court concluded that the evidence created a triable issue as to whether Advocate held the physicians out as its agents and therefore reversed summary judgment in the hospital’s favor. *Id.* ¶ 40. *Brayboy* thus illustrates that in applying the *Gilbert* test, holding out can be satisfied by the language used in hospital advertisements or patient-facing documents, as well as by the appearance of the physicians themselves. *Id.*

Similarly, in *York v. Rush-Presbyterian-St. Luke’s Medical Center*, the Illinois Supreme Court found that an independent-contractor anesthesiologist’s hospital-branded attire was relevant to whether the hospital had held him out as its employee. 222 Ill. 2d 147, 196-197 (2006). The anesthesiologist testified that his scrubs were “covered” with the Rush Hospital logo and that he wore a Rush branded white lab coat outside the operating room. *Id.* at 169. In conjunction with the absence of adequate notice of his independent-contractor status, the hospital’s prominent branding supported an inference that the patient neither knew nor had reason to know that the anesthesiologist was not a hospital employee. *Id.* at 197. *See also Martin v. Layman*, 2025 IL App (4th) 240278, ¶ 119 (finding that physicians’ identification badges displaying both the hospital’s name and the independent contractor’s name contributed to the appearance of employment). Thus, *Brayboy*, *York*, and *Layman* demonstrate that a hospital’s representations and branding may support an inference of apparent agency.

Here MHS’s manifestations and representations at least meet, and arguably exceed, those found sufficient to create a triable issue found in *Brayboy*, *York*, and *Layman*. MHS exclusively

controlled the patient-facing interface, displayed its branding throughout the platform, and contractually prohibited CCS's marks from appearing on any patient-facing page. R0004 .

Further, patients could access Cyber MD only through MHS's own domain. *Id.*

In *Layman*, the court found a triable issue as to apparent agency even though the physicians' identification badges displayed both the hospital's name and the independent contractor's name, "Infinity Healthcare Physicians." 2025 IL App (4th) 240278, ¶ 199. Here, by contrast, MHS did not merely place its branding alongside an independent contractor's identity; it prohibited CCS's branding from appearing anywhere on the patient-facing platform. R0004. Similarly, in *York*, hospital-branded scrubs and lab coats contributed to a triable issue of apparent agency despite a consent form disclaiming an employment relationship. 222 Ill. 2d at 196–97. Although Miller did not encounter a physician wearing MHS-branded clothing, the MHS branding served the same communicative function throughout his digital encounter. Cyber MD was accessible exclusively through MHS's web domain and operated within a platform displaying MHS branding throughout the diagnostic process, while CCS's identity was absent from the patient-facing interface. R0004. Thus, the branding here did more than associate MHS with CSS's telehealth system; it presented the entire diagnostic encounter through MHS's own institutional identity. If hospital branding alongside an independent contractor's name was sufficient to create a factual question in *Layman*, and hospital branded attire was sufficient in *York* and *Brayboy*, a jury could likewise find that MHS's exclusive branding and control of the patient-facing platform created a reasonable appearance that the diagnostic services were being provided by MHS. At minimum, these circumstances create a factual question as to whether MHS's representations reasonably led Miller to understand that Cyber MD's diagnostic services were provided on MHS's behalf.

Given the novelty of AI systems, courts have not yet specifically addressed vicarious liability for the diagnostic output of an autonomous software application. That novelty, however, does not require a new rule of apparent agency. Technology may have changed the manner in which medical care is delivered, but it has not changed the legal question governing apparent agency. Under *Gilbert*, the relevant inquiry is whether the principal held itself out as the provider of care without adequately informing the patient that the care was provided by an independent entity. 156 Ill. 2d at 525. The question, therefore, is what Miller knew or reasonably should have known about the actor providing his care—not whether that actor was human or artificial.

The record therefore contains ample evidence from which a jury could find that MHS held itself out as the provider of care through the CSS’s Cyber MD platform. As *Gilbert* recognized, a hospital’s appearances “speak much louder than the words of whatever private contractual arrangements” it makes with its providers. 156 Ill. 2d at 521. Here, MHS’s patient-facing representations pointed to a single source of care: MHS itself. A reasonable jury could therefore find that MHS’s representations created an appearance that Cyber MD provided care on MHS’s behalf. Thus, summary judgment in favor of MHS was improper.

2. MHS’s manifestations support a finding that Miller justifiably relied on MHS to provide his care.

After establishing that a reasonable jury could find MHS held itself out as Miller’s provider of care, the next inquiry is whether Miller *relied* on MHS to provide his care. *Gilbert*, 156 Ill. 2d at 525. The third *Gilbert* element asks whether the patient “acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence.” *Id.* This analysis is simple: justifiable reliance is met “if the plaintiff relies upon the hospital to provide complete emergency room care, rather than upon a specific physician.” *Id.* If a person voluntarily enters a hospital without objecting to his or her admission to the hospital, then that person is

seeking care from the hospital itself.” *Id.* “Unless the patient is in some manner put on notice of the independent status, it would be natural for the patient to assume that these people are employees of the hospital.” *Pamperin v. Trinity Mem’l Hosp.*, 144 Wis. 2d 188, 210 (1988). That assumption is not limited to the physician who directly treats the patient; it extends to the ancillary and supporting services through which hospitals deliver complete medical care, including radiology, pathology, and anesthesiology. *Brayboy*, 2024 IL App (1st) 221846, ¶ 36. (recognizing that patients who seek care from a hospital itself rely on the hospital to provide complete medical care, including blood testing, radiological services, and other medical support)

Brayboy reinforces that justifiable reliance may arise from a patient’s decision to entrust the hospital itself with providing comprehensive medical care, rather than from reliance on any particular physician. *Id.* ¶ 37. Advocate’s marketing campaign marketed the hospital as an organization providing quality and reputable healthcare and advertised its physicians and services to the public. *Id.* Based on those representations, the plaintiff alleged that she relied on Advocate to provide her son with “full and complete medical care,” including the necessary tests and services. *Id.* The court found that Advocate “marketed itself in such a manner that could lead a reasonable person to conclude that the hospital accepted responsibility for its choice of doctors,” supporting an inference that the physicians acted as Advocate’s agents. *Id.* The circumstances surrounding the plaintiff’s decision to seek treatment from Advocate further supported that inference: her son did not have a pediatrician to provide follow-up care, she did not know any particular physician, and she selected Advocate in part because of its reputation. *Id.* ¶ 40. Thus, *Brayboy* recognized that a patient’s reliance may be directed to the hospital itself, where the patient entrusts the institution with providing the necessary care rather than selecting or relying on a particular physician. *Id.* ¶ 37.

Williams v. Tissier illustrates the same principle from a different angle: a hospital's representations about the services it provides may support reliance when those representations are directly relevant to the care sought. 2019 IL App (5th) 180046, ¶ 55. There, the plaintiff researched St. Elizabeth's website after learning she would deliver her twins there. *Id.* ¶ 55. The website promoted the hospital's "comprehensive array of healthcare services," experience in delivering babies, and specialized staff and equipment, including neonatal care. *Id.* Because those representations concerned services directly relevant to the plaintiff's anticipated delivery, the court found a material issue of fact as to whether she relied on St. Elizabeth's to provide quality maternity care through its staff and agents. *Id.* Together, consistent with *Gilbert's* totality of the circumstance analysis, *Brayboy* and *Williams* demonstrate that the reliance inquiry encompasses the hospital's representations, the nature of the care sought, and the circumstances indicating that those representations informed the patient's decision to entrust the hospital with providing that care.

The same considerations support an inference that Miller relied on MHS to provide his diagnostic care. Like the plaintiff in *Brayboy*, Miller sought care from MHS itself; he did not select CCS or enter any independent relationship with it. He accessed Cyber MD through MHS's primary domain and received diagnostic services through a system MHS controlled and presented as its own. R0004–005. And, as in *Williams*, MHS's representations concerned the very care Miller sought. Cyber MD obtained his medical history, ordered imaging, interpreted the scans, reached diagnostic conclusions, and established a follow-up plan. R0005–006. MHS incorporated those functions into its patient-facing healthcare system, making the connection between its representations and the care Miller sought direct rather than incidental.

MHS’s presentation of Cyber MD further supports that inference. Cyber MD operated within an interface displaying “MHS branding throughout,” and Miller accessed it exclusively through MHS’s primary domain, while CCS’s marks were “strictly prohibited on all patient-facing pages.” R0004. Thus, MHS did more than permit an independent provider to operate within its facilities; it presented the entire patient-facing diagnostic experience as part of its own healthcare system. That presentation, coupled with Miller’s circumstances, supports an inference that he entrusted MHS—not CCS—with providing his care. Miller had no personal physician directing his care and lived in a designated Health Professional Shortage Area with no local hospital, urgent care facility, or permanent imaging center, and only three primary-care practices serving approximately 7,500 residents. R0004. Faced with those limitations, he turned to MHS “as an integrated healthcare delivery system.” R0022. These circumstances provide a factual basis for finding that Miller sought out MHS itself as the institution capable of providing the healthcare services he needed. *See Gilbert*, 156 Ill. 2d at 524.

Nor does the existence of a disclaimer resolve the reliance inquiry as a matter of law. Both *Brayboy* and *Williams* recognized triable issues concerning whether patients knew or reasonably should have known that the treating physicians were independent contractors despite signed consent forms containing liability disclaimers. *Williams*, 2019 IL App (5th) 180046 ¶ 33; *Brayboy*, 2024 IL App (1st) 221846 ¶ 26. As *Brayboy* explained, apparent agency is determined from the totality of the circumstances, and a single factor—such as a signed consent form containing a liability disclaimer—is not dispositive. *Id.* ¶¶ 26–33. The same principle applies here. MHS’s disclaimer must be considered alongside the manner in which MHS presented Cyber MD, its exclusive control over the patient-facing platform, and the circumstances under which Miller sought care. The next section will complete this analysis, showing that MHS’s

disclaimer does not eliminate the factual dispute over whether Miller reasonably understood that the diagnostic services were being provided independently of MHS.

B. “Holding out” and “justifiable reliance” are not defeated by a disclaimer of liability buried in a sign-in wrap agreement that gave Miller no reasonably conspicuous notice of CSS’s independent contractor status.

The facts in the record present triable issues as to whether MHS held itself out as Miller’s provider of care and whether Miller reasonably relied on MHS for his healthcare, and these issues are not defeated by MHS’s disclaimer of liability. The burden rests with the hospital to provide patients with adequate notice of the independent-contractor status of their treating physicians. *See Kane v. Doctors Hosp.*, 302 Ill. App. 3d 755, 762 (1999). Courts in numerous jurisdictions have recognized that a hospital’s disclaimer of liability for the negligence of independent contractors does not, standing alone, preclude a finding of apparent agency. *See Brayboy*, 2024 IL App (1st) 221846, at ¶26 (holding that a signed consent form is an important, but not dispositive, factor); *Boren ex rel. Boren v. Weeks*, 251 S.W.3d 426, 437 (Tenn. 2008) (finding a liability disclaimer ineffective where factual disputes remained regarding whether the hospital provided adequate notice of the contractual arrangement between the hospital and its emergency-room physicians); *Williams v. Dimensions Health Corp.*, 480 Md. 24, 42 (2022) (holding that notice of an emergency-room physician’s independent-contractor status must be meaningful to be effective). These decisions make clear that the relevant inquiry is not simply whether a hospital included independent-contractor language in a consent form, but whether the disclosure was sufficient to dispel the patient’s reasonable belief that the treating provider was acting on the hospital’s behalf. A disclaimer is effective only when presented “in a meaningful way, at a meaningful time, in order to sufficiently disclaim reliance by the patient.” *Brayboy*, 2024 IL App (1st) 221846, ¶ 30. And critically, the adequacy of the disclaimer must be measured

against the hospital's own representations: the stronger the hospital's holding out of medical personnel as its agents, the stronger and clearer its disclaimer must be. *Martin*, 2025 IL App (4th) 240278, ¶ 229. Where the circumstances surrounding the presentation or substance of the disclaimer fail to provide the patient with meaningful notice, a reasonable patient may continue to believe that the hospital or its employees are providing the patient's care. *See Churkey v. Rustia*, 329 Ill. App. 3d 239, 245 (2002) (recognizing that a patient may sign a consent form containing a liability disclaimer while other circumstances nevertheless create a triable issue as to whether the hospital held the physician out as its agent).

Lamb-Rosenfeldt v. Burke Medical Group, Ltd. illustrates the circumstances in which a disclaimer may provide sufficiently meaningful notice to defeat a claim of apparent agency. There, the plaintiff sued St. James Hospital for the alleged medical negligence of its agents arising from the hospital's failure to timely screen, diagnose, and treat the patient's lung cancer. *Lamb-Rosenfeldt v. St. James Hosp.*, 2012 IL App (1st) 101558, ¶16. Before the patient's visit, the hospital provided a one-page "Consent for Medical Treatment Form" containing a specific independent contractor disclosure. *Id.* ¶ 4. The disclosure prominently stated, in capital letters, that "PHYSICIANS ARE NOT EMPLOYEES OF THE MEDICAL CENTER: I understand that St. James Hospital utilizes independent physicians and consultants to perform services for patients at its hospitals." *Id.* A few lines down, the form expressly stated, "NONE OF THE PHYSICIANS WHO ATTEND TO ME AT THE HOSPITAL ARE AGENTS OR EMPLOYEES OF THE HOSPITAL, and therefore, they, and not the hospitals, are legally liable for the physicians' acts." *Id.*

The court found that the form provided sufficient notice that the physicians were not hospital employees. *Id.* ¶ 36. In reaching that conclusion, the court emphasized that the plaintiff

had been repeatedly exposed to the form and that the independent-contractor disclosure appeared in clear, bold, capitalized language. *Id.* ¶ 30. The court therefore concluded that the decedent knew or reasonably should have known that the primary physician was an independent contractor. *Id.* Under *Gilbert*, once a patient knows or has reason to know of the physician's independent-contractor status, the patient cannot reasonably rely on an appearance of agency, and the doctrine of apparent agency does not apply. *Gilbert*, 156 Ill. 2d at 522.

In contrast, *Williams v. Tissier* found the hospital's independent contractor disclosure insufficient to place the patient on notice, focusing heavily on the disclaimer's presentation and context. 2019 IL App (5th) 180046, ¶¶ 40-42. The *Williams* disclaimer was not in bold type or capital letters, appeared in small font, and was embedded among the form's other provisions. *Id.* ¶ 39. The plaintiff had also signed the form while in labor and experiencing contractions, circumstances that could have affected her ability to comprehend the disclosure. *Id.* ¶ 12. Considering the language, presentation, and surrounding circumstances, the court held that the disclaimer was unclear and insufficiently prominent, creating genuine issues of material fact as to the holding-out and reliance elements of apparent agency. *Id.* ¶ 39.

Here, MHS's disclaimer more closely resembles the ineffective disclosure in *Williams* than the conspicuous disclaimer in *Lamb-Rosenfeldt*. Although MHS's disclaimer expressly stated that the physicians and software applications providing care through MHS domain were independent contractors and not MHS employees, Miller did not receive that disclosure in a meaningful or reasonably conspicuous manner. The disclaimer was not presented to Miller in a prominent, stand-alone disclosure. Instead, it appeared approximately three-quarters of the way down a separate webpage containing 34 lines of single-spaced, unformatted, small black text, buried in the middle of other unrelated provisions. R0023.

Additionally, the Appellate Court recognized that MHS's liability disclaimer, which was accessible only through a hyperlink, constituted a sign-in wrap agreement. R0023. Courts have recognized that sign-in wrap agreements may be unenforceable when they bind users to hyperlinked terms through a separate action, such as clicking "Enter Portal," without requiring users to review the terms or affirmatively acknowledge their assent before proceeding. *See Keebaugh v. Warner Bros. Ent. Inc.*, 100 F.4th 1005, 1014 (9th Cir. 2024) (holding that an agreement requiring a user to press a "Play" button before accessing a game, without requiring the user to review the Terms of Service and confirm assent, constituted a sign-in wrap agreement). Such agreements require both "(1) reasonably conspicuous notice of the terms to which the consumer will be bound" and "(2) an unambiguous manifestation of assent to those terms." *Keebaugh*, 100 F.4th 1005 at 1014; see also *Domer v. Menard, Inc.*, 116 F.4th 686, 695 (7th Cir. 2024). Whether notice is reasonably conspicuous depends on the website's overall presentation, including the simplicity and clarity of the disclosure, font size and color, hyperlink placement, and timing. *Domer*, 116 F.4th at 695. These principles reinforce the underlying question present in any *Gilbert* analysis: whether MHS presented its disclaimer in a manner reasonably calculated to notify Miller that the physicians and software applications providing his care were not agents or employees of MHS. *Gilbert*, 156 Ill. 2d at 524.

Here, as in *Keebaugh*, the patient interface did not require Miller to affirmatively accept the Terms and Conditions before entering the portal. R0020. Instead, Miller accessed them through a hyperlink leading to a separate webpage containing 34 single-spaced lines of small, unformatted black text, with the independent-contractor disclaimer appearing approximately three-quarters of the way down the page. *Id.* Although Miller accessed the hyperlink once for approximately four seconds, that brief interaction establishes, at most, that he knew the Terms

and Conditions existed—not that he understood MHS was disclaiming responsibility for the physicians and software applications providing his care. R0023.

Nor did Miller’s entry into the portal unambiguously manifest assent to the disclaimer. Had MHS required him to click “I agree” after presenting the Terms and Conditions, the record would provide stronger evidence that he intended to be bound by them. *See Berman v. Freedom Fin. Network, LLC*, 30 F.4th 849, 853 (9th Cir. 2022). Instead, MHS treated Miller’s entry into the healthcare portal as assent to terms contained in a separate document he had not meaningfully reviewed. His decision to access MHS’s healthcare services therefore does not necessarily demonstrate that he knowingly agreed to disclaim an agency relationship with the providers of that care. Because enforceability requires both reasonably conspicuous notice and an unambiguous manifestation of assent, whether MHS’s interface provided adequate notice and whether Miller’s conduct manifested assent to the disclaimer present triable issues of fact.

Furthermore, MHS cannot rely on the pre-session Cyber MD pop-up to cure these deficiencies. The warning stated only that “Cyber MD is not a licensed health care professional” and “is an artificial intelligence software program.” R005. It did not disclose that Cyber MD was operated by a separate company, that MHS disclaimed responsibility for its diagnostic errors, or that the technology was independent of MHS’s healthcare system. Thus, Miller could understand that Cyber MD was not itself a licensed physician while still reasonably believing that MHS provided, controlled, or adopted the technology as part of its healthcare services. The pop-up therefore did not dispel the appearance of agency created by MHS’s branding and interface. The pop-up also exposes the shortcomings of the disclaimer. When the platform wanted users to notice a warning, it knew how: red, 16-point type and a mandatory “Accept” click before proceeding. R005. The disclosure that mattered for establishing apparent agency got the opposite

treatment. It was tucked behind a hyperlink and placed three-quarters of the way down a page of small, unformatted text. R0004-005. The pop-up shows that the platform had the capacity to provide conspicuous notice, but it simply did not employ the same level of notice for the disclaimer which it now relies on to defeat apparent agency. Accordingly, although the disclaimer's language may have been clear once located, whether MHS presented it in a manner sufficient to meaningfully alert Miller that it was disclaiming an agency relationship with CCS presents a triable issue of fact.

II. Respondent's claims are timely because continuous monitoring and diagnostic activities for a specific condition constitutes continuing care under § 12-404 and the technological complexity of AI algorithms coupled with medical sophistication would not allow a defect to be found by an ordinarily reasonable prudent person.

A. Miller remained in continuous treatment because his ongoing diagnostic monitoring was part of an established course of care for the same condition

This Court has not previously addressed the scope of the continuous-course-of-treatment exception contained in Shawnee Rev. Statute § 12-404. Section 12-404 provides, in relevant part:

Repose Period. In no event shall such action be brought more than four (4) years after the date on which occurred the act or omission or occurrence alleged to have been the cause of such injury or death. However, such period shall not bar an action where the defendant healthcare provider **engaged in a continuous course of treatment of the patient for the same illness, injury, or condition that gives rise to the claim of negligence.**

Id.

Because this Court has not previously addressed this issue, decisions from other jurisdictions provide persuasive guidance. *See People ex rel. LeGout v. Decker*, 146 Ill. 2d 389, 399 (1992) (“[I]n construing an Illinois statute, decisions of other States construing similar statutes are entitled to respect and consideration.”); *Peralta Cmty. Coll. Dist. v. Fair Emp. & Hous. Comm’n*, 52 Cal.

3d 40, 59 (1990) (“[W]e find persuasive the reasoning of the numerous courts in our sister states with statutes similar to ours . . .”). New York’s continuous-treatment statute similarly provides:

An action for medical, dental or podiatric malpractice must be commenced within two years and six months of the act, omission or failure complained of **or last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission or failure;**

N.Y. C.P.L.R. 214-a.

Under the continuous-treatment doctrine, the limitations period does not begin to run until the conclusion of treatment where the course of treatment containing the alleged wrongful acts or omissions has continued uninterrupted and relates to the same original condition or complaint. *Borgia v. City of New York*, 12 N.Y.2d 151,155 (1962). Application of the doctrine generally requires that (1) the patient continued to seek and received a course of treatment from the defendant during the relevant period; (2) the treatment concerned the same condition or complaints underlying the malpractice claim; and (3) the treatment was continuous. *Weinstein v. Gewirtz*, 208 A.D.3d 717, 718 (N.Y. App. Div. 2022).

1. Cyber MD’s ongoing monitoring constituted treatment because its periodic diagnostic examinations, coupled with imaging, were expressly contemplated as part of Miller’s continuing care.

The first factor asks whether the patient continued to seek and receive a course of treatment from the defendant during the relevant period. *Weinstein*, 208 A.D.3d at 718. “Treatment” generally refers to the medical or surgical management and care of a patient undertaken to combat disease or disorder. *Johnson v. Bishof*, 2015 IL App (1st) 131122, ¶ 49 (distinguishing diagnosis from treatment, which involves the management and care of a patient for the purpose of combating disease or disorder).

The continuous-treatment doctrine likewise requires more than the mere existence of a physician-patient relationship. *Massie v. Crawford*, 78 N.Y.2d 516, 519 (1991). Rather, there must be ongoing medical efforts directed toward the patient’s condition. *Id.* (“A patient is not entitled to the benefit of the toll in the absence of continuing efforts by a doctor to treat a particular condition.”). A “course of treatment” therefore ordinarily involves affirmative and ongoing medical conduct, such as surgery, therapy, or the prescription of medication. *Gomez v. Katz*, 61 A.D.3d 108, 111–12 (N.Y. App. Div. 2009). By contrast, a continuing general provider-patient relationship, routine periodic examinations, or diagnostic activity undertaken merely to determine a patient’s condition do not, standing alone, establish treatment. *Young v. N.Y.C. Health & Hosps. Corp.*, 91 N.Y.2d 291, 296 (1998); *Nykorchuck v. Henriques*, 78 N.Y.2d 255, 258–60 (1991); *Massie*, 78 N.Y.2d at 519–20.

Diagnostic services, however, are not categorically excluded from treatment. Periodic diagnostic examinations may constitute treatment when they are prescribed as part of ongoing care for an existing condition and are expressly anticipated by both provider and patient. *Goldschmidt v. Cortland Reg’l Med. Ctr., Inc.*, 190 A.D.3d 1212, 1214 (N.Y. App. Div. 2021). Thus, the relevant distinction is not simply whether a service is diagnostic, but whether it remains a discrete and completed examination or instead becomes part of an established plan of continuing medical care. *See id.*; *Kaufmann v. Fulop*, 47 A.D.3d 682, 684 (N.Y. App. Div. 2008) (finding no continuous diagnostic course where no future lung-related visit or periodic chest X-ray was planned).

Goldschmidt illustrates when recurring diagnostic imaging crosses that line. There, a radiologist identified a questionable lung nodule and recommended additional CT scans at

specified future intervals to monitor the abnormality. 190 A.D.3d at 1213–14. Those scans were not merely contemplated; they were “planned and executed,” and the radiologist repeatedly compared each new scan against the patient’s prior imaging. *Id.* at 1214. The court therefore held that a question of fact existed as to continuous treatment because the scans were scheduled and explicitly anticipated as part of ongoing care to monitor the patient’s condition. *Id.* Recurring examinations directed at an identified abnormality may likewise rise above routine screening. *Prinz-Schwartz v. Levitan*, 17 A.D.3d 175, 177–79 (N.Y. App. Div. 2005) (finding triable issues where annual and semiannual breast examinations over approximately twelve years revealed recurring irregularities and, on multiple occasions, prompted shortened six-month follow-up intervals). Taken together, isolated diagnostic activity is distinct from diagnostic monitoring incorporated into an ongoing course of medical care. Routine screening, a general provider-patient relationship, and discrete examinations are insufficient. *Massie*, 78 N.Y.2d at 519–20; *Nykorchuck*, 78 N.Y.2d at 258–60. But where a provider prescribes recurring examinations, imaging, or monitoring as part of the continuing management of an identified medical concern, those services may constitute treatment for purposes of the continuous-treatment doctrine. *Goldschmidt*, 190 A.D.3d at 1214; *Prinz-Schwartz*, 17 A.D.3d at 177–79.

Here, Miller did not merely maintain a passive provider-patient relationship with Cyber MD or return for isolated independent screenings to simply maintain his health. He sought care from Cyber MD in April 2018 for shortness of breath, disclosed a thirty-five-year occupational history involving asbestos, and underwent the chest X-ray and CT scan that Cyber MD ordered so it could evaluate his respiratory condition. R0016. After reviewing those scans, Cyber MD diagnosed adult-onset asthma, referred Miller for inhaler management, and—critically—recommended annual follow-up imaging. R0016. That recommendation transformed later imaging

from a series of disconnected diagnostic encounters into part of Cyber MD's prospective management of Miller's respiratory care.

Miller then did exactly what Cyber MD's treatment plan required. He returned for annual follow-up evaluations in 2019, 2020, and 2021, and each time Cyber MD reviewed newly obtained imaging, which Miller sought at Cyber MD's behest, before reporting "zero evidence" of malignancy. R0016. The recurring examinations therefore did not occur just because Miller independently decided to have his condition checked to ensure his general health. The examinations occurred because Cyber MD had affirmatively prescribed a continuing regimen of annual imaging and then repeatedly interpreted those scans as part of the follow-up care it had established in 2018. The structure of Miller's care closely tracks the circumstances in which courts distinguish treatment from discrete diagnostic activity. Cyber MD first evaluated Miller's respiratory complaints, ordered diagnostic imaging, reached a diagnosis, and then prescribed future imaging as part of that diagnosis and care plan. R0016. Miller thereafter underwent that prescribed imaging at regular intervals, and Cyber MD continued to assess each new scan against the same respiratory concern. R0016.

The imaging was therefore not merely diagnostic in purpose; it was the mechanic in which Cyber MD selected to continue monitoring Miller's lung condition after the initial diagnosis. Cyber MD's own conduct further demonstrates that the annual scans were part of an established course of care rather than independent screenings. After the 2021 follow-up, Cyber MD affirmatively advised Miller that annual imaging was no longer necessary. R0016; R0005. That instruction is perhaps the most important fact because a provider cannot discontinue a course of monitoring that never existed. Since Cyber MD itself determined when the annual imaging

regimen should end strongly supports that the prior examinations had been components of a continuing plan of care, not unrelated one-off encounters.

Accordingly, Miller continued to seek and actually receive treatment from Cyber MD throughout the relevant period. Cyber MD diagnosed his respiratory condition, prescribed annual imaging, reviewed the resulting scans over successive years, and ultimately terminated the imaging regimen only after concluding that further annual monitoring was unnecessary. R0016; R0005. Taken in sum, Miller's care was on the treatment side of the line between isolated diagnostic activity and recurring medical monitoring incorporated into an established course of care.

2. Cyber MD's care concerned the same respiratory condition underlying Miller's malpractice claim despite its failure to correctly diagnose the disease.

Cyber MD's care concerned the same condition underlying Miller's malpractice claim because the continuous-treatment doctrine does not require a provider to correctly identify the ultimate disease so long as it continues treating symptoms attributable to that condition. The second factor asks whether the course of treatment concerned "the same conditions or complaints underlying the plaintiff's medical malpractice claim." *Weinstein*, 208 A.D.3d 718 (N.Y. App. Div. 2022). In failure-to-diagnose cases, "[t]he critical inquiry is not whether the defendant failed to make a diagnosis . . . but whether the plaintiff continued to seek treatment for the same or related conditions giving rise to his or her claim of malpractice." *Id.* at 718 (quoting *Cohen v. Gold*, 165 A.D.3d 879, 882 (N.Y. App. Div. 2018)). Accordingly, a provider "cannot defeat the application of the continuous treatment doctrine merely because of a failure to make a correct diagnosis" where it continues treating symptoms ultimately traced to the underlying condition. *Id.* (quoting *Cohen*, 165 A.D.3d at 882).

Lewis v. Rutkovsky applies the same principle. 153 A.D.3d 450, 454 (N.Y. App. Div. 2017). There, the court explained that “[w]here the malpractice claim is based on an alleged failure to properly diagnose a condition, the continuous treatment doctrine may apply as long as the symptoms being treated indicate the presence of that condition.” *Id.* (quoting *Wilson v. Southampton Urgent Med. Care, P.C.*, 112 A.D.3d 499, 500 (N.Y. App. Div. 2013)). The court found a factual issue where the plaintiff received treatment for recurring severe headaches and vision problems that were later traced to an undiagnosed meningioma. *Id.* (finding evidence of treatment for symptoms “traceable to plaintiff’s meningioma”). Likewise, in *Wilson*, the decedent visited a walk-in clinic eleven times over nearly two years complaining of headaches before she was diagnosed with metastatic lung cancer. *Wilson*, 112 A.D.3d at 500. One defendant acknowledged that a brain tumor from metastatic lung cancer could cause headaches and testified that he had recommended an MRI and neurological consultation. *Id.* The court held that a triable issue existed as to whether those visits constituted continuous treatment for headaches ultimately traceable to the lung cancer that caused her death. *Id.* (finding a question of fact as to whether the decedent’s repeated headache treatment was “traceable to the lung cancer that killed her”).

Even jurisdictions applying narrower versions of the continuous-treatment doctrine recognize that misdiagnosis does not categorically bar tolling where the misdiagnosed condition remains the subject of ongoing treatment or monitoring. *See Bogue v. Gillis*, 311 Neb. 445 (2022); *Fabio v. Bellomo*, 504 N.W.2d 758 (Minn. 1993); *Grey v. Stamford Health Sys., Inc.*, 282 Conn. 745 (2007). Thus, the relevant inquiry is whether Cyber MD’s care remained directed toward symptoms or conditions ultimately attributable to Miller’s undiagnosed disease, not whether Cyber MD correctly labeled that disease during treatment. *See Weinstein*, 208 A.D.3d at 718; *Lewis*, 153 A.D.3d at 454.

Here, Cyber MD's care remained directed toward the same respiratory complaints and abnormalities that ultimately gave rise to Miller's malpractice claim. Miller initially sought treatment for shortness of breath after decades of occupational asbestos exposure, and Cyber MD responded by ordering chest imaging to evaluate those respiratory complaints. R0016. Although Cyber MD diagnosed adult-onset asthma rather than lung cancer, the diagnosis did not change the underlying medical problem for which Miller sought care: persistent respiratory symptoms requiring evaluation and monitoring. R0016. Cyber MD then continued to evaluate that same respiratory condition through recurring imaging. After the initial workup, Cyber MD recommended annual follow-up imaging and reviewed new scans in 2019, 2020, and 2021, repeatedly reporting no evidence of malignancy. R0016. Those examinations were therefore not directed toward unrelated ailments that happened to occur during the same provider-patient relationship. Each follow-up returned to the same part of Miller's body, the same respiratory concern, and the same diagnostic question that had prompted Cyber MD's initial imaging.

The later cancer diagnosis confirms rather than severs that relationship. Miller's malpractice claim arises from Cyber MD's alleged failure to identify the disease responsible for the respiratory condition it had already undertaken to evaluate and monitor. Cyber MD may have labeled Miller's condition as asthma, but it continued to examine and image the very respiratory system in which the undiagnosed malignancy existed. R0016. Put differently, Cyber MD did not treat one condition while Miller later developed an unrelated disease; the alleged malpractice is that Cyber MD repeatedly failed to recognize the true cause of the condition it was already following.

The comparison to *Wilson* and *Lewis* strongly favors Miller. In those cases, courts found sufficient continuity even though the connection between the treated symptom and the undiagnosed disease required an additional inferential step: headaches and vision problems were later traced to an underlying brain tumor or metastatic cancer. Here, the connection is far more direct. Cyber MD was not treating a seemingly remote symptom and later discovering an unrelated pathology; it repeatedly evaluated Miller's respiratory complaints through imaging of the very organ system in which the undiagnosed malignancy existed. R0016. If headaches can remain sufficiently related to a later-discovered cancer because they were manifestations of that disease, then repeated respiratory imaging directed at Miller's lungs presents an even tighter fit. The causal and anatomical link here is not a bridge—it is the same roadway.

Accordingly, the second *Weinstein* factor is satisfied because Cyber MD's course of care remained directed toward the same respiratory complaints and condition underlying Miller's malpractice claim. Its failure to correctly diagnose that condition as cancer does not transform the care into treatment of a different disease; it is the alleged malpractice itself.

3. Miller's treatment remained continuous because Cyber MD repeatedly monitored the same condition through an established course of recurring examinations and imaging.

The third factor asks whether the course of treatment remained continuous throughout the relevant period. *Weinstein*, 208 A.D.3d at 718. Continuity does not require uninterrupted office visits or constant physical contact between provider and patient. Rather, treatment may remain continuous where further care or monitoring is explicitly anticipated by both parties. *Young*, 91 N.Y.2d at 296; *Richardson v. Orentreich*, 64 N.Y.2d 896, 898–99 (1985). In *Richardson*, the Court of Appeals explained that a patient remains under continuous treatment between visits where the

next appointment is part of the same ongoing course of care and the physician and patient reasonably contemplate the patient's "uninterrupted reliance upon the physician's observation, directions, concern, and responsibility for overseeing the patient's progress." *Id.* at 899.

Accordingly, the passage of time between encounters does not, standing alone, terminate continuous treatment. *See Id.* at 898–99. Even substantial gaps may be consistent with continuity where the surrounding circumstances show that care for the condition was expected to resume. *Lohnas v. Luzi*, 30 N.Y.3d 752, 755–56 (2018) (holding that a nineteen-month gap and a later thirty-month gap were not per se dispositive of whether treatment remained continuous). The inquiry therefore turns on whether the parties understood that the provider's responsibility for the patient's care remained ongoing, not simply on the amount of time separating individual encounters.

The doctrine does, however, require more than a continuing general provider-patient relationship or a series of routine periodic examinations. There must be an established course of care that remains ongoing rather than a collection of isolated encounters. *Young*, 91 N.Y.2d at 296; *Nykorchuck*, 78 N.Y.2d at 258–59. Thus, where follow-up examinations or monitoring are prospectively planned as part of the provider's continuing management of the patient, the intervals between those encounters do not necessarily sever treatment. *See Richardson*, 64 N.Y.2d at 898–99; *Goldschmidt*, 190 A.D.3d at 1214 (recognizing that periodic diagnostic examinations may fall within the doctrine when prescribed as part of ongoing care and expressly anticipated by provider and patient). The relevant distinction is therefore between treatment that has actually ended and treatment that merely pauses between scheduled or anticipated encounters. Where the provider continues to retain responsibility for monitoring the patient's condition and future examinations

are contemplated as part of the same established course of care, treatment remains continuous notwithstanding gaps between visits. *See Richardson*, 64 N.Y.2d at 898–99; *Lohnas*, 30 N.Y.3d at 755–56.

Here, Miller’s treatment remained continuous because Cyber MD prospectively established annual follow-up imaging as part of his respiratory care. After the initial evaluation, Cyber MD recommended yearly imaging, and Miller returned in 2019, 2020, and 2021 for those follow-up examinations. R0016. The intervals between visits therefore reflected Cyber MD’s prescribed monitoring schedule, not the termination of treatment. Those annual gaps do not defeat continuity. Cyber MD did not merely remain available if Miller chose to return; it directed him to undergo recurring imaging and continued reviewing those scans as part of the same course of care. R0016. Indeed, the approximately one-year intervals were substantially shorter than gaps courts have declined to treat as dispositive, and here the timing was itself built into the monitoring plan. Cyber MD’s 2021 instruction that annual imaging was no longer necessary further confirms that the course of care had remained ongoing until that point. R0016; R0005. Miller’s treatment therefore did not stop and restart each year; it continued through scheduled periods of monitoring until Cyber MD itself ended the regimen.

B. Cyber MD’s latent algorithmic defect falls within § 12-410(b)(3)’s exception to repose.

Shawnee Revised Statute § 12-410 bars product-liability actions brought more than four years after the first sale, lease, or delivery of possession to the initial user or consumer, but expressly excepts claims where “the injury-causing aspect of the product that existed at the time of delivery was not discoverable by an ordinary reasonably prudent person until more than four (4) years after delivery.” Shawnee Rev. Stat. § 12-410(b)(3). That exception closely tracks the

Model Uniform Product Liability Act (“MUPLA”), which recognizes “the unusual situation in which a product contains, at the time of delivery, a hidden defect that is not discoverable by a reasonably prudent product user and does not manifest itself until after a ten-year period has expired.” Model Uniform Product Liability Act § 110(B)(2), analysis, 44 Fed. Reg. 62,714, 62,734 (Oct. 31, 1979). The MUPLA likewise provides that repose does not apply where “the injury-causing aspect of the product that existed at the time of delivery was not discoverable by an ordinary reasonably prudent person until more than ten (10) years after the time of delivery.” *Id.* § 110(B)(2), 44 Fed. Reg. at 62,732. Several states adopted versions of the MUPLA or materially similar provisions. *See, e.g.*, Kan. Stat. Ann. § 60-3303(b)(2)(D); Idaho Code § 6-1403(2)(b)(4); *Anderson v. M.W. Kellogg Co.*, 766 P.2d 637, 643–44 (Colo. 1988). Because Shawnee uses substantially similar language, decisions construing those provisions are persuasive. *See Decker*, 146 Ill. 2d at 399.

Accordingly, § 12-410(b)(3) requires Respondent to show that (1) flaw in Cyber MD’s existed at the time of delivery, and (2) that aspect was not discoverable by an ordinarily reasonably prudent person until more than four years after delivery.

1. Cyber MD’s injury-causing defect existed when CCS delivered the original algorithm in 2017.

The requirement that the injury-causing aspect “existed at the time of delivery” is temporal. It asks whether the defect was already present in the product when it was delivered, as opposed to arising later through alteration, repair, misuse, or other post-sale conduct. *See Stump v. Indiana Equip. Co.*, 601 N.E.2d 398, 402 (Ind. Ct. App. 1992) (explaining that the repose provision applies only where the complained-of defect was “present at or before the time” the product was delivered to the initial user or consumer). Courts applying materially similar provisions separately examine

whether the defect existed at delivery and whether it was then reasonably discoverable. *See Kerns v. G.A.C., Inc.*, 255 Kan. 264, 273 (1994) (considering whether the alleged defect “existed” when the fence was installed); Thus, a defect may satisfy the existence requirement even though it remains hidden or does not manifest injury until later. *See Niemet v. Gen. Elec. Co.*, 843 P.2d 87, 90 (Colo. App. 1992). In terms of computer software or algorithms, courts have treated delivery as occurring when the software is furnished or made available to the user. *See Dreier Co. v. Unitronix Corp.*, 218 N.J. Super. 260, 271, 527 A.2d 875 (App. Div. 1986). In *SAP America, Inc. v. Gerregano*, a tax case involving cloud-based software and services, the court interpreted an undefined statutory use of “delivery”, like here, by looking to its plain and ordinary meaning. 2026 WL 1318338 at *9 (Tenn. Ct. App. May 13, 2026). The court concluded that “the plain and ordinary meaning of ‘deliver’ includes services where something is physically transferred to a particular place and where something is made accessible to someone electronically,” and held that “[d]elivery . . . was completed when SAP’s customers electronically accessed these services.” *Id.*

Here, Cyber MD’s injury-causing defect existed when the software was delivered in 2017. MHS integrated Cyber MD into its telehealth portal that year, and retrospective review later established that Cyber MD’s 2017 baseline coding algorithm consistently failed to identify Miller’s lesion. R0003. The defect therefore was not introduced by a later repair, modification, or update; it was embedded in the software from the outset. And because Cyber MD operated through CCS’s cloud infrastructure, delivery occurred when the software was made electronically available to MHS for use through its telehealth platform. Thus, the injury-causing aspect existed at the time of delivery within the meaning of § 12-410(b)(3).

2. The defect was not discoverable by an ordinarily reasonably prudent person within four years because it was concealed within proprietary code and required specialized technical and medical analysis to identify.

The claimant bears the burden of showing that the statutory latent-defect exception applies. *See Oats v. Nissan Motor Corp. in U.S.A.*, 126 Idaho 162, 166, (1994). The latent-defect inquiry is objective. The question is not whether the plaintiff actually discovered the defect, but whether the defect was “readily apparent or discoverable by a reasonably prudent user.” *Anderson*, at 643–44 (“[T]he test . . . is whether the defect was not readily apparent or discoverable by a reasonably prudent user.”). *Anderson* expressly rejected a subjective standard focused on the individual user’s actual knowledge. *Id.* (“[W]e do not agree . . . that the test for a hidden defect is a subjective test based on the user’s knowledge of the existence of a defect.”). Stated another way, the inquiry asks whether a careful person, would have been able to comprehend the danger and determine how to avoid the danger. *Baumann v. Excel Indus., Inc.*, 17 Kan. App. 2d 807, 819 (1993).

Accordingly, defects that are open, visible, or appreciable through ordinary observation or use are generally discoverable by a reasonably prudent user. *See Kerns*, 255 Kan. at 273 (“If the use of the large size mesh to enclose a swimming pool was the defect, that defect existed and was discoverable by a reasonably prudent person at the time the fence was installed.”); *Oats*, 126 Idaho (rejecting the hidden-defect exception where the alleged limitation was one “an ordinary adult could not sit in the rear seat . . . without noticing”). Likewise, an openly exposed mechanical danger falls outside the latent-defect exception where an ordinary user could perceive and understand the hazard through normal use. *See Anderson*, 766 P.2d at 643–44 (distinguishing hidden mechanical defects from an “openly and obviously dangerous” condition).

By contrast, the nature and extent of the inspection necessary to reveal a defect is central to whether an ordinarily prudent person could discover it. A defect may remain latent where it is concealed within internal, inaccessible, or technically complex components and cannot be identified through ordinary observation or customary use. *See Niemet v. Gen. Elec. Co.*, 843 P.2d 87, 90 (Colo. App. 1992) (defect “was not discovered, and could not have been discovered, until the entire transformer was cut in half”); *Scott v. Cont’l Ins. Co.*, 44 Cal. App. 4th 24, 32 (1996) (defining a latent defect as one “both not readily observable and not discoverable to any but the most searching inspection”). Other courts similarly define latency by reference to whether the defect could be uncovered through ordinary inspection. *See Brown v. City of Oil City*, 294 A.3d 413, 422 (Pa. 2023) (“A latent defect is a defect which cannot be discovered by observation or inspection made with ordinary care.”); *Maycock v. Asilomar Dev., Inc.*, 207 Ariz. 495 (Ct. App. 2004) (describing a latent defect as one “that could not be discovered by reasonable and customary observation or inspection”).

Courts also distinguish ordinary inspection from extraordinary measures such as disassembly, destructive testing, or invasive examination. In *Gray v. Certain Underwriters at Lloyd’s London*, the court found a structural defect latent where “there was no testimony at trial that [the owners] could have found this defect other than removing the keel from the hull or by drilling holes in the hull,” and where the owners “could not have found the defect during ordinary safety or maintenance procedures due to the hidden, unsuspected nature of the defect.” 1999 WL 22844 (E.D. La. Jan. 15, 1999). Similarly, *Walker v. Travelers Indemnity Co.* treated a defect as latent where it was “not discoverable by any known and customary test.” 289 So. 2d 864, 867 (La. Ct. App. 1974). Expert involvement, standing alone, does not automatically establish latency. *Scott* cautioned that defects discoverable only through expert examination are not “per se latent.” 44

Cal. App. 4th at 33–34. But the depth, methodology, and technical sophistication of the inspection required remain relevant to the objective inquiry. *Chadwick v. Fire Ins. Exchange*, 17 Cal.App.4th 1112, 1123 (Cal.App. 1 Dist., 1993).

Here, Cyber MD’s defect was not “readily apparent or discoverable by a reasonably prudent user.” The defect was embedded in Cyber MD’s 2017 baseline coding algorithm and operated entirely within CCS’s proprietary cloud infrastructure. R0023. Miller therefore could not observe the defect through ordinary use, and neither he nor his treating providers could inspect the underlying source code through ordinary diligence. *Id.* Indeed, nothing about Cyber MD’s outward operation suggested a defect. The initial software was trained on 40,000 images and achieved a reported 97% overall accuracy rate in classifying lung lesions. R0003–04. To an ordinary user, Cyber MD appeared to be functioning as designed.

The nature of the inspection necessary to reveal the defect further demonstrates why it was not reasonably discoverable. In *Niemet*, the defect could not be identified until the transformer was physically cut in half. 843 P.2d at 90. In *Gray*, discovery required removing a yacht’s keel or drilling through its hull. 1999 WL 22844. Those measures were extraordinary, but the hidden components were at least physically accessible once sufficiently invasive measures were undertaken. *A transformer may be cut open and a yacht hull may be drilled into by a person owning a buzzsaw from Home Depot and a drill from Lowe’s; Miller had no comparable means of piercing into Cyber MD’s proprietary algorithm.* The defect-bearing component existed remotely within CCS’s cloud infrastructure and remained outside Miller’s, and even his healthcare providers’, access. R0023. Thus, the obstacle was not simply that inspection would have been difficult; the relevant component was proprietary and unavailable for inspection in the first place.

Miller could not simply “look under the hood,” because CCS controlled the hood, the engine, and access to both. Even if Miller had suspected that Cyber MD was malfunctioning, there was no physical component in his possession to open, inspect, test, or disassemble. The source code necessary to understand how Cyber MD interpreted his scans belonged to CCS and operated within its proprietary cloud infrastructure. R0023. This places Cyber MD even further from ordinary observation than the physically concealed defects in *Niemet* and *Gray*. There, extraordinary inspection could eventually expose the defective component. Here, ordinary users lacked access to the component altogether. But proprietary access was only the first barrier. Discovering Cyber MD’s defect also required substantial medical sophistication. The defect did not cause Cyber MD to fail uniformly or visibly. Rather, its diagnostic performance deteriorated specifically when evaluating images of patients with prior occupational asbestos exposure because pleural shadowing could mask underlying tumors. R0003–04. That meant identifying the defect required understanding not just computer code but the interaction between that code and a specialized radiological phenomenon associated with asbestos-exposed lungs. *The flaw was hidden twice: first inside proprietary code, and again behind a medical condition that obscured the very tumors Cyber MD was supposed to detect.*

Miller’s experience illustrates why ordinary use could not reveal that interaction. In April 2018, Miller told Cyber MD about his thirty-five-year occupational asbestos exposure. R0004. Cyber MD ordered a chest X-ray and CT scan, reviewed the resulting images, and nevertheless reported “zero evidence” of malignancy. R0004. Miller returned for new scans and annual evaluations in 2019, 2020, and 2021, and Cyber MD reiterated during each evaluation that there was “zero evidence” of disease. R0004. After the 2021 evaluation, the system affirmatively advised Miller that annual imaging was no longer necessary. *Id.* Thus, ordinary use of Cyber MD

did not expose an obvious malfunction or warning sign. It repeatedly represented that the precise disease later discovered was absent.

Retrospective review ultimately demonstrated how concealed the failure had been. After Miller suffered a spontaneous pneumothorax in October 2023, scans revealed a 6.4-centimeter malignant lung mass with extensive metastases. R0004. Expert retrospective review established that a seven-millimeter lesion had already been visible on Miller's 2018 scans, partially obscured by pleural changes, and had grown continuously to forty-seven millimeters by 2022. *Id.* Yet Cyber MD's 2017 baseline coding algorithm had consistently failed to identify it. *Id.* The defect therefore hid behind Cyber MD's apparent success: while the lesion grew year after year, the software continued to report that nothing was there.

Most importantly, the defect was not readily apparent even to CCS, the entity possessing the technical sophistication, proprietary access, and control that Miller lacked. CCS developed Cyber MD, trained the original system on 40,000 images, and necessarily possessed access to its own algorithm and performance data. R0003–04. Yet CCS did not discover until 2022 that Cyber MD's accuracy dropped to 85% when evaluating asbestos-exposed patients. *Id.* That was approximately five years after Cyber MD's 2017 integration and delivery. Only after identifying the asbestos-specific problem did CCS retrain Cyber MD using an additional 10,000 asbestos-exposed image sets and release a corrected version in 2023. *Id.* That five-year delay is especially probative under an objective reasonable-user standard. If CCS, with access to the proprietary code, knowledge of the system's architecture, control over its training data, the ability to perform sophisticated performance testing, and presumably its own medical experts, did not identify the asbestos-specific flaw for approximately five years, the defect cannot fairly be characterized as

readily apparent to an ordinary patient. And the problem required more than software expertise alone: recognition depended upon understanding that pleural shadowing in asbestos-exposed lungs could mask malignant tumors in a manner that caused Cyber MD's algorithm to underperform. R0003–04. Thus, identifying the defect required a combination of technical access and specialized medical knowledge that an ordinary user could not reasonably be expected to possess.

The contrast with ordinary inspection is therefore substantial. A person may perceive an exposed mechanical danger, measure visible dimensions, or eventually uncover a concealed physical component through invasive inspection. Cyber MD presented no comparable path. Its injury-causing aspect was proprietary, remotely housed on a server, technically complex, and medically specific. Even those best positioned to detect the problem did not recognize it until more than four years after delivery. Accordingly, an ordinarily reasonably prudent person could not have discovered Cyber MD's injury-causing defect within the four-year repose period.

CONCLUSION

For these reasons, this Court should affirm the judgment of the Shawnee Court of Appeals. As a matter of policy, a hospital should not escape liability from the care it presents to the public as its own when a patient reasonably relies on that presentation. MHS's representations concerning the healthcare it provided, the manner in which it presented and delivered Miller's care, and the surrounding circumstances give rise to genuine disputes as to whether apparent agency has been established. Those factual disputes preclude summary judgment. Additionally, this Court should affirm in finding that Respondent's claims are not barred by Shawnee's four-year statutes of repose because Cyber MD's annual evaluations constituted a continuous course of treatment under § 12-404 and because the latent defect in Cyber MD's algorithm falls within the exception set forth in § 12-410.

Respectfully submitted,

ATTORNEYS FOR RESPONDENT