
No. 26-338

IN THE

Shawnee Supreme Court

OCTOBER TERM 2026

METROPOLITAN HEALTH SYSTEM, INC., ET AL.,

Petitioners,

— *versus* —

Evelyn MILLER, individually and as special administrator for the estate of
Elias Miller, deceased,

Respondent.

*On Writ of Certiorari to the
Shawnee Court of Appeals
for the Second District*

BRIEF FOR PETITIONERS

The Standard of Care

Attorneys for Petitioners

QUESTIONS PRESENTED

- I. Under the doctrine of apparent agency, can a software program be the negligent “agent” of a health system when the program, though offered on the system’s branded telehealth platform, was developed by another company and identified to the patient before every session as artificial-intelligence and not a licensed healthcare professional?
- II. Under Sn. Rev. Stat. §§ 12-404(b) and 12-410, does the four-year period of repose bar claims filed in 2024 when:
 - (a) Diagnostic software evaluated a patient’s scans once a year from 2018 to 2021 and reported no disease each time; and
 - (b) The developer delivered the software in 2017 and identified its reduced accuracy for asbestos-exposed patients in 2022?

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OPINIONS BELOW

The Shawnee Court of Appeals for the Second District reversed the trial court's grant of summary judgment in favor of Metropolitan Health System, Inc. and Cyber-Care Solutions, LLC. R. at 16, 28. The opinion is reported at *Miller v. Metropolitan Health System, Inc.*, No. 25-123 (Sn. Ct. App. 2026) and can be found in the record at pages 16–28.

The Circuit Court of Simmons County for the State of Shawnee granted summary judgment in favor of Metropolitan Health System, Inc. and Cyber-Care Solutions, LLC, entered judgment in their favor, and dismissed the Respondent's complaint with prejudice. The order can be found in the record at pages 2–13.

STATUTORY PROVISIONS INVOLVED

The following provisions of the Shawnee Revised Statutes are relevant in this proceeding:

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

- (a) *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.
- (b) *Wrongful Death.* An action for wrongful death shall be commenced within two (2) years from the date of the decedent's death.
- (c) *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.

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

- (a) *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.
- (b) *Repose Period.* In no event shall such action be brought for more than four (4) years after the date on which 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.

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

- (a) *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.
- (b) *Exceptions to Statute of Repose.* The four (4) year period of repose shall not apply if:
 - 1. The product seller expressly warrants that its product can be utilized safely for a period longer than four (4) years;
 - 2. The product seller intentionally misrepresents fact about its product, or fraudulently conceals information about it; or
 - 3. 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 the time of delivery, or if the harm, caused within four (4) years after the time of delivery, did not manifest itself until after that time.

STATEMENT OF THE CASE

I. STATEMENT OF FACTS

Cyber MD is created. In 2012, Metropolitan Health System, Inc. (“Metropolitan”) contracted with Cyber-Care Solutions, LLC (“Cyber-Care”) to design and host a proprietary remote health platform for its patients. R. at 4. Five years later, Metropolitan integrated Cyber MD, an artificial-intelligence diagnostic tool developed by Cyber-Care, into that platform. R. at 5. Cyber MD had received FDA clearance and, when introduced, achieved a 97% overall accuracy rate in classifying lung lesions. R. at 5. In October 2022, several years after Cyber MD’s initial release, Cyber-Care identified reduced diagnostic accuracy in images of patients with prior occupational asbestos exposure. R. at 5–6. Cyber-Care thereafter retrained the software using 10,000 additional asbestos-exposed image sets and released the updated version in December 2023. R. at 6.

Before a patient could begin a Cyber MD session, the platform expressly informed the patient—in red, 16-point font—that Cyber MD “is not a licensed healthcare professional” and “is an artificial intelligence software program.” R. at 5. Users are required to click “Accept” before proceeding. R. at 5. The platform also directed users to Metropolitan’s Terms and Conditions (the “Terms”) upon attempting to log in and explicitly stated: “By entering the portal, I accept the MHS Terms and Conditions.” R. at 4. These Terms contained the following clause:

All clinical evaluations, imaging reviews, and diagnostic interpretations provided through this digital portal are performed by independent contractor physicians or automated software applications developed by another company. *The physicians and software are not employees or agents of Metropolitan Health System. MHS exercises no operational control over the clinical judgment or diagnostic methods used by the independent contractor physicians or any automated software applications.*

R. at 5. (emphasis added). Digital audit records establish that Elias Miller (“Miller”) opened these Terms and briefly remained on the page before his first Cyber MD encounter in April 2018. R. at 5–6.

Miller uses Cyber MD. Miller first used Cyber MD in April 2018 after experiencing shortness of breath. R. at 6. He told Cyber MD about his 35-year occupational asbestos history and Cyber MD ordered a chest X-ray and CT scan through a mobile radiology service. R. at 6. Two weeks later, Cyber MD analyzed the scans, reported no evidence of malignancy, diagnosed Miller with adult-onset asthma, and recommended annual imaging. R. at 6.

Miller accessed and used the Cyber MD platform three more times in May 2019, May 2020, and June 2021. R. at 6. During each visit, Cyber MD reviewed new mobile scans and determined there was no evidence of disease. R. at 6. Following the 2021 report, Cyber MD advised Miller that he no longer needed annual imaging. R. at 6.

In October 2023, Miller experienced a spontaneous pneumothorax and was airlifted to Metropolitan’s flagship hospital, where imaging revealed a 6.4cm malignant mass in his left lung. R. at 6. Retrospective review revealed that the cancer had been visible on the 2018 scan and had grown continuously since. R. at 6.

On April 14, 2024, Miller died following his stage IV lung adenocarcinoma diagnosis. R. at 2, 7.

II. NATURE OF THE PROCEEDINGS

The Circuit Court of Simmons County. In July 2024, Evelyn Miller, individually and as Special Administrator of Elias Miller’s estate (“Respondent”), filed suit against Metropolitan and Cyber-Care, asserting vicarious liability against Metropolitan under apparent agency for Cyber MD’s diagnostic errors and strict product liability against Cyber-Care based on design defect and failure to warn. R. at 2.

Following discovery, Metropolitan and Cyber-Care filed a combined motion for summary judgment under Shawnee Rule of Civil Procedure 56. R. at 2. Metropolitan argued that Cyber MD was not its employee or agent and that its Terms expressly disclaimed agency. R. at 2. Both Metropolitan and Cyber-Care also argued that the applicable four-year statutes of repose barred Respondent’s claims. R. at 2–3.

The Circuit Court of Simmons County granted summary judgment for both Metropolitan and Cyber-Care. R. at 13. The court held there was no genuine issue of material fact as to apparent agency and that Metropolitan was entitled to summary judgment. R. at 10. It also concluded that the four-year statutes of repose barred the claims and thus Cyber-Care was similarly entitled to summary judgment. R. at 11–12. As a result, the court entered final judgments for both Metropolitan and Cyber-Care, and Miller’s claims were dismissed with prejudice. R. at 13.

The Shawnee Court of Appeals. The appellate court concluded that the trial court committed reversible error and overlooked genuine issues of material fact concerning apparent agency and the repose statutes. R. at 17. It held that there were unconscionability concerns and a material dispute as to Miller’s assent, and that the statute of repose did not bar Miller’s claims. R. at 24–25, 27. It reversed summary judgment for both Metropolitan and Cyber-Care and remanded to the trial court. R. at 28.

SUMMARY OF THE ARGUMENT

This case concerns the boundaries of liability when healthcare is delivered through evolving technology. Those boundaries do not disappear merely because the provider is artificial intelligence rather than a physician. Established doctrines still define when one actor’s conduct may be attributed to another and how long liability may remain open after the conduct giving rise to a claim. Apparent agency ties vicarious liability to the relationship an institution objectively represents to the patient, while statutes of repose establish fixed limits on how long claims may remain actionable. Both doctrines provide predictable limits on liability by looking to defined manifestations and events rather than imposing responsibility based on hindsight.

The Court of Appeals departed from those limits in both respects. It attributed Cyber MD’s diagnostic conduct to Metropolitan despite Metropolitan’s specific manifestations distinguishing the software from itself, and it permitted claims outside Shawnee’s four-year repose periods by extending statutory exceptions beyond what their terms require. The novelty of artificial intelligence does not justify altering

either inquiry. Applied to the undisputed facts here, the same principles that govern traditional healthcare relationships and established repose rules resolve both issues.

I.

The Shawnee Court of Appeals incorrectly held that Metropolitan may be vicariously liable for Cyber MD's diagnostic errors under apparent agency. As a threshold matter, Cyber MD cannot be an apparent agent because common-law agency requires an agent to be a person with legal capacity. The Restatement instead treats computer programs as instrumentalities of those who use them, regardless of their autonomy or unanticipated operation. That distinction is especially significant here because Respondent herself characterizes Cyber MD as a product in pursuing strict liability against Cyber-Care. Apparent agency may create a relationship where one does not actually exist, but it cannot confer the legal capacity necessary to occupy that relationship. Cyber MD's diagnostic errors therefore cannot be imputed to Metropolitan through apparent agency.

Even if Cyber MD were legally capable of being an agent, Respondent cannot establish either holding out or justifiable reliance. Apparent agency turns on what Metropolitan's manifestations, viewed as a whole, would communicate to a reasonable patient. Although Metropolitan branded and controlled the telehealth platform, it made more specific manifestations concerning Cyber MD itself. Its Terms expressly identified automated diagnostic software as independently developed and outside an employment or agency relationship with Metropolitan, and a separate pre-treatment warning identified Cyber MD as artificial-intelligence software.

Metropolitan therefore held the platform out as its own without holding Cyber MD out as its agent.

Metropolitan communicated those manifestations before Cyber MD exercised any of the diagnostic judgment underlying Respondent's claims. Before Miller's first encounter, Metropolitan made available the Terms containing the no-agency disclosure and separately required Miller to acknowledge that Cyber MD was artificial-intelligence software before proceeding. Miller received reasonably conspicuous notice of the Terms, actually opened them, and then entered the portal after Metropolitan informed him that entry constituted acceptance. His brief review does not negate that objective assent, and the circumstances surrounding his acceptance do not establish procedural unconscionability. The Terms therefore remain part of Metropolitan's manifestations concerning Cyber MD's status.

Nor can Respondent establish justifiable reliance merely because Miller looked to Metropolitan to provide his healthcare. Institutional reliance and reliance on an apparent agency relationship are related but distinct. Although Miller relied on Metropolitan to provide access to care, Metropolitan informed him before Cyber MD treated him that automated diagnostic software was independently developed and was not Metropolitan's employee or agent. And before each subsequent encounter, Metropolitan again identified Cyber MD as artificial-intelligence software rather than a licensed healthcare professional. The limited healthcare options in Simmons County may explain why Miller continued to seek care through Metropolitan, but they do not change the relationship Metropolitan represented Cyber MD to have.

Because Metropolitan gave Miller reason to distinguish the institution providing access to care from the software making the diagnostic decisions, reliance on Cyber MD being Metropolitan's agent was not consistent with ordinary care and prudence.

II.

The Shawnee Court of Appeals incorrectly held that Respondent's claims survive Shawnee's four-year statutes of repose because neither statutory exception applies. Section 12-404(b) requires a continuous course of treatment, and § 12-410(b)(3) requires an injury-causing aspect that was objectively undiscoverable for more than four years after delivery. The Court of Appeals permitted both claims to proceed by extending those exceptions beyond what their terms require.

Miller's annual evaluations were discrete diagnostic screenings, not a continuous course of treatment. Cyber MD reviewed new imaging approximately once a year, repeatedly reported "zero evidence" of malignancy, and ultimately advised that further annual imaging was unnecessary. It never identified a malignancy or suspicious lesion for ongoing management. The later discovery that Miller's cancer existed throughout those years establishes continuity of the disease, not continuity of treatment, and repeated failures to diagnose that disease do not retroactively unite otherwise separate encounters into a single course of care. Without the continuous-treatment exception, repose ran from the April 2018 evaluation, when Cyber MD first failed to identify Miller's lesion, and expired before Respondent sued in July 2024. Alternatively, even if each subsequent missed diagnosis triggered its own repose period, the April 2018, May 2019, and May 2020 evaluations remain barred. At most,

Respondent could proceed on the June 2021 evaluation and would have to establish that the omission at that encounter, independent of the three time-barred failures that preceded it, caused Miller's death. Under either approach, the Court of Appeals erred in treating all four evaluations as a single continuous course of treatment.

Respondent likewise cannot establish § 12-410(b)(3)'s latent-defect exception. That exception asks whether the particular injury-causing aspect of the product was objectively undiscoverable by an ordinary reasonably prudent person for more than four years after delivery—not when Miller, Cyber-Care, or anyone else actually discovered it. The Court of Appeals concluded that Cyber MD's defect became discoverable only after Miller's October 2023 diagnosis, even though Cyber-Care had identified the relevant asbestos-specific performance problem a year earlier. But Cyber-Care's 2022 actual discovery likewise does not establish that the defect was objectively undiscoverable before the repose period expired in March 2021, and Cyber MD's proprietary nature does not establish that its performance disparity could not have been discovered through other objectively reasonable means. Respondent therefore failed to carry her burden to establish the statutory exception.

Finally, Cyber-Care's December 2023 retraining did not restart repose. Section 12-410 measures repose from the product's first delivery and contains no exception restarting that period upon a later modification or update. More fundamentally, the retrained version could not have caused Miller's injuries because it was released more than two years after his final Cyber MD evaluation. Miller encountered only the original algorithm alleged to contain the injury-causing defect. A version of Cyber MD

that never treated Miller cannot restart repose for injuries allegedly caused by the version that did.

This Court should reverse the judgment of the Court of Appeals.

ARGUMENT

Standard of Review. The Court reviews an intermediate court’s reversal of a trial court’s summary judgment grant de novo, applying the same analytical framework as the trial court. *See Rush Univ. Med. Ctr. v. Sessions*, 980 N.E.2d 45, 50 (Ill. 2012) (“When an appeal before this court arises as a result of the appellate court’s reversal of a trial court’s order granting summary judgment, this court’s review is de novo.”); *Mills v. Davis Oil Co.*, 11 F.3d 1298, 1301 (5th Cir. 1994) (“The standard of review at the appellate level of a district court’s grant of summary judgment requires the same analysis as employed by the trial court.”). Summary judgment is appropriate only where “the movant shows there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a).

On appeal, the Court should review all evidence and draw reasonable inferences in the nonmovant’s favor. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). Summary judgment must be denied if “the evidence is such that a reasonable jury could return a verdict” for the nonmovant. *Anderson*, 477 U.S. at 248.

The applicability and interpretation of a statute of repose likewise present questions of law reviewed de novo. *See Bonnette v. Triple D Auto Parts, Inc.*, 409 P.3d

865, 869 (Kan. Ct. App. 2017); *Inmon v. Air Tractor, Inc.*, 74 So. 3d 534, 537 (Fla. Dist. Ct. App. 2011). The same applies to statutory exceptions to repose: the meaning and legal requirements of an exception are questions of law, while factual disputes concerning whether those requirements are satisfied—such as whether treatment was continuous or a defect was discoverable—are evaluated under the summary-judgment standard. *See Follis v. Watkins*, 855 N.E.2d 579, 586 (Ill. App. Ct. 2006). Thus, where the material facts are undisputed, whether those facts satisfy a statutory exception to repose presents a question of law appropriate for resolution on summary judgment. *See Martinelli v. Fusi*, 963 A.2d 640, 644, 648–49 (Conn. 2009).

I. Metropolitan is entitled to summary judgment because apparent agency reaches persons, not a software product that Metropolitan disclosed as independent.

This issue decides whether a doctrine developed for hospitals that staff emergency rooms with independent physicians also makes a health system answerable for the output of software. Apparent agency has always imputed one person’s negligence to another. Cyber MD is not a person. It is a program that another company developed and that was identified to Miller before every session as “an artificial intelligence software program.” R. at 5, 19. If a logo on a telehealth portal turns that program into the health system’s agent, the same is true of every device and application a hospital puts in front of a patient, and the law of products gives way to the law of agency.

Under the apparent-agency doctrine, a hospital may be held liable for the negligence of an independent provider when the hospital’s conduct would lead a reasonable patient to believe that provider was its agent and the patient justifiably relied on that appearance. *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 795–96

(Ill. 1993). Because apparent agency in this context is a matter of first impression in Shawnee, this Court should look to comparable state authority applying those principles. See R. at 7; *City of Erie v. Guar. Nat'l Ins. Co.*, 109 F.3d 156, 159–60 (3d Cir. 1997); *Sloan v. Motorists Mut. Ins. Co.*, 368 F.3d 853, 855–56 (8th Cir. 2004); *Burlington Ins. Co. v. Oceanic Design & Constr., Inc.*, 383 F.3d 940, 944 (9th Cir. 2004).

Respondent's theory fails first because Cyber MD cannot occupy the agency relationship she seeks to create. Common-law agency requires an agent to be a "person" with legal capacity, and the Restatement expressly provides that a computer program cannot act as an agent but instead remains an instrumentality of the person who uses it. Restatement (Third) of Agency §§ 1.01, 1.04(5), & cmt. e. (Am. L. Inst. 2006). Cyber MD is just that—a software program that Respondent herself alleges is a defective *product*. R. at 2. Its diagnostic errors therefore cannot be imputed to Metropolitan through apparent agency.

Even if Cyber MD were legally capable of being an agent, Respondent cannot establish the traditional elements of apparent agency. Metropolitan held its platform out as its own. It did not hold Cyber MD out as its agent. The Court of Appeals blurred that distinction by treating Metropolitan's branding and integration of Cyber MD as evidence of agency without giving sufficient effect to Metropolitan's more specific manifestations concerning Cyber MD itself. Before Cyber MD provided any diagnostic care, Metropolitan identified automated diagnostic software as independently developed and outside an agency relationship with Metropolitan and separately

identified Cyber MD as artificial-intelligence software. R. at 4–5, 18–19. Those undisputed manifestations defeat the Court of Appeals’ apparent-agency theory: Metropolitan did not hold Cyber MD out as its agent, and Miller could not justifiably rely on an agency relationship after Metropolitan communicated otherwise.

A. Apparent agency imputes the negligence of a person, and Cyber MD is a software program that Respondent herself pleads is a defective product.

Apparent agency cannot reach Cyber MD’s diagnostic errors because an agent must be a person capable of committing a tort, and Cyber MD is a software program that Respondent herself pleads is a product. Thus, Respondent’s apparent-agency theory fails at the threshold because Cyber MD cannot be an agent under common-law agency principles. Agency is “the fiduciary relationship that arises when one person (a ‘principal’) manifests assent to another person (an ‘agent’)” that the agent will act on the principal’s behalf and subject to its control. Restatement (Third) of Agency § 1.01 (Am. L. Inst. 2006). Section 1.04(5) defines a “person” as an individual or an entity possessing the legal capacity to hold rights and incur obligations. *Id.* § 1.04(5). Thus, “[t]o be capable of acting as a principal or agent, it is necessary to be a person.” *Id.* § 1.04 cmt. e.

That requirement explicitly excludes Cyber MD. Comment e expressly provides that “a computer program is not capable of acting as a principal or agent as defined by the common law.” *Id.* Instead, computer programs “are instrumentalities of the persons who use them.” *Id.* And even when a program malfunctions in a manner unanticipated by its designer or user, “[t]hat a program may malfunction does not create capacity to act as a principal or agent.” *Id.* Cyber MD’s autonomy therefore

does not alter its legal status. However sophisticated its diagnostic functions, Cyber MD remains computer software without the legal capacity necessary to be an agent.

Apparent agency does not eliminate that threshold requirement. “Apparent agency creates an agency relationship that would not otherwise exist, while apparent authority expands the authority of an existing agent.” *Cefaratti v. Aranow*, 141 A.3d 752, 756, 757 n.6 (Conn. 2016). But creating an agency relationship is different from creating the legal capacity to occupy one. Apparent agency may supply a relationship that does not actually exist; it cannot convert an instrumentality into a person capable of being an agent. *See Intelligent Agency, LLC v. 7-Eleven, Inc.*, No. 4:20-CV-0185-ALM, 2022 WL 760203, at *11 (E.D. Tex. Mar. 11, 2022) (distinguishing autonomous “software agents” from agents in the legal sense and construing “agent” to mean a “person representing a principal”).

That limitation fits with the rationale underlying hospital apparent agency. *Gilbert* and *Sword* address the problem that arises when a patient cannot determine whether the physician providing treatment is a hospital employee or an independent contractor. *See* 622 N.E.2d at 793–95; *Sword v. NKC Hosps., Inc.*, 714 N.E.2d 142, 148–52 (Ind. 1999). Apparent agency allows that physician’s negligence to be imputed to the hospital when the hospital created a reasonable appearance that the physician acted on its behalf. *See Gilbert*, 622 N.E.2d at 795–96; *Sword*, 714 N.E.2d at 152. The doctrine thus addresses uncertainty about the relationship between legally cognizable actors; it does not transform the instrumentality through which healthcare is delivered into one.

Respondent's own claims illustrate the distinction. She alleges that Cyber MD is artificial-intelligence software developed by Cyber-Care and seeks to hold Cyber-Care strictly liable because that software was a defective *product*. R. at 2. Yet her apparent-agency theory treats the same software as the *agent* whose diagnostic errors may be imputed to Metropolitan. But Cyber MD does not acquire legal capacity depending on which defendant Respondent seeks to hold liable. Under the Restatement, it remains an instrumentality, not an agent. Respondent therefore cannot impute Cyber MD's alleged diagnostic errors to Metropolitan through apparent agency.

B. Metropolitan's disclosures, made before any diagnosis, defeat the holding-out element as a matter of law.

The first element of apparent agency requires conduct by the hospital or alleged apparent agent that would lead a reasonable person to conclude that the allegedly negligent provider was the hospital's employee or agent. *Gilbert*, 622 N.E.2d at 795. In the hospital context, that inquiry considers the institution's manifestations as a whole, including both conduct suggesting affiliation and disclosures identifying a provider as independent. See *Martin v. Layman*, 278 N.E.3d 616, 647, 656 (Ill. App. Ct. 2025). Thus, Metropolitan's institutional branding cannot be considered in isolation. The question is what its manifestations collectively communicated about Cyber MD's relationship to Metropolitan.

Those manifestations did not hold Cyber MD out as Metropolitan's agent. First, Metropolitan specifically distinguished Cyber MD from itself despite presenting the telehealth platform under Metropolitan's branding. Its Terms identified automated

diagnostic software as independently developed and expressly disclaimed an employment or agency relationship, while the Cyber MD-specific warning identified Cyber MD as artificial-intelligence software. R. at 4–5, 18–19. Second, Metropolitan communicated that information before Cyber MD exercised any diagnostic judgment, when Miller could receive and consider it before proceeding with care. R. at 4–5, 18–19. Third, Metropolitan provided reasonably conspicuous notice of the Terms containing the no-agency disclosure, and Miller objectively manifested assent by entering the portal after actually opening them. R. at 4–5, 18–19. The circumstances surrounding that assent do not render the agreement procedurally unconscionable. Accordingly, Metropolitan’s branding established that the platform was Metropolitan’s while its more specific manifestations established that Cyber MD was not.

1. Metropolitan’s Terms stated that diagnostic software was “developed by another company” and was not Metropolitan’s employee or agent.

The holding-out inquiry considers Metropolitan’s manifestations as a whole, asking whether they would lead a reasonable patient to conclude that Cyber MD was Metropolitan’s employee or agent. *Gilbert*, 622 N.E.2d at 795–96. That analysis accounts for both manifestations suggesting institutional affiliation and manifestations identifying a provider as independent. *Martin*, 278 N.E.3d at 647. Thus, the relevant question is not whether Metropolitan associated the healthcare environment with itself, but what its manifestations collectively communicated about Cyber MD’s status within that environment.

Metropolitan’s branding plainly communicated that the telehealth platform

belonged to Metropolitan. Cyber MD was accessed through Metropolitan's domain, Metropolitan's branding appeared throughout, and Metropolitan controlled the interface. R. at 4, 18. But those facts establish institutional affiliation with the platform; they do not necessarily establish that every provider available through it was Metropolitan's agent. The alleged apparent agent is Cyber MD, and Metropolitan made more specific manifestations concerning Cyber MD's independent status.

In particular, Metropolitan's Terms did not merely state that unidentified providers "may" be independent. *See id.* ("The disclaimer must be clear, concise, and unequivocal, and language stating that 'all physicians' or 'none of the physicians' are employees or agents of the hospital is often highly effective."). They expressly provided that clinical evaluations, imaging reviews, and diagnostic interpretations were performed by independent physicians or "automated software applications developed by another company," that those providers were "not employees or agents of Metropolitan," and that Metropolitan exercised no operational control over their clinical judgment or diagnostic methods. R. at 5, 19. The disclosure therefore addressed the precise provider type, clinical functions, legal relationship, and absence of control.

That specificity matters because the strength of Metropolitan's branding does not make any contrary manifestations irrelevant but determines how clear those manifestations must be. As *Martin* explained, "[t]he more a hospital holds out medical personnel as its agents, the stronger and clearer its disclaimer of that agency must be." 278 N.E.3d at 656. Metropolitan's disclosure met that demand by directly

addressing Cyber MD, whose status its institutional branding might otherwise leave ambiguous.

Comparable cases likewise recognize that a sufficiently specific disclosure can distinguish a provider from the institution delivering the provider's services. In *Lamb-Rosenfeldt v. Burke Medical Group, Ltd.*, the hospital's forms clarified that physicians providing identified services were independent rather than hospital agents. 967 N.E.2d 411, 420–22 (Ill. App. Ct. 2012). And in *Churkey v. Rustia*, a disclosure that anesthesiology services were provided by independent physicians defeated an inference of agency, even though those services were integrated into the patient's hospital care. 768 N.E.2d 842, 846–47 (Ill. App. Ct. 2002). Metropolitan likewise distinguished the entity providing the healthcare environment from the provider making diagnostic decisions within it.

Mizyed v. Palos Community Hospital further shows the significance of identifying the category encompassing the allegedly negligent provider. 58 N.E.3d 102, 106 (Ill. App. Ct. 2016). There, a disclosure covering “all physicians providing services” and specifically identifying categories of physicians eliminated uncertainty over whether the treating physician fell within the hospital's no-agency disclaimer. *Id.* Here, the Terms specifically included automated software performing diagnostic services, and the separate pop-up identified Cyber MD as “an artificial intelligence software program.” R. at 5, 19. Thus, Miller did not need to infer whether Cyber MD fell within some generic category of independent providers: Metropolitan identified automated diagnostic software as non-agent providers and identified Cyber MD as that type of

software. Metropolitan therefore held the portal out as its own but did not hold Cyber MD out as its agent.

2. Metropolitan made those disclosures before the first evaluation and repeated the software notice before every session.

A no-agency disclosure must be communicated in a meaningful manner and at a meaningful time. *Sword v. NKC Hosps., Inc.*, 714 N.E.2d 142, 151 (Ind. 1999); *Brayboy v. Advoc. Health and Hosp. Corp.*, 252 N.E.3d 317, 326–27 (Ill. App. Ct. 2024). A disclosure made only after treatment has begun may be insufficient because it cannot inform the patient’s understanding before accepting the provider’s care. *Brayboy*, 252 N.E.3d at 328. Courts also consider the circumstances under which the disclosure was presented, including whether the patient’s condition impaired his ability to receive or understand it. *Martin*, 278 N.E.3d at 647, 656–57.

Metropolitan communicated Cyber MD’s independent status before Miller’s first encounter. R. at 4–5, 18–19. Before Miller entered the portal, Metropolitan made the Terms available expressly identifying automated diagnostic software as independently developed and not Metropolitan’s employee or agent. R. at 4–5, 18–19. Before Miller could then interact with Cyber MD, Metropolitan separately identified Cyber MD as artificial-intelligence software and required Miller to accept that warning. R. at 5, 19. Only after those disclosures did Cyber MD begin providing care, and Metropolitan repeated the Cyber MD-specific warning before every subsequent encounter. R. at 5, 19.

That sequence distinguishes *Brayboy*. There, the hospital first communicated the physician’s independent status after the patient had been at the hospital for nearly

two hours and the physician had already begun treatment. 252 N.E.3d at 328–30. Here, Miller had not yet interacted with Cyber MD, much less received treatment from it, when Metropolitan presented its disclosure. R. at 4–5, 18–19. Most importantly, Cyber MD had not exercised any of the diagnostic judgment for which Respondent seeks to hold Metropolitan vicariously liable. Metropolitan therefore communicated contrary information before the alleged reliance on Cyber MD’s apparent relationship with Metropolitan could arise.

Nor do the circumstances surrounding Miller’s encounter resemble those that created a factual dispute in *Martin*. There, the patient was experiencing stroke symptoms when presented with a potentially confusing disclosure. *Martin*, 278 N.E.3d at 652–53, 656–57. Nothing in this record indicates that Miller was cognitively impaired, confused, incapable of reading, or otherwise unable to receive information through the portal. He accessed the portal from home before treatment began, independently opened the Terms, and acknowledged the separate Cyber MD pop-up warning before proceeding. R. at 4–6, 18–20. Thus, unlike *Martin*, no evidence suggests that Miller’s medical condition prevented Metropolitan’s pre-treatment disclosures from meaningfully informing him.

Metropolitan disclosed the relevant relationship before Cyber MD exercised any diagnostic judgment and continued to identify Cyber MD as artificial intelligence software before subsequent encounters. R. at 4–5, 18–19. Its manifestations were thus communicated at a meaningful time and under circumstances allowing Miller to meaningfully receive them.

3. Miller opened the Terms and entered the portal after the login page stated that entry meant acceptance, so the Terms are enforceable.

The Court of Appeals discounted Metropolitan’s no-agency disclosure in part because it concluded a factfinder could determine that Miller did not meaningfully assent to the Terms containing it. R. at 23–24. It characterized the interface as a sign-in-wrap agreement because Miller was not required to click a separate “I Agree” button specifically associated with the Terms. R. at 23. But sign-in-wrap agreements are enforceable when the interface provides reasonably conspicuous notice of the contractual terms and the user then unambiguously manifests assent. *Meyer v. Uber Techs., Inc.*, 868 F.3d 66, 75 (2d Cir. 2017); *Berman v. Freedom Fin. Net., LLC*, 30 F.4th 849, 856 (9th Cir. 2022). Thus, the absence of a separate “I Agree” button is not dispositive here. *See Meyer*, 868 F.3d at 75.

Metropolitan’s interface provided reasonably conspicuous notice. The login screen expressly stated, “By entering the portal, I accept the MHS Terms and Conditions,” and displayed the Terms as a blue, underlined hyperlink. R. at 4, 18. That presentation identified the agreement, made it immediately accessible, and expressly informed Miller that entering the portal constituted acceptance. And “[a] reasonably prudent [internet] user knows that text that is highlighted in blue and underlined is hyperlinked” to additional information. *Meyer*, 868 F.3d at 77–78. The issue is therefore not whether Metropolitan employed the strongest conceivable method of notice, but whether the interface would put a reasonably prudent user on notice that contractual terms governed entry to the portal. *See id.* at 74–75, 77. It would.

Indeed, the record provides more than an inference that the hyperlink was

perceptible and accessible to Miller: he actually clicked it and opened the Terms before entering the portal. R. at 5, 19. There can therefore be no factual dispute that Miller encountered Metropolitan’s reference to the Terms, recognized the hyperlink as interactive, and successfully accessed the agreement. The Court of Appeals’ concern that the interface lacked a separate acceptance checkbox does not undermine those undisputed facts. *See* R. at 23. Metropolitan expressly identified the conduct constituting acceptance and gave Miller immediate access to the Terms before he performed that conduct.

Miller then objectively assented by entering the portal. Contract formation turns on objective manifestations rather than unexpressed subjective intent. *See Selden v. Airbnb, Inc.*, 4 F.4th 148, 156 (D.C. Cir. 2021). Neither *Meyer* nor *Selden* required a separate “I Agree” checkbox. In *Meyer*, Uber informed users that creating an account constituted agreement to hyperlinked terms, and the user’s subsequent registration manifested assent. 868 F.3d at 70–71, 75–76. Similarly, *Selden* enforced terms where Airbnb informed users that signing up constituted agreement and provided hyperlinks to those terms. 4 F.4th at 152–53, 156–58. Metropolitan’s interface followed the same structure: it identified the Terms, informed Miller that entering the portal constituted acceptance, and Miller entered after actually accessing the agreement. R. at 4–5, 18–19. His entry therefore objectively manifested assent.

The four-second audit log does not create a factual dispute over that assent. It permits an inference that Miller did not read every provision in the Terms, but actual reading is not required once a user receives inquiry notice. *Selden*, 4 F.4th at 157–58.

As *Meyer* explained, whether users “bother reading” accessible terms is “the choice the user makes; the user is still on inquiry notice.” 868 F.3d at 79. Metropolitan identified the Terms, made them accessible, and informed Miller that portal entry constituted acceptance. R. at 4–5, 18–19. Miller actually opened them and then entered. R. at 5, 19. The audit log therefore shows the brevity of Miller’s review, not a failure by Metropolitan to provide notice or obtain objective assent.

Nor do the circumstances surrounding Miller’s assent render the agreement procedurally unconscionable. Procedural unconscionability examines whether the circumstances surrounding formation deprived a party of meaningful choice, considering factors including age, education, intelligence, experience, relative bargaining power, the conspicuousness and comprehensibility of the agreement, and the availability of meaningful alternatives. *Hines v. Nat’l Ent. Grp., LLC*, 140 F.4th 322, 328 (6th Cir. 2025); *Payne v. Savannah Coll. of Art and Design, Inc.*, 81 F.4th 1187, 1194 (11th Cir. 2023). Unequal bargaining power or standardized terms, without more, do not necessarily establish that assent was involuntary. *See Hines*, 140 F.4th at 328–31; *Westmoreland v. High Point Healthcare*, 721 S.E.2d 712, 717 (N.C. Ct. App. 2012).

Nothing in the record indicates that Miller lacked the capacity or opportunity to understand the agreement. He independently accessed the portal, located and opened the Terms hyperlink, and proceeded through the interface before treatment began. R. at 4–6, 18–20. Nor is there evidence that Metropolitan imposed a time limit, denied Miller an opportunity to review the agreement or seek assistance, misrepresented its

contents, or pressured him to proceed before he was ready. Those circumstances distinguish *Hines*, where the court rejected procedural unconscionability despite allegations that the plaintiff felt rushed to sign a standardized, take-it-or-leave-it agreement. 140 F.4th at 328–31. Metropolitan supplied Miller the opportunity to review the Terms and Miller determined its duration.

The healthcare shortage in Simmons County undoubtedly constrained Miller's practical alternatives, but it does not by itself establish that Metropolitan coerced his assent. Those circumstances made Cyber MD substantially more accessible than in-person care and bear on whether Miller possessed meaningful alternatives. But nothing in the record indicates that Metropolitan exploited that shortage, conditioned treatment already underway on immediate acceptance, prevented Miller from reviewing the Terms, or otherwise pressured him to proceed. Practical difficulty in pursuing an alternative does not, without more, establish that Metropolitan deprived Miller of meaningful choice in accepting the Terms.

Finally, the placement of the no-agency provision does not create a sufficient basis for finding unfair surprise. The Terms consisted of thirty-four lines of single-spaced, unformatted text in relatively small font, and the provision appeared approximately three-quarters of the way through the agreement. R. at 4, 19. Those features weigh against Metropolitan in evaluating the provision's prominence. But lack of special emphasis is not equivalent to concealment. The agreement itself was only thirty-four lines long, and the provision directly and unequivocally identified automated diagnostic software as independently developed and not Metropolitan's employee or

agent. R. at 5, 19. Thus, although Metropolitan could have displayed the provision more prominently, its placement within a short, accessible agreement containing specific and comprehensible language does not permit a reasonable finding that Miller's assent was procured through unfair surprise.

Metropolitan therefore provided reasonably conspicuous notice of the Terms, Miller objectively manifested assent by entering the portal, and the circumstances do not support procedural unconscionability. The Terms accordingly remain part of Metropolitan's objective manifestations concerning Cyber MD's relationship to Metropolitan.

C. Metropolitan's disclosures made reliance on an agency relationship unjustified.

Apparent agency requires a plaintiff to show that he "acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence." *Gilbert*, 622 N.E.2d at 795. In the hospital context, justifiable reliance may be established when the patient relies on the hospital to provide complete care "rather than upon a specific physician." *Id.* at 796. But *Gilbert* requires more than reliance on the institution generally; that reliance must remain justifiable under the circumstances. *Id.* at 795. Thus, whether Miller looked to Metropolitan to furnish his healthcare and whether he could reasonably attribute Cyber MD's services to Metropolitan are related but distinct inquiries.

Miller did look to Metropolitan for healthcare rather than independently selecting Cyber MD. But that establishes the reason for Miller's reliance, not necessarily that his reliance on Cyber MD's apparent agency was "consistent with ordinary care and

prudence.” *Id.* Metropolitan informed Miller before Cyber MD treated him that automated software performing diagnostic services was independently developed and was not Metropolitan’s employee or agent, while separately identifying Cyber MD as artificial-intelligence software. R. at 5, 19. Those manifestations gave Miller reason to distinguish the institution furnishing access to care from the software providing the diagnostic services. Thus, although Miller relied on Metropolitan to furnish his healthcare, that fact does not alone establish that he could justifiably rely on Cyber MD being Metropolitan’s agent.

Sword confirms why that distinction matters. There, the court explained that reliance may be presumed when the hospital fails to provide meaningful notice of a provider’s independent status, the patient has no special knowledge of the hospital’s arrangement with the provider, and nothing otherwise gives the patient reason to know of that relationship. *Sword*, 714 N.E.2d at 152. That presumption reflects the information available to the patient: absent notice to the contrary, a patient who looks to an institution for care may reasonably attribute the furnished provider’s services to that institution. *Id.* But the justification for that inference is weakened when the hospital gives the patient reason to distinguish the provider from the institution. Here, Metropolitan provided the very information missing in *Sword* by disclosing, before Miller accepted Cyber MD’s care, that the automated diagnostic software was independently developed and not Metropolitan’s agent. R. at 5, 19.

Gilbert illustrates the contrast. There, the hospital did not advise emergency-room patients that its physicians were independent contractors; instead, its consent form

stated that treatment would be performed by “physicians and employees of the hospital.” *Gilbert*, 622 N.E.2d at 791–92. The decedent then accepted treatment from a physician he had never met, and the court concluded that reasonable people could differ as to whether he justifiably relied on the hospital to provide his care. *Id.* at 796. Miller encountered materially different circumstances. Metropolitan did not affirmatively associate Cyber MD with its employees while withholding information about the provider’s actual status. Before Cyber MD exercised any diagnostic judgment, Metropolitan supplied information distinguishing the automated diagnostic provider from itself. R. at 5, 19. The inference of agency available to the patient in *Gilbert* therefore does not follow from the same facts present here.

Miller’s subsequent encounters with Cyber MD further distinguish his reliance from the single hospital encounter at issue in *Gilbert*. After the initial 2018 consultation, Miller returned to Cyber MD for annual virtual follow-ups in 2019, 2020, and 2021. R. at 6, 20. Before each encounter, Metropolitan again identified Cyber MD as “not a licensed health care professional” but “an artificial intelligence software program.” R. at 5, 19. That warning did not independently disclaim an agency relationship, but it repeatedly reinforced the distinction between Cyber MD and an ordinary Metropolitan healthcare professional. Miller’s continued reliance on Metropolitan to provide access to Cyber MD’s services therefore does not itself establish that he reasonably understood the software providing those services to be Metropolitan’s agent.

Nor does the shortage of healthcare options in Simmons County establish

otherwise. Those circumstances explain why Miller relied on Metropolitan for healthcare and why Cyber MD may have been his most practical option. But they do not establish what relationship Miller could reasonably attribute to Cyber MD after Metropolitan communicated its independent status. Limited alternatives may have made Miller more dependent on Metropolitan as a source of healthcare, but they did not alter the status Metropolitan represented Cyber MD to have. The practical necessity of using a provider and a reasonable belief that the provider is the institution's agent are different propositions.

That distinction is especially important here because Respondent need not show that Miller would have declined Cyber MD's services had he understood its independent status. *Gilbert* asks whether the patient looked to the institution to furnish care rather than independently selecting the particular provider. 622 N.E.2d at 796. Miller did look to Metropolitan. But the element also expressly requires that his reliance be "consistent with ordinary care and prudence." *Id.* at 795. Giving dispositive weight to Miller's decision to seek care from Metropolitan would eliminate that qualification whenever an institution selected the provider. The better reading gives effect to both parts of the inquiry: Miller's decision to seek care from Metropolitan establishes institutional reliance, while Metropolitan's manifestations concerning Cyber MD determine whether his attributing Cyber MD's diagnostic services to Metropolitan was justifiable.

Accordingly, Miller's reliance on Metropolitan to supply healthcare does not establish justifiable reliance on an agency relationship with Cyber MD. Unlike the

patients in *Gilbert* and *Sword*, Miller was not left without contrary information about the status of the provider Metropolitan furnished. Metropolitan gave him reason to distinguish Cyber MD from itself before Cyber MD provided care, and Miller continued using Cyber MD after Metropolitan repeatedly identified the nature of that provider. On those undisputed facts, reliance on Cyber MD being Metropolitan's agent was not "consistent with ordinary care and prudence." *Gilbert*, 622 N.E.2d at 795.

II. Petitioners are entitled to summary judgment because Shawnee's four-year periods of repose expired before Respondent sued in 2024, and no statutory exception extended them.

This issue turns on dates. Cyber-Care delivered Cyber MD to Metropolitan on March 1, 2017. R. at 5, 19. Cyber MD first evaluated Miller in April 2018, reported zero evidence of malignancy, and recommended annual follow-up imaging. R. at 6, 20. It evaluated new scans in May 2019, May 2020, and June 2021, reported the same result each time, and then advised that annual imaging was no longer necessary. R. at 6, 20. Miller's cancer was found in October 2023, and Respondent sued in July 2024. R. at 6–7, 20–21. By then, more than seven years had passed since delivery and more than six since the first evaluation. The legislature set both periods of repose at four.

Both claims fall outside Shawnee's four-year repose periods. Respondent filed suit in July 2024, more than seven years after Cyber-Care delivered Cyber MD to Metropolitan and more than six years after Cyber MD first evaluated Miller. R. at 5–7, 19–20. The Court of Appeals nevertheless permitted both claims to proceed by expanding the statutory exceptions to those repose periods. But statutes of repose

establish an outer boundary on liability measured from the defendant's conduct, and the exceptions Shawnee enacted must be applied according to their terms. *See CTS Corp. v. Waldburger*, 573 U.S. 1, 8 (2014). Miller's periodic diagnostic encounters do not satisfy § 12-404(b)'s continuous-treatment exception, and Respondent has not established the objective undiscoverability required by § 12-410(b)(3). The Court of Appeals therefore erred in allowing either claim to proceed beyond Shawnee's four-year repose periods.

A. Section 12-404(b)'s four-year period ran from the April 2018 evaluation because four separate annual screenings are not a continuous course of treatment.

Section 12-404 establishes an absolute four-year period of repose for medical-malpractice claims, measured from "the date on which occurred the act or omission or occurrence alleged in such action to have been the cause of such injury or death." Sn. Rev. Stat. § 12-404(b). The statute creates a limited exception where "the defendant healthcare provider has 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.* Unlike a statute of limitations, which ordinarily turns on accrual or discovery, a statute of repose fixes an outer boundary on liability by reference to the defendant's conduct. *See CTS Corp.*, 573 U.S. at 8 (explaining that statutes of repose generally run from the defendant's last culpable act or omission and reflect a legislative judgment that liability should end after a specified period). Thus, Respondent may avoid § 12-404's four-year bar only if Miller's encounters with Cyber MD satisfy the statutory continuous-treatment exception.

They do not. Cyber MD first evaluated Miller's chest imaging in April 2018 and

reported “zero evidence” of malignancy. R. at 6, 20. It then conducted new virtual evaluations approximately once a year—in May 2019, May 2020, and June 2021—reviewing new scans and again reporting no evidence of disease at each encounter. R. at 6, 20. After the 2021 clear report, Cyber MD advised that annual imaging was no longer necessary. R. at 6, 20. The Court of Appeals nevertheless characterized those encounters as a single “annual cancer surveillance protocol” extending through 2021 and therefore concluded that § 12-404 did not begin to run until that course ended. R. at 25. That conclusion conflates three distinct concepts: a continuing provider relationship, repeated diagnostic examinations, and a continuous course of treatment.

Section 12-404 requires the last of those. Periodic diagnostic encounters do not become continuous treatment merely because the same provider conducts them. *See Mandel v. Herrmann*, 706 N.Y.S.2d 195, 196 (N.Y. App. Div. 2000); *Shiffman v. Harris*, 720 N.Y.S.2d 262, 263 (N.Y. App. Div. 2001). Nor does the later discovery that the same disease existed throughout transform repeated diagnostic failures into a continuous course of treatment. *Howell v. Zottoli*, 691 S.E.2d 564, 566–67 (Ga. Ct. App. 2010). Miller’s annual evaluations were discrete screenings undertaken to determine whether disease was present, not ongoing management of an identified condition. And Cyber MD’s repeated failure to detect the cancer cannot retroactively transform those separate encounters into continuous treatment of a disease it never diagnosed. Because neither the nature of the annual evaluations nor the persistence of Miller’s undiagnosed cancer establishes the “continuous course of treatment” § 12-

404(b) requires, the statutory exception does not apply.

1. A continuous course of treatment means ongoing care for an identified condition, which is more than a continuing relationship or repeated examinations.

Section 12-404 extends the repose period only when “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.” Sn. Rev. Stat. § 12-404(b). Consistent with that language, courts applying the continuous-treatment doctrine require more than recurring contact between a patient and provider. The patient must remain in an ongoing course of care directed toward the particular condition underlying the malpractice claim. *See Castillo v. Emergency Med. Assocs., P.A.*, 372 F.3d 643, 650 (4th Cir. 2004). Thus, the relevant analysis has two related components: whether the provider-patient relationship continued and whether the care itself constituted a “continuous and substantially uninterrupted course of treatment for the same ailment.” *Id.* A continuing relationship alone does not establish continuous treatment.

The doctrine instead contemplates affirmative, ongoing care for the condition at issue. Courts therefore distinguish routine diagnostic examinations from examinations prescribed as part of ongoing care for an existing condition. *See Mandel*, 706 N.Y.S.2d at 196. Routine diagnostic examinations, even when repeated over time, do not themselves constitute a course of treatment; but diagnostic examinations specifically prescribed to monitor an existing condition may. *Id.* Thus, where examinations are conducted merely to determine whether a condition exists or whether treatment may become necessary in the future, they remain diagnostic

rather than continuous treatment. *See Shiffman*, 720 N.Y.S.2d at 263 (holding that annual diagnostic examinations were not continuous treatment where no treatment had begun and the examinations were intended to determine whether future treatment would be necessary). And even comparing successive tests does not alone transform otherwise discrete diagnostic procedures into continuous treatment. *See Noack v. Symenow*, 518 N.Y.S.2d 495, 496 (N.Y. App. Div. 1987) (holding that successive scans were “complete and discrete” diagnostic procedures despite comparison with prior scans).

Castillo illustrates the distinction between repeated care and continuous treatment. There, the patient sought treatment for the same underlying abdominal illness on multiple occasions within nine days: an emergency-room visit, a telephone consultation four days later, and a second emergency-room visit five days after that. 372 F.3d at 645–46. Each encounter gave rise to a physician-patient relationship, and the same medical associated employed each physician. *Id.* at 650–51. Yet the Fourth Circuit held that the encounters were “discrete and isolated” rather than continuous because the treatment was neither coordinated nor part of a substantially uninterrupted course of care. *Id.* The fact that the same underlying illness persisted throughout the encounters did not itself establish continuous treatment.

The doctrine’s rationale reinforces that distinction. Continuous treatment protects a patient who remains in an ongoing course of care with the negligent provider because requiring suit before that treatment concludes could force the patient to disrupt care intended to address the very condition underlying the claim. *See Ulrich*

v. Veterans Admin. Hosp., 853 F.2d 1078, 1080–81 (2d Cir. 1988). In *Ulrich*, for example, the doctrine applied where the hospital began corrective treatment immediately after the plaintiff's injury and provided intensive and continuous care throughout a hospitalization lasting less than three months. *Id.* The court contrasted that uninterrupted treatment with intermittent care extending over substantial periods, which does not implicate the same concern. *Id.* The doctrine therefore protects a patient from having to interrupt an existing course of treatment—not from the consequences of repose whenever a patient periodically returns to the same provider.

The treatment must also remain directed toward the same condition that forms the basis of the malpractice action. In *Miller v. United States*, the Fourth Circuit explained that the rationale for continuous treatment permits its application only when subsequent care is “for the same problem” and is provided by the same physician or by providers acting in coordination with that physician. 932 F.2d 301, 305–06 (4th Cir. 1991). Later medical care therefore does not become part of an earlier course merely because the patient continues receiving healthcare after the alleged negligence. *Id.*

Accordingly, § 12-404 does not extend repose whenever a patient maintains a relationship with the same provider, returns for recurring examinations, or ultimately learns that the same disease existed throughout those encounters. Its text requires a continuous course of treatment for the same condition. *See* Sn. Rev. Stat. § 12-404(b). That requirement is satisfied when successive encounters constitute

ongoing management of that condition; it is not satisfied when otherwise distinct diagnostic examinations merely occur at intervals over time. The distinction preserves the exception for patients actually engaged in continuing treatment without converting every recurring provider relationship into an indefinite extension of Shawnee's four-year repose period.

2. Each annual evaluation asked anew whether disease was present and reported none.

Cyber MD never identified the lung cancer for which Respondent claims Miller received continuous treatment. To the contrary, each encounter ended with Cyber MD concluding that Miller showed no evidence of malignancy. R. at 6, 20. In April 2018, Cyber MD evaluated Miller's chest X-ray and CT scan, reported "zero evidence" of malignancy, diagnosed adult-onset asthma, referred Miller elsewhere for management of that diagnosis, and recommended annual follow-up imaging. R. at 6, 20. Miller then returned in May 2019, May 2020, and June 2021, when Cyber MD reviewed newly obtained scans and again reported "zero evidence" of disease. R. at 6, 20. After the 2021 evaluation produced the same negative result, Cyber MD advised that annual imaging was no longer necessary. R. at 6, 20. Those encounters establish recurring diagnostic screening, not an ongoing course of treatment for lung cancer.

That distinction places Miller's encounters on the opposite side of the line recognized in *Mandel*. There, diagnostic examinations could constitute continuous treatment when they were prescribed as ongoing care for an existing medical condition. *Mandel*, 706 N.Y.S.2d at 196. Here, Cyber MD identified no suspicious lung lesion, malignancy, or other abnormality that subsequent scans were intended to

monitor. Instead, each annual evaluation asked anew whether disease was present and answered that question in the negative. That is materially closer to *Shiffman*, where annual diagnostic examinations did not constitute continuous treatment because no treatment had begun and the examinations were intended to determine whether treatment might become necessary in the future. *See Shiffman*, 720 N.Y.S.2d at 754. It likewise resembles *Noack*, where successive scans remained complete and discrete diagnostic procedures notwithstanding their relationship to prior imaging. *See Noack*, 518 N.Y.S.2d at 496.

Nor did Cyber MD undertake ongoing management of the condition it actually diagnosed. After diagnosing adult-onset asthma in 2018, Cyber MD referred Miller to a local practitioner for inhaler management. R. at 6, 20. The record therefore separates Cyber MD's two functions: another practitioner managed the diagnosed asthma, while Cyber MD periodically performed new imaging to determine whether malignancy existed. Section 12-404 asks whether the defendant engaged in a continuous course of treatment for the condition giving rise to the negligence claim. *See* Sn. Rev. Stat. § 12-404(b). Neither function satisfies that requirement as to Miller's lung cancer. Cyber MD did not treat the cancer because it never diagnosed it, and its annual scans did not manage an identified cancer or suspicious abnormality because Cyber MD repeatedly concluded that neither existed.

The Court of Appeals reached the opposite conclusion by characterizing these encounters as an "annual cancer surveillance protocol" and reasoning that Cyber MD "established a mandatory annual follow-up imaging protocol." R. at 25. But that

characterization adds continuity the underlying facts do not establish. The undisputed facts say only that Cyber MD recommended annual follow-up imaging after its 2018 evaluation. R. at 6, 20. They do not describe the recommendation as mandatory, identify a scheduled course of treatment, or state that Cyber MD was monitoring a known lesion or suspected malignancy. More importantly, calling periodic diagnostic screening “surveillance” does not change what Cyber MD actually did: at approximately one-year intervals, it reviewed new scans to determine whether disease was present and repeatedly concluded there was none. R. at 6, 20.

The retrospective discovery that Miller’s cancer was present throughout this period does not alter the character of the care Cyber MD actually provided. Expert review later established that a 7mm lesion was visible in 2018 and grew continuously through the years in which Cyber MD failed to identify it. R. at 6, 20. But § 12-404 focuses on whether the provider engaged in a continuous course of treatment, not whether the undiagnosed disease continuously existed. Cyber MD was repeatedly looking for disease, not continuously treating one. Its annual diagnostic encounters therefore do not satisfy § 12-404(b)’s continuous-treatment exception.

3. A disease that persists across missed diagnoses shows continuity of the condition, not of treatment.

The fact that Miller’s cancer existed throughout his encounters with Cyber MD does not convert separate diagnostic failures into continuous treatment. Courts addressing repeated failures to diagnose distinguish between the continuity of the patient’s underlying disease and the continuity of the provider’s treatment. Indeed, courts have treated successive failures to diagnose the same disease as discrete acts

of malpractice even when the disease persisted and worsened between encounters. See, e.g., *Woodward v. Olson*, 107 So. 3d 540, 543–44 (Fla. Dist. Ct. App. 2013) (treating failures to respond to chest X-ray findings in 2002, 2005, and 2008 as discrete incidents of malpractice subject to separate repose periods); *Kollross v. Goldstein*, 191 N.E.3d 39, 47–49 (Ill. App. Ct. 2021) (rejecting continuous-course-of-treatment doctrine where treatment was not continuous and, in any event, the alleged negligence was a discrete misdiagnosis and “not a continuing act”).

Howell v. Zottoli is particularly instructive. 691 S.E.2d 564, 566–67 (Ga. Ct. App. 2010). There, the court held that when a disease already exists at the time of an initial misdiagnosis, a provider’s later failure to diagnose and treat the same continuing condition does not restart repose. *Id.* A later negligent act cannot supply a new starting point where it is merely another failure to diagnose a “continuing though worsening condition.” *Id.* at 566. Other courts have similarly declined to transform an initial diagnostic failure into continuing treatment merely because the provider subsequently remains involved in the patient’s care. In *Ferrara v. Wall*, for example, the physician’s failure to respond to abnormal results did not constitute a continuing course of negligent treatment sufficient to postpone repose. 753 N.E.2d 1179, 1183–84 (Ill. App. Ct. 2001). These cases recognize the critical distinction here: a condition may continue without the treatment of that condition being continuous.

Other courts take a different approach to the repose consequences of repeated diagnostic failures, but even those decisions do not support the Court of Appeals’ continuous-treatment theory. In *Marshall v. Dodds*, the South Carolina Supreme

Court held that repeated failures to recognize signs of the same cancer constituted separate negligent acts, each triggering its own repose period. 827 S.E.2d 570, 577 (S.C. 2019). Critically, *Marshall* expressly distinguished that conclusion from continuous treatment: the court did not toll repose based on a single continuing course of care. Rather, it treated each later failure as an independently actionable act while leaving earlier time-barred acts outside the repose period. Similarly, *Woodward* treated a physician’s failures in 2002, 2005, and 2008 to respond to radiological findings as separate incidents, each subject to its own repose period. 107 So. 3d at 543–44. Thus, whether a jurisdiction measures repose from the initial misdiagnosis or separately from each subsequent diagnostic failure, repeated failures do not themselves establish a single continuous course of treatment.

That distinction matters because § 12-404(b) does not ask whether Miller’s cancer continuously existed or whether Cyber MD’s diagnostic error continuously went uncorrected. It asks whether Petitioners “engaged in a continuous course of treatment of the patient for the same illness, injury, or condition.” Sn. Rev. Stat. § 12-404(b). The undisputed facts show that Miller’s cancer was present—and retrospectively visible—from 2018 onward. R. at 6, 20. But Cyber MD failed to identify that lesion at every encounter, instead repeatedly reporting “zero evidence” of disease. R. at 6, 20. The lesion’s uninterrupted growth therefore establishes continuity of the disease, not continuity of Cyber MD’s treatment.

The Court of Appeals collapsed those distinct concepts when it characterized Miller’s annual evaluations as a single course of “diagnostic surveillance for the same

underlying health threat.” R. at 25. That reasoning effectively makes the later discovery of a continuously existing disease sufficient to retroactively unite every earlier missed diagnosis into one course of treatment. Section 12-404 does not say that. Its exception turns on what the healthcare provider continuously *treated*, not what later evidence reveals the patient continuously *had*. Otherwise, nearly any series of missed diagnoses of a slowly progressing disease could become continuous treatment once retrospective review established that the disease existed throughout the relevant period—expanding the statutory exception precisely because the provider repeatedly failed to diagnose the condition.

Cyber MD’s repeated diagnostic failures therefore do not establish the continuous treatment necessary to invoke § 12-404. At most, they establish separate failures to detect the same underlying cancer. Because the persistence of the disease cannot substitute for continuity of treatment, the annual evaluations do not extend Shawnee’s four-year repose period.

4. Without the exception, repose ran from the April 2018 evaluation, and at most only the June 2021 evaluation remains.

Because no continuous course of treatment joined Miller’s evaluations, § 12-404(b)’s general rule governs, and it measures four years from “the act of omission or occurrence alleged to have been the cause of such injury or death.” Sn. Rev. Stat. § 12-404(b). Respondent alleges one injury, a cancer that went undetected while it could still be treated. That injury began in April 2018, when a 7mm lesion was “clearly visible” on scans that Cyber MD reported showed “zero evidence” of malignancy. R. at 6, 20. Each later evaluation repeated the same omission as to the same lesion, and

a later failure to diagnose a “continuing though worsening condition” supplies no new starting point. *Howell*, 691 S.E.2d at 566–67. The encounters were separate; the injury was single. Repose therefore ran from April 2018, as the trial court held, and expired more than two years before Respondent filed suit in July 2024. R. at 7, 11.

Respondent fares little better under the rule that gives each missed diagnosis its own repose period. *See Marshall*, 827 S.E.2d at 577; *Woodward*, 107 So. 3d at 543–44. Counting back four years from July 2024, the April 2018, May 2019, and May 2020 evaluations are barred. That leaves only June 2021, when the lesion had already grown to 47 mm and Cyber MD advised that annual imaging was no longer necessary. R. at 6–7, 20–21. A claim confined to that evaluation would require proof that the June 2021 omission, apart from the three time-barred ones, caused Miller’s death, a question the Court of Appeals never reached. R. at 25. Under either rule, the judgment below cannot stand: the claim against Metropolitan is barred in full, or, at most, survives only as to the June 2021 evaluation.

B. Section 12-410 bars the product-liability claim because Cyber-Care delivered Cyber MD in March 2017 and the flaw was discoverable within four years.

Respondent’s product-liability claim is presumptively barred by § 12-410’s four-year statute of repose. The statute requires a product-liability action to be commenced “in any event” within four years of the product’s “first sale, lease, or delivery of possession to its initial user or consumer.” Sn. Rev. Stat. § 12-410(a). Cyber-Care delivered Cyber MD to Metropolitan no later than March 1, 2017, when Metropolitan integrated the software into its telehealth platform. R. at 5, 19. Respondent did not file suit until July 2024, more than seven years later. R. at 7. Thus, unless one of §

12-410(b)'s enumerated exceptions applies, the product-liability claim falls outside the repose period.

Respondent relies on § 12-410(b)(3), which exempts an action when 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 the time of delivery.” Sn. Rev. Stat. § 12-410(b)(3). The exception therefore focuses on the objective discoverability of the particular injury-causing aspect that existed when the product was delivered—not simply when the defect was actually discovered or later corrected.

The Court of Appeals concluded that Cyber MD's algorithmic defect “became discoverable only after Mr. Miller suffered a collapsed lung on October 30, 2023 and expert oncologists performed retrospective reviews of the baseline code.” R. at 27. But the undisputed record shows that Cyber-Care had already discovered in October 2022 that Cyber MD's diagnostic accuracy dropped to 85% for patients with prior occupational asbestos exposure because pleural shadowing masked underlying tumors. R. at 5–6, 19–20. The Court of Appeals therefore erred by treating Miller's 2023 diagnosis as the point at which the defect became discoverable. The relevant question is not when Miller's particular injury revealed the defect, or even when Cyber-Care actually discovered it, but whether Respondent has shown that the injury-causing aspect was objectively undiscoverable by an ordinary reasonably prudent person during the four-year repose period. *See* Sn. Rev. Stat. § 12-410(b)(3).

1. Respondent bears the burden of showing that the injury-causing aspect of Cyber MD was not discoverable by an ordinary reasonably prudent person for four years after delivery.

Section 12-410 begins with an absolute rule: a strict product-liability action must be brought “in any event” within four years of the product’s “first sale, lease, or delivery of possession to its initial user or consumer.” Sn. Rev. Stat. § 12-410(a). The latent-defect exception removes that bar only 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 the time of delivery.” *Id.* § 12-410(b)(3). The exception therefore requires more than showing that a defect existed at delivery and remained unknown. Respondent must establish that the particular aspect of Cyber MD that caused Miller’s injury was not discoverable, measured from the perspective of an ordinary reasonably prudent person, for more than four years after delivery.

That language imposes an objective standard. Courts construing materially similar latent-defect exceptions focus not on whether the particular plaintiff actually discovered the defect, but whether the defect was not readily apparent or discoverable by a reasonably prudent user. *See Anderson v. M.W. Kellogg Co.*, 766 P.2d 637, 643 (Colo. 1988) (rejecting a subjective test based on the particular user’s knowledge in favor of an objective reasonably-prudent-user standard); *Oats v. Nissan Motor Corp.*, 879 P.2d 1095, 1099–1101 (Idaho 1994) (holding that an alleged defect was not hidden because it was discoverable by an ordinary reasonably prudent person). Thus, actual ignorance and objective undiscoverability are not interchangeable. A defect may remain unknown to a particular user without being legally undiscoverable, just as its

eventual discovery does not itself establish when an ordinary reasonably prudent person could have discovered it.

Section 12-410(b)(3)'s text further defines the perspective from which discoverability must be assessed. Shawnee's general discovery rule asks when the "claimant" knew or reasonably should have known of the injury and its cause. Sn. Rev. Stat. § 12-402(c). The latent-defect exception uses different language, asking whether the injury-causing aspect was discoverable by an "ordinary reasonably prudent person." *Id.* § 12-410(b)(3). That distinction matters. The relevant inquiry is not what Miller, as the claimant and patient, personally could have discovered. Rather, consistent with *Anderson's* reasonably prudent "user," the ordinary reasonably prudent person is one positioned to use and evaluate the product at issue. *See Anderson*, 766 P.2d at 643. For diagnostic software, that means a person positioned to evaluate Cyber MD's performance by comparing the diagnostic conclusions it produced with the medical images it analyzed.

The statute likewise focuses that person's inquiry on the "injury-causing aspect of the product," not the technical mechanism responsible for it. Sn. Rev. Stat. § 12-410(b)(3). Here, the injury-causing aspect was Cyber MD's failure to detect malignancy in scans of asbestos-exposed patients because pleural shadowing masked underlying tumors. R. at 5–6, 19–20. Respondent therefore need not have had access to Cyber MD's proprietary source code to discover the relevant defect. The statutory question is whether an ordinary reasonably prudent person positioned to evaluate Cyber MD could have discovered that the product was failing on asbestos-exposed

scans, not whether that person could identify why the underlying algorithm produced those failures.

The statutory text also narrows the inquiry in two additional respects. First, the relevant object of the discoverability inquiry is not Cyber MD generally, but the “injury-causing aspect of the product.” Sn. Rev. Stat. § 12-410(b)(3). Respondent therefore cannot satisfy the exception merely by characterizing Cyber MD as proprietary or its algorithm as complex. The inquiry must focus on the particular product characteristic alleged to have caused Miller’s injury—the deficiency that caused Cyber MD to misclassify imaging of asbestos-exposed lungs. Second, that injury-causing aspect must have “existed at the time of delivery.” *Id.* The exception thus ties both the defect and the discoverability inquiry to the product delivered to its initial user; it does not ask when the manufacturer later recognized, investigated, or corrected the problem.

Finally, because § 12-410(b)(3) constitutes an exception to an otherwise applicable statute of repose, Respondent bears the burden of establishing facts sufficient to bring the claim within that exception. *See Estate of Rowe v. Wellmont Health Sys.*, 714 S.W.3d 521, 531 (Tenn. Ct. App. 2024) (“Once a statute of repose defense has been ‘asserted and established,’ the burden of proof shifts to the plaintiff ‘to establish the exception to the statute being claimed.’”). That burden matters here. Once Cyber-Care established that Cyber MD was delivered to Metropolitan in March 2017 and that suit was not filed until July 2024, the four-year period prescribed by § 12-410(a) had expired. Respondent therefore must establish more than that Cyber-Care did not

actually identify the reduced accuracy until 2022. She must show that the specific injury-causing aspect present in the delivered product was objectively undiscoverable by an ordinary reasonably prudent person until after March 2021.

2. Cyber-Care’s 2022 identification of the flaw shows when it was found, not when it could have been found.

The Court of Appeals conflated actual discovery with objective discoverability. Section 12-410(b)(3) does not ask when a particular plaintiff, manufacturer, or expert actually discovered the alleged defect. It asks whether the “injury-causing aspect of the product” was “not discoverable by an ordinary reasonably prudent person until more than four (4) years after the time of delivery.” Sn. Rev. Stat. § 12-410(b)(3). That language imposes an objective inquiry. *See Anderson*, 766 P.2d at 643; *Oats*, 879 P.2d at 1099–1101. Thus, neither the date on which the defect was actually discovered, nor the particular plaintiff’s ignorance of the defect establishes that it was objectively undiscoverable during the repose period.

The Court of Appeals nevertheless concluded that Cyber MD’s defect “became discoverable only after Mr. Miller suffered a collapsed lung on October 30, 2023 and expert oncologists performed retrospective reviews of the baseline code.” R. at 25. But the stipulated facts contradict 2023 as the point at which the alleged defect first became discoverable. In October 2022, Cyber-Care had already discovered that Cyber MD’s diagnostic accuracy fell from 97% overall to 85% when evaluating patients with prior occupational asbestos exposure because pleural shadowing masked underlying tumors. R. at 5, 19. Cyber-Care responded by retraining Cyber MD on 10,000 asbestos-exposed image sets, restoring high accuracy. R. at 6, 20. Miller’s October

2023 diagnosis therefore did not first reveal the underlying performance problem identified by the Court of Appeals; Cyber-Care had identified that problem a year earlier.

Nor does Cyber-Care's October 2022 discovery establish the proposition Respondent must prove. The trial court recognized that Respondent relied on Cyber-Care's 2022 discovery to argue that the defect was undiscoverable until after the four-year repose period expired. R. at 12–13. But the fact that Cyber-Care actually discovered the performance disparity in October 2022 does not establish that the disparity was not discoverable by an ordinary reasonably prudent person before March 2021. Section 12-410(b)(3) makes the latter showing necessary. And because Respondent bears the burden of establishing the exception once the repose defense is established, the absence of actual discovery during the four-year period cannot itself establish objective undiscoverability. *See Estate of Rowe*, 714 S.W.3d at 531.

The Court of Appeals' reliance on Cyber MD's proprietary nature does not fill that evidentiary gap. To be sure, Cyber-Care provided Cyber MD's verification and training data to the FDA rather than making that information publicly available. R. at 4, 18. And after Cyber-Care identified the asbestos-specific reduction in accuracy in October 2022, it did not publicly disclose that information. R. at 5–6, 19–20. But those facts concern access to Cyber MD's internal data and Cyber-Care's disclosure of what it later learned; neither establishes when the injury-causing aspect of the product was objectively discoverable. Section 12-410(b)(3) asks whether that aspect was discoverable by an ordinary reasonably prudent person, not whether Miller could

inspect Cyber MD’s proprietary source code or whether Cyber-Care publicly disclosed the defect after discovering it. Indeed, Cyber-Care’s failure to disclose its October 2022 discovery occurred more than a year after the four-year repose period had already expired in March 2021 and therefore cannot establish that the defect was undiscoverable during the statutory period.

More importantly, the record contains affirmative evidence that Cyber MD’s diagnostic failure manifested externally without access to its source code or training data. Retrospective expert review established that a 7mm lesion was “clearly visible” on Miller’s 2018 imaging—the same imaging Cyber MD interpreted as showing “zero evidence” of malignancy. R. at 6, 20. The discrepancy between the information available in the medical image and Cyber MD’s diagnostic output was therefore observable from the product’s performance itself. Discovering that discrepancy did not require identifying the coding error that caused it or examining Cyber MD’s proprietary internals. And because § 12-410(b)(3) asks whether the “injury-causing aspect of the product” was discoverable, the relevant question is whether an ordinary reasonably prudent person positioned to evaluate Cyber MD’s diagnostic performance could discover that Cyber MD was failing to identify malignancy in the relevant imaging, not whether that person could determine why its algorithm produced that failure. *See* Sn. Rev. Stat. § 12-410(b)(3).

Respondent therefore cannot satisfy § 12-410(b)(3) merely by pointing to Miller’s 2023 diagnosis, Cyber-Care’s 2022 discovery, or the proprietary nature of Cyber MD’s internal workings. The first occurred after Cyber-Care had already identified the

relevant performance problem; the second establishes actual discovery rather than objective undiscoverability; and the third does not negate the affirmative evidence that Cyber MD's diagnostic failure manifested in its output. The record instead shows that the lesion Cyber MD missed was visible in the very imaging it analyzed. Because Respondent has not established that the injury-causing aspect of Cyber MD was undiscoverable by an ordinary reasonably prudent person before the four-year repose period expired in March 2021, the Court of Appeals erred in applying § 12-410(b)(3).

3. Repose runs from first delivery in 2017, and the 2023 retraining produced a version Miller never used.

Section 12-410 measures repose from a fixed event: the product's "first sale, lease, or delivery of possession to its initial user or consumer." Sn. Rev. Stat. § 12-410(a). Nothing in the statute provides a new repose period when a manufacturer later modifies, repairs, or updates the product. That omission matters. Courts interpreting similar statutes of repose decline to create a new repose period for post-delivery modifications where the legislature did not provide one. In *Estabrook v. Mazak Corp.*, for example, the Indiana Supreme Court held that a statute running from "delivery of the product to the initial user or consumer" could not be extended by a manufacturer's later repair, refurbishment, or reconstruction because the statutory text contained no such exception. 140 N.E.3d 830, 834 (Ind. 2020). The court refused to add a modification exception that the legislature "could have enacted but did not." *Id.* at 834.

The same reasoning applies with greater force here. Section 12-410 expressly identifies first delivery as the event triggering repose and separately enumerates

circumstances in which the four-year period “shall not apply.” Sn. Rev. Stat. § 12-410(a)–(b). Those exceptions include an injury-causing aspect existing at delivery that remains undiscoverable for more than four years; they do not include subsequent repair, retraining, or modification. Treating every later alteration of a product as a new delivery would add a restart provision to a statute that contains none and undermine the legislature’s choice to measure repose from the product’s first delivery.

More importantly, Cyber-Care’s 2023 retraining could not have caused the injuries Respondent alleges. Cyber-Care delivered the original version of Cyber MD to Metropolitan in March 2017. R. at 5, 19. Miller’s diagnostic encounters occurred in 2018, 2019, 2020, and 2021, during which the 2017 baseline algorithm repeatedly failed to identify his lesion. R. at 6, 20. Cyber-Care did not release the retrained version until December 13, 2023—more than two years after Miller’s final Cyber MD evaluation. R. at 6, 20. The product that allegedly caused Miller’s injuries was therefore the original version, not the retrained version.

Courts confronting analogous post-delivery changes distinguish claims arising from the original product from claims arising from a genuinely new or redesigned component. In *Butchkosky v. Enstrom Helicopter Corp.*, the court refused to permit later repairs or updated repair instructions to revive a time-barred claim based on an original design defect. 855 F. Supp. 1251, 1257–58 (S.D. Fla. 1993). Although a newly designed replacement component could potentially support a claim based on a defect in that new component, later work on the original product could not provide a “back-door means” of pursuing the original design claim after repose had run. *Id.* at 1258.

Respondent’s claim presents the latter situation. The alleged injury-causing defect was embedded in Cyber MD’s 2017 baseline coding algorithm, which consistently failed to identify Miller’s lesion. R. at 5–6, 19–20. The 2023 retraining was undertaken to correct that preexisting problem by adding 10,000 asbestos-exposed image sets and restoring higher diagnostic accuracy. R. at 6, 20. Respondent does not allege that the retrained version introduced a new defect that injured Miller. Nor could she: Miller never received a diagnostic evaluation from that version. The later correction therefore cannot supply a new repose period for injuries allegedly caused years earlier by the original algorithm.

The Court of Appeals’ contrary reasoning would detach the repose period from both the statutory trigger and the product that allegedly caused the injury. Under that approach, a manufacturer that improves a product after the repose period has expired could revive liability for an original defect merely by correcting it. That is precisely the kind of nontextual extension *Estabrook* rejected. 140 N.E.3d at 836–37. Section 12-410 instead ties repose to first delivery and its latent-defect exception to an “injury-causing aspect of the product that existed at the time of delivery.” Sn. Rev. Stat. § 12-410(a), (b)(3). Cyber-Care’s later retraining does not change either fact.

A version of Cyber MD that never treated Miller cannot restart repose for injuries allegedly caused by the version that did. Because the December 2023 retraining neither constitutes a new statutory trigger nor caused Miller’s alleged injuries, it cannot revive Respondent’s otherwise time-barred product-liability claim.

CONCLUSION

This Court should REVERSE the Shawnee Court of Appeals' judgment outright and RENDER judgment in Metropolitan Health System, Inc. and Cyber-Care Solutions, LLC's favor; OR alternatively REVERSE and REMAND limited to an analysis of the June 2021 Cyber MD evaluation.

Respectfully submitted,

The Standard of Care
ATTORNEYS FOR PETITIONERS

DATE: October 2, 2026