

No. 26-338

IN THE

Shawnee Supreme Court

NOVEMBER TERM 2026

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

PETITIONERS,

— VERSUS —

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

RESPONDENT

BRIEF FOR RESPONDENT

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QUESTIONS PRESENTED

- I. Whether a hospital's integration and presentation of a third-party "AI clinician" within its branded telehealth platform can create a triable question of apparent agency.
- II. Whether Respondent's claims are timely under the express statutory exceptions to Shawnee's four-year statutory repose period, including a) the "continuous course of treatment" doctrine for medical malpractice claims under Shawnee Revised Statute § 12-404, and b) the requirement that the injury-causing aspect of a product be discoverable by an ordinary reasonably prudent person for strict product liability claims under Shawnee Revised Statute § 12-410.

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OPINIONS BELOW

The unreported opinion of the Circuit Court of Simmons County State of Shawnee in *Evelyn Miller v. Metropolitan Health System, Inc. and Cyber-Care Solutions, LLC*, No. 25-L-24601 (Mar. 6, 2025), is contained in the Record of Appeal at pages 1–14. The Circuit Court GRANTED the Defendants’ Motion for Summary Judgment pursuant to Rule 56 and DISMISSED WITH PREJUDICE the Plaintiff’s Complaint in its entirety. The unreported opinion of the Shawnee Court of Appeals for the Second District in *Evelyn Miller v. Metropolitan Health System, Inc. and Cyber-Care Solutions, LLC*, No. 25-cv-123 (Feb. 24, 2026), is contained in the Record of Appeal at pages 15–25. The Shawnee Court of Appeals REVERSED the Circuit Court’s grant of summary judgment on both claims, finding there are genuine issues of material fact, and REMANDED for trial on the vicarious liability issue. The Shawnee Supreme Court GRANTED Metropolitan Health System, Inc. and Cyber-Care Solutions, LLC’s petition for leave to appeal pursuant to Shawnee Supreme Court Rule 315.

STATUTORY PROVISIONS INVOLVED

The following provisions are relevant to this proceeding: Kan. Stat. Ann. § 60-3303(b)(2)(D)

N.Y. C.P.L.R. 214-a; Sn. R. Civ. P. 56; Sn. Rev. Stat. § 12-402(b); Sn. Rev. Stat. § 12-402(c)(1); Sn. Rev. Stat. § 12-404(b); Sn. Rev. Stat. § 12-410(a); Sn. Rev. Stat. § 12-410(b)(3); Wash. Rev. Code § 1.80.010(8); Wash. Rev. Code § 1.80.130; 15 U.S.C. § 7001(h);

STATEMENT OF THE CASE

I. STATEMENT OF FACTS

This case concerns a multi-year failure to detect a lung lesion after Elias Miller sought diagnostic care through Metropolitan Health System's ("MHS") telehealth platform.

Elias Miller worked in the maintenance department at the Shawnee Steel Company's primary mill in Cartersville from 1970 until his retirement in 2016. His work regularly required him to handle asbestos-insulated machinery. Safety protocols were loosely enforced, and he frequently worked without respiratory protective equipment. Mr. Miller was a lifelong nonsmoker, was not asthmatic, with no family or personal history of respiratory disease. His last employment-sponsored chest screening was in 2012 and read as "unremarkable." R. at 15.

Mr. Miller lived in rural Simmons County. Following economic decline and the 2016 closure of the steel mill, Simmons County's population fell to approximately 7,500, and the county has since lost more than seventy-five percent of its healthcare professionals. R. at 15. Both local hospitals closed, and there are no urgent-care facilities or permanent diagnostic-imaging centers. R. at 15. Only three primary-care practices served the county. MHS's flagship hospital in Goshen, the nearest facility providing in-person radiology consultation and CT imaging, was 190 miles and approximately three and one-half hours from Cartersville. R. at 15. State and federal authorities designated Simmons County a Health Professional Shortage Area and a Medically Underserved Area. R. at 15.

MHS is a regional healthcare network based in Goshen. In 2012, MHS contracted with Cyber-Care Solutions, LLC (“CCS”) to design and host a proprietary remote telehealth platform. MHS exclusively controlled the patient-facing interface, which displayed MHS branding throughout. CCS marks were prohibited on all patient-facing pages. Patients accessed the platform through MHS’s primary domain. R. at 15.

Below the login, the platform stated: “By entering the portal, I accept the MHS Terms and Conditions.” The phrase “Terms and Conditions” appeared as a blue, underlined hyperlink. Clicking the hyperlink opened a separate webpage containing thirty-four lines of single-spaced, unformatted black text on a plain white background, rendered in a font noticeably smaller than the rest of the website. Approximately three-quarters down the page, the Terms stated: “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 15–16. Digital audit logs show that Mr. Miller opened the Terms once, in April 2018, remained on the page for four seconds, and did not access it again during later portal visits. R. at 16.

February 2017, CCS received FDA clearance for Cyber MD, an conversational AI diagnostic system that accepts symptoms through text or voice, asks follow-up questions, compiles clinical history, generates diagnoses, orders and interprets diagnostic tests. CCS marketed Cyber MD under the slogan “Cyber MD: Care Everywhere.” R. at 16. Before launching each Cyber MD session, users encountered a pop-up, displayed in red, sixteen-point font, stating: Cyber MD is not a licensed health care professional. It is an artificial intelligence software program. Users had to click “Accept” to proceed. R. at 16–17.

MHS integrated Cyber MD into its telehealth platform in March 2017. The initial Cyber MD version was trained on 40,000 images from three hospital systems and achieved a reported overall accuracy rate of ninety-seven percent in classifying lung lesions. In October 2022, CCS discovered that Cyber MD’s diagnostic accuracy declined to eighty-five percent for patients with occupational asbestos exposure because pleural shadowing could mask underlying tumors. CCS retrained Cyber MD using 10,000 asbestos-exposed image sets and released an updated version to clients on December 13, 2023. R. at 16–17.

On April 9, 2018, Mr. Miller experienced shortness of breath and logged into MHS’s portal. During a virtual intake session with Cyber MD, he reported his occupational asbestos exposure at the steel mill. Cyber MD ordered a chest X-ray and CT scan through a mobile radiology service serving Cartersville and stated: “Once I have your scans, I will analyze them closely, and go over the results with you.” R. at 17. After the mobile radiology service uploaded Mr. Miller’s imaging, Cyber MD

evaluated the scans and reported “zero evidence” of malignancy. It diagnosed adult-onset asthma, referred Mr. Miller to a local practitioner for inhaler management, and recommended annual follow-up imaging. R. at 17. Mr. Miller completed annual virtual follow-up evaluations with Cyber MD in May 2019, May 2020, and June 2021. During each evaluation, Cyber MD reviewed new mobile scans and again reported “zero evidence” of disease. After the 2021 report, Cyber MD advised Mr. Miller that annual imaging was no longer necessary. R. at 17.

On October 30, 2023, Mr. Miller suffered a spontaneous pneumothorax and was airlifted to MHS’s flagship hospital. Imaging revealed a 6.4-centimeter malignant mass in his left lung with extensive metastases to the pleura and spine. Retrospective expert review concluded that a seven-millimeter lesion was visible on Mr. Miller’s 2018 scans, although partially obscured by pleural changes, and that the lesion had grown continuously to forty-seven millimeters by 2021. The review also concluded that Cyber MD’s 2017 baseline coding algorithm had consistently failed to identify the lesion. R. at 17–18. Mr. Miller died on April 14, 2024, at age seventy-four. Plaintiff filed this action in July 2024. R. at 18.

II. NATURE OF PROCEEDINGS

The Circuit Court Of Simmons County, Shawnee. In July 2024, three months after her husband Elias Miller died, Plaintiff Evelyn Miller, individually and as Special Administrator of the Estate of Elias Miller, filed separate suits against MHS and CCS in the Circuit Court of Simmons County, Shawnee. R. at 1. Miller asserted a vicarious liability claim against MHS under the doctrine of apparent

agency for the diagnostic errors of the Cyber MD tool. R. at 1. Miller asserted a strict product liability claim against CCS based on design defect and failure to warn of the hidden dangers within the Cyber MD software algorithm. R. at 1.

After the discovery period, the Defendants filed a combined Motion for Summary Judgment pursuant to Shawnee Rule of Civil Procedure 56 arguing there was no genuine dispute as to any material fact in the claim. R. at 1. MHS argued it could not be held liable under the apparent-agency doctrine because 1) Cyber MD was neither an employee nor an agent of MHS; 2) MHS expressly denied any such agency relationship in its hyperlinked Terms and Conditions, which Miller assented to; and 3) the claim is time-barred as the applicable statutory repose period in § 12-404 expired in April 2022, four years after Mr. Miller's initial interaction with the Cyber MD algorithm. R. at 7-8. CCS argued that the strict product liability claim is barred as the applicable statutory repose window in § 12-410 expired in 2021, four years after MHS integrated Cyber MD into its telehealth portal. R. at 12.

In March 2025, the Circuit Court GRANTED the Defendants' Motion for Summary Judgment pursuant to Rule 56 and DISMISSED WITH PREJUDICE the Plaintiff's Complaint in its entirety. R. at 12. The Circuit Court held that there was no triable issue of fact as to whether Miller assented to the Terms and Conditions in the Cyber MD clickwrap agreement, as federal courts have consistently held that affirmatively clicking a button constitutes legally sufficient notice of contract formation. The Circuit Court rejected the Plaintiff's argument that any contract formed was unconscionable, concluding that the disparity in bargaining power

between Miller and MHS was not so significant as to warrant invalidating the agreement. R. at 9. Furthermore, the Circuit Court found that Miller's claims were barred as a matter of law under the expiration of the applicable statutory repose periods, thereby warranting summary judgment in favor of the Defendants. R. at 12.

Shawnee Court of Appeals for the Second District. Plaintiff Evelyn Miller appealed from the March 2025 order of the Circuit Court granting summary judgment on the medical malpractice and strict product liability claims in favor of Defendants MHS and CCS. The parties argued this appeal before the Court of Appeals on October 14, 2025. The Court of Appeals concluded that, given the essential nature of the care Miller sought and the structural barriers to care in rural areas like Simmons County, it is plausible a jury may find that the clickwrap agreement Miller assented to was unconscionable. R. at 20. The Court of Appeals also noted it was plausible a jury may find that a reasonable patient in Miller's position would not understand that MHS was denying vicarious liability in the pop-up box that appeared before a Cyber MD chat session. R. at 21. Therefore, the Circuit Court erred in ruling that there were no genuine questions of material fact for a jury to resolve on the vicarious liability issue.

The Circuit Court also erred in ruling that the four-year statutes of repose in § 12-404 and 12-410 barred Plaintiff's medical malpractice and strict product liability claims. The Court of Appeals found that exceptions in the Shawnee statutes of repose applied to both claims, rendering them timely. The Court of Appeals rejected the Circuit Court's narrow application of the continuous course of treatment exception.

R. at 22. It found that Miller's interactions with MHS and Cyber MD constituted ongoing diagnostic care for the same underlying health threat that extended through 2021. R. at 22. Accordingly, the four-year repose period under § 12-404(b) for Miller's medical malpractice claim began to run in 2021. The Court of Appeals also found the Circuit Court misinterpreted the express statutory exceptions for latent defects in § 12-410(b)(3). R. at 24. As the injury-causing aspect of the Cyber MD algorithm was not discoverable by ordinary reasonably prudent persons, Miller or his treating providers, within four years of MHS's adoption of the tool, the absolute four-year repose bar under § 12-410(a) does not apply. R. at 24.

On February 24, 2026, the Court of Appeals REVERSED the Circuit Court's grant of summary judgment on both claims, finding there are genuine issues of material fact, and REMANDED for trial on the vicarious liability issue. R. at 25.

Shawnee Supreme Court. Defendants MHS and CCS petitioned for leave to appeal both issues under Shawnee Supreme Court Rule 315. The Supreme Court GRANTED the petition and limited its review to two issues: 1) vicarious liability under the apparent-agency doctrine; and 2) the applicability of Shawnee's four-year statutes of repose. R. at 26.

SUMMARY OF THE ARGUMENT

I. MHS's Inconspicuous and Incomplete Disclosures Do Not Defeat Apparent Agency as a Matter of Law.

A hospital cannot present diagnostic care as its own, deliver it through AI, and then claim that the technology puts the care beyond apparent-agency law. Cyber MD's technology impacts how CCS furnishes the service, but it does not erase MHS's role in presenting that service to Miller. MHS controlled the patient-facing portal, displayed its branding throughout, and prohibited CCS marks. Miller sought and repeatedly received diagnostic care through that portal. A jury could find that MHS held out CCS-furnished care as its own and that Miller relied on that presentation.

The disclosures do not settle that question as a matter of law. The Terms referred to software developed by another company without naming CCS; the prominent pop-up told Miller that Cyber MD was AI, not that CCS furnished the diagnostic care. Nor did the Terms expressly release MHS from apparent-agency liability. MHS cannot turn those communications into a complete defense without confronting what they said, how they were presented, and the appearance MHS created across the encounter.

Apparent agency doctrine supplies a guardrail for emerging technology quickly becoming commonplace. The doctrine incentivizes institutions to account for the risks of the care they present as their own, prioritize patient safety, and preserve a remedy when that care goes wrong. There is no reason to abandon established common-law principles simply because care is delivered through new technology. The Shawnee

Supreme Court should affirm the Court of Appeals' reversal of summary judgment and allow Mrs. Miller's claim to proceed.

II. Undiscoverable to Reasonably Prudent Software Users, Cyber MD's Latent Algorithmic Defect Satisfies the Product Liability Exception.

Miller's product liability claim is timely because the algorithmic defect that led to Mr. Miller's death existed at the time of delivery and was not discoverable by an ordinary reasonably prudent person. Therefore, due to the latent nature of the defect, Miller's product liability claim is tolled under the express statutory exception enacted by the Shawnee legislature in §12-410(b)(3). Cyber MD's reduced accuracy for asbestos-exposed patients was hidden within CCS's proprietary algorithm and was unknown to CCS, Mr. Miller, and Mr. Miller's treating providers. Neither Mr. Miller nor any other ordinary user had access to the source code or the training data necessary to identify this defect. The defect was not discovered until after Miller's October 2023 pneumothorax resulted in the diagnosis of Stage IV lung cancer and CCS engaged oncology experts to conduct a retrospective review of the algorithm.

Miller's claim also satisfies Shawnee's two-year limitations periods for personal injury and wrongful death. Under § 12-402(c), when an injury is not immediately discoverable, the limitations period does not begin until the plaintiff knows, or through reasonable diligence should know, of both the injury and the tortfeasor's identity. Miller did not discover that he was inaccurately declared healthy by Cyber MD until his spontaneous pneumothorax in October 2023, after which he was diagnosed with Stage IV lung cancer. Miller's action for wrongful death then

accrued in April 2024 when Mr. Miller passed away. Since both the moment of discovery in October 2023 and Mr. Miller's death in April 2024 occurred within two years of the claim being filed in July 2024, Miller's product liability claim is timely under Shawnee's statute of limitations.

III. Cyber MD's Ongoing Diagnostic Evaluations For The Same Injury Or Condition Satisfy the Continuous Treatment Exception.

Miller's medical malpractice claim against MHS is timely because of the Shawnee legislature's adoption of the continuous treatment doctrine, which allows a repose period to be tolled when a provider continuously treats the patient for the same illness, injury, or condition underlying the malpractice claim. Under § 12-404, medical malpractice claims are subject to a two-year limitations period and a four-year repose period.

Miller satisfies the requirements for the doctrine because he received ongoing care from MHS through Cyber MD from 2018 through 2021. When Mr. Miller sought care from MHS in 2018 after experiencing shortness of breath, Cyber MD ordered scans, evaluated them, issued an adult-onset asthma diagnosis, referred Mr. Miller to a local practitioner for inhaler management, and committed to monitoring his condition through a mandatory annual follow-up imaging protocol. Although the visits occurred annually, they were part of a prescribed, ongoing monitoring protocol to manage Miller's misdiagnosed asthma and high-risk respiratory status. Cyber MD's prescribed course of treatment aimed to address the underlying respiratory condition which ultimately manifested as Stage IV lung adenocarcinoma.

Accordingly, the Court should hold that the repose period was tolled under the continuous treatment doctrine until Miller's final Cyber MD visit in June 2021, rendering his July 2024 filing timely. His claim also falls within the two-year limitations period because his lung cancer was not discovered until October 2023, and he filed suit in July 2024, only three months after his death.

ARGUMENT

Standard of Review. This Court reviews a grant of summary judgment de novo, applying the same standard that governed in the circuit court. *Vance v. Oakridge Health Sys., Inc.*, 142 Sn.2d 88, 94 (2018). Summary judgment is proper only when the movant shows that no genuine dispute of material fact exists and that it is entitled to judgment as a matter of law. Sn. R. Civ. P. 56. A dispute is genuine when the evidence permits a reasonable jury to return a verdict for the nonmovant. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The movant bears the initial burden of identifying portions of the record that demonstrate the absence of a genuine factual dispute. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). If that burden is met, the nonmovant must identify specific facts showing a genuine issue for trial. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). In conducting this inquiry, the Court must construe the evidence and draw all reasonable inferences strictly against the movant and liberally in the nonmovant favor. *Anderson*, 477 U.S. at 255. Summary judgment is proper only when the evidence is so one-sided that no reasonable jury could find for the nonmovant. *Id.* at 251–52.

Under this standard, summary judgment was improper. MHS and CCS did not eliminate the material factual disputes presented here. The record, construed strictly against the movant and in favor of Miller, permits a reasonable jury to find MHS can be vicariously liable with timely medical malpractice and product liability claims under express statutory exceptions enacted by the Shawnee legislature.

I. MHS CANNOT PRESENT CYBER MD AS MHS CARE AND THEN DISCLAIM RESPONSIBILITY FOR ITS DIAGNOSTIC ERRORS

The Shawnee Supreme Court should affirm the Court of Appeals' reversal of summary judgment for MHS on apparent agency. MHS offered diagnostic care through its branded telehealth portal, controlled the patient-facing interface, and selected CCS to furnish that care through Cyber MD. A reasonable jury could find that MHS's presentation led Miller to accept CCS-furnished diagnostic care as MHS care. Shawnee's apparent-agency test protects reliance on the care an institution presents to patients, regardless of how it privately arranges for that care to be delivered. *Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d 511, 523–25 (1993).

The application of apparent agency to AI-delivered diagnostic care is a question of first impression in Shawnee. The Court of Appeals looked to comparable law in addressing that question, as federal courts do when they must predict how a state's highest court would resolve an unsettled issue. *City of Erie v. Guaranty National Insurance Co.*, 109 F.3d 156, 159–60 (3d Cir. 1997); *Burlington Insurance Co. v. Oceanic Design & Construction, Inc.*, 383 F.3d 940, 944–45 (9th Cir. 2004); *Sloan v. Motorists Mutual Insurance Co.*, 368 F.3d 853, 856–57 (8th Cir. 2004). This Court now decides Shawnee law for itself. The weight of persuasive authority and application of Shawnee's operative test make clear that established agency principles apply when an institution presents care furnished through another provider. The Court of Appeals came to the same conclusion when they applied that test by

reference to *Gilbert and Webster v. CDI Indiana, LLC*, 917 F.3d 574, 577–78 (7th Cir. 2019).

That test calls for the totality of the patient-facing circumstances: what MHS offered, what Miller encountered, what he knew about CCS, and whose care he reasonably understood he was receiving. Applying agency roles, MHS is the proposed principal, CCS is the proposed apparent agent, Cyber MD is the instrument through which CCS furnished the negligent care. MHS's branding, its ostensible ownership and control of the portal, and its exclusion of CCS marks support the inference that Miller encountered CCS's diagnostic work as part of MHS's service. The language and presentation of the Terms and AI pop-up were insufficient to dispel MHS's digital manifestations of authority as a matter of law. Summary judgment was inappropriate because the results of the test showed this can only be decided by a jury.

Section A addresses the doctrine's reach and its application to CCS-furnished care through Cyber MD. Section B addresses Shawnee's test for holding out and reliance; Section C evaluates what the Terms and AI pop-up actually disclosed; Section D addresses, in the alternative, MHS's proposed contractual bar; and Section E reiterates the importance of safe access to AI-assisted care without sacrificing accountability. Timeliness under Sn. Rev. Stat. §§ 12-402, 12-404, and 12-410 is addressed separately.

A. MHS's Presentation of CCS-Furnished Diagnostic Care Supports Apparent Agency.

Neither the location of the care nor the innovative nature of delivery foreclose apparent agency. MHS pushed CCS's diagnostic system to its patients through an exclusively MHS-branded portal without meaningful notice, thereby obscuring the relationship. Apparent agency applies when an institution presents another provider's care as its own, and the patient reasonably relies on the appearance the institution created. *Gilbert*, 156 Ill. 2d at 523–25. Understanding the origins of the doctrine illustrates why this situation is within its reach.

1. Apparent agency follows the institution's presentation of care across healthcare settings.

Sometimes referred to as ostensible agency or apparent authority in *Gilbert*, the apparent agency doctrine rests on a settled principle: a principal bears the consequences when its conduct creates a reasonable appearance of authority on which another relies. *See Baptist Memorial Hospital System v. Sampson*, 969 S.W.2d 945, 948 n. 2 (Tex.1998) (holding that “Regardless of the term used, the purpose” of the term, a principal who held out an agent may be held vicariously liable for the person's negligence in order “to prevent injustice and protect those who have been misled”). *Gilbert* was the vehicle for apparent agency doctrine to reach hospitals in Illinois, and since then, a majority of jurisdictions apply it to independent contractors held out by a hospital. 156 Ill. 2d at 524–25.

As healthcare delivery and the role of providers modernized, courts have applied the flexible doctrine to a variety of settings, agents, and principles. *See*

Arrendale v. American Imaging & MRI, LLC, 183 N.E.3d 1064, 1071–76 (Ind. 2022) (treating an outpatient imaging center as principal institution, and remote radiologist as an agent, despite never meeting the patient); *George v. Fadiani*, 772 A.2d 1065, 1068–69 (R.I. 2001) (applying doctrine to an independent orthodontist in a dental clinic); *Soule v. Blessing Hospital*, No. 20-cv-1398 (C.D. Ill. Sept. 11, 2025) (applying to hospital telemedicine encounters). The Eleventh Circuit allowed an apparent-agency claim arising from a cruise line’s onboard medical service and care furnished by a shipboard doctor and nurse. *Franza v. Royal Caribbean Cruises, Ltd.*, 772 F.3d 1225, 1249–51 (11th Cir. 2014). Remote delivery and corporate layering do not erase the apparent-agency question, and technology that can replace certain human functionality does not obscure the effect that unified, institutional care can have on a patient’s reasonable understanding of the provider. These considerations make MHS’s presentation of CCS’s tool, Cyber MD, to Miller especially important. "Where the agency principles that we have outlined are satisfied, however, there is no reason why vicarious liability should not attach." *Eads v. Borman*, 351 Or. 729, 740, 277 P.3d 503, 511 (2012).

2. CCS furnished the diagnostic function MHS presented through Cyber MD.

Here, the apparent relationship runs from MHS to CCS, and Cyber MD is the instrument through which CCS furnished care to Miller. This makes MHS the principal who could be vicariously liable for tortious conduct of their agent, CCS. MHS engaged CCS to build and host the platform and later integrated Cyber MD to be routed to patients seeking remote diagnostic care through that MHS-branded

interface. MHS held out CCS, and Miller reasonably relied. During Miller's continued care under Cyber MD, the system elicited his asbestos-exposure history, ordered chest imaging, interpreted the scans, diagnosed asthma, and directed follow-up to manage his respiratory symptoms for several years. If Cyber MD was a person, the analysis would be simpler, because it would be the agent. But agents cannot be software. Restatement (Third) of Agency § 1.01. So courts treat the controlling person or entity as the agent who uses that software. Thus, CCS is an agent through the system's instrumentality. Put another way, the system's tortious acts can be traced to the entity that controlled it. CCS being an agent preserves the agency doctrine central to healthcare liability and aligns with how courts are treating technological tools and AI-caused harm.

Mobley v. Workday, Inc., shows how using an AI system to delegate tasks to a third party does not sever the deployer's liability for AI-based harm. 740 F. Supp. 3d 796, 805–09 (N.D. Cal. 2024). There, Workday supplied AI-driven screening tools used by employers to evaluate job applicants, but the acts and impact of the tools were alleged to have violated several federal anti-discrimination laws. The court held that Workday, as a company, could be treated as an agent for an employer using their tool, reasoning that the causal chain is not severed just because the employer delegated a consequential function (screening applicants) to Workday, and Workday performed that function through AI. *Id.* at 806–08. The delegated work remained Workday's work even though Workday performed it through an automated system. The court in *Mobley* recognized that assigning consequential decisions to an AI-

enabled vendor should not create an accountability gap between the organization presenting the service and the entity performing it. 740 F. Supp. 3d at 806–08. "This is the very gap that the agency theory is intended to address," and granting dismissal and thereby "ignoring this gap would allow companies to escape liability for hiring decisions by saying that function has been handed over to someone else (or here, artificial intelligence)." *Id.* at 806. The court reiterated that this outcome cuts against the "well recognized directive" that courts are to construe remedial statutes broadly in order to effectuate their purpose. *Id.* Likewise, Shawnee's § 12-404 wrongful death statute is remedial in nature, and allowing a similar gap would allow hospitals to reduce their liability by replacing human providers with AI.

Louis v. Saferent Sols., supplies another example of courts attributing human or corporate responsibility for automating decision-making. Saferent's automated software performs screening functions for residential landlords, marketed as a means to "automate human judgment." 685 F. Supp. 3d 19 (D. Mass. 2023). The details of SafeRent's algorithm were proprietary and not shown to landlords who used it. *Id.* The software functioned as a "black box" thereby preventing landlords from altering any of the factors or weights assigned to them in the tenant screening process. 685 F. Supp. 3d 19, 41 (D. Mass. 2023). The court allowed a discrimination case against the landlords and SafeRent to proceed based on the pleadings, citing the remedial nature of anti-discrimination statutes and how they require a "results-oriented" analysis that focuses on the "consequences of an action rather than the actor's intent". 685 F. Supp. 3d 19, 35 (D. Mass. 2023). Liability can still attach, even if principals cite a

lack of operational control, or if agents use automation to distance themselves from the harm. *See also Amazon.com Services LLC v. Perplexity AI, Inc.*, No. 26-1444 (9th Cir. Aug. 4, 2026) (emphasizing that agentic AI is a tool that can subject a user to liability for its actions). Similarly, in *Moffatt v. Air Canada*, a Canadian tribunal found an airline company liable for negligent misrepresentation by its website's customer-facing AI chatbot. 2024 BCCRT 149, ¶¶ 24–29 (B.C. Civ. Resol. Trib.). The court rejected Air Canada's argument that because AI is not a corporation or a person, it cannot make them liable. Liability is not erased by automation, because courts scrutinize the developers and deployers as if they themselves caused the harm.

A survey of electronic-transactions law reinforces the attribution trend. For example, Washington's Uniform Electronic Transactions Act defines an electronic agent as a program used to act without individual review and recognizes contracts formed through interactions involving such agents. Wash. Rev. Code § 1.80.010(8); *id.* § 1.80.130. Likewise, E-SIGN recognizes the legal effect of an electronic agent's role in a transaction when its action is legally attributable to the person to be bound. 15 U.S.C. § 7001(h). Those transactional rules provide an analogy for locating responsibility for automated acts by agents and principals.

The nature of Cyber MD does not prevent CCS from acting as MHS's agent. This is consistent with the current legal understanding of AI demonstrated in *Mobley*, *Louis*, *Perplexity*, and *Moffat*. It also aligns with the doctrine's inherent and historical flexibility. Apparent agency has followed institution-furnished care from inpatient settings, outpatient imaging centers, dental clinics, cruise ships and telehealth

platforms, evidenced by *Gilbert*, *Arrendale*, *George*, *Franza*, and *Soule*. It applies here. MHS selected CCS, placed Cyber MD in its portal, controlled the patient-facing presentation, and offered the resulting diagnostic service under MHS's name. The Court should affirm the Court of Appeals' reversal of summary judgment for MHS and allow Miller's apparent-agency claim to proceed.

B. MHS Held Out Cyber MD as an Integrated Part of Their Diagnostic System

Under *Gilbert*, Apparent agency requires holding out and reliance. 156 Ill. 2d 511, 523–25. Miller's reliance in this case is not disputed, and both sides acknowledge he relied on the services of Cyber MD. MHS asserts that they did not hold CCS's tool out as a part of their system, but the record, construed in favor of Miller, shows otherwise.

The holding-out element asks what the institution's conduct or omissions or digital signals would lead a reasonable patient to understand about who furnished the care, focusing on the principal's manifestations to the patient or the public. An agent's conduct cannot create apparent authority unless the principal's own words, actions, or omissions support the appearance of affiliation. *Eads v. Borman*, 351 Or. 729, 737, 277 P.3d 503, 509 (2012). *See also Sword v. NKC Hosps., Inc.*, 714 N.E.2d 142, 151 (Ind. 1999) ("general and implied" representations about the hospital's reputation in signage or advertising can satisfy the element of holding out). Courts do not require proof that the patient actually saw or remembered each signal for each

signal to be considered. The appearance created by the hospital matters more than the appearance remembered by the patient.

Courts evaluate holding out from the perspective of a reasonable patient, using a totality-of-circumstances framework. Individual signals or elements cannot be assessed in isolation. *D.C. v. Wesby*, 583 U.S. 48, 60–61 (2018); *United States v. Arvizu*, 534 U.S. 266, 274–75 (2002). All patient-facing manifestations must be weighed cumulatively, because the sum of the whole is often greater than its parts. Courts also recognize that hospitals communicate their manifestations through the branding they choose, the trade names they deploy, the logos and color schemes they apply, and the patient-facing channels through which care is delivered. *Petrovich v. Share Health Plan of Ill., Inc.*, 188 Ill. 2d at 32–37. Cumulatively, these signals define a reasonable patient’s understanding of the provider more than “contractual formalities” in “an increasingly complicated and opaque medical environment.” *Webster v. CDI Indiana, LLC*, 917 F.3d 574, 578 (7th Cir. 2019).

When a hospital presents a service through a unified brand, patients reasonably understand that service to be part of the hospital’s integrated system. Hospitals today are comprehensive providers of medical care, not merely as physical sites where independent clinicians practice. *Popovich v. Allina Health Sys.*, 946 N.W.2d 885, 897 (Minn. 2020) (hospitals are businesses who advertise to induce “the public to rely on them in their time of medical need.”). Modern hospitals foster a reputation for medical and technical expertise through coordinated advertising campaigns and signage. *Id.* Those public-facing signals naturally shape how patients

interpret care before they seek it, and while they seek it. Under this barrage of institutional indicia, it is not unreasonable for a patient to expect that care provided at the hospital is affiliated, associated, or in some way related to the hospital's authority.

Indicia of authority is not limited to visual signals. Spatial signals also weigh in favor of holding out. Courts acknowledge that geographic or digital proximity to a hospital's other services can be a meaningful indicator. *Pamperin v. Trinity Mem'l Hosp.*, 144 Wis. 2d 188, 210–12, 423 N.W.2d 848, 856–57 (1988). When independent clinicians work inside the hospital or deliver care through the same patient-facing channels the hospital uses for its own services, patients reasonably understand those clinicians to be part of the hospital's integrated service. *Id.*

Digital platforms for telehealth replicate the effect of spatial association. A patient who enters a single branded digital environment encounters the functional equivalent of a unified physical campus. Every design choice and every point of access is selected by the hospital, and patients see only what the hospital chooses to display. The hospital's name, visual identity, and navigational structure define the entire space in which care is delivered, making the absence of a competing provider identity a design choice, not an accident. Unlike a physical hospital, where incidental signage or unplanned visual cues may dilute institutional signals, a hospital-controlled digital platform is fully curated. This makes electronic presentation a particularly strong manifestation of apparent authority.

A hospital's continuous, comprehensive digital presentation is far more powerful than a single report bearing institutional letterhead, which courts have found sufficient to create a triable issue. *See Arrendale v. Am. Imaging & MRI, LLC*, 183 N.E.3d 1064, 1072–73 (Ind. 2022). When all diagnostic communications, reports, and clinical outputs appear under the hospital's domain name and visual identity, the reasonable patient experiences a seamless institutional environment that strongly signals unified care. Under these principles, MHS's conduct establishes holding out.

MHS cannot create such a strong, unified appearance through its portal and then insist that its private arrangement with the unnamed CCS defines what Miller should have reasonably understood. The Terms and pop-up must be assessed against the institutional identity MHS deliberately placed before him; they do not erase that identity by their mere existence. The reasonable patient standard does not require mind-readers or contract lawyers.

The following section explains why the Terms and pop-up did not establish, as a matter of law, that Miller knew CCS independently furnished the diagnostic care.

C. MHS's Disclosures Did Not Meaningfully Inform Miller That CCS Independently Furnished His Diagnostic Care

Meaningful notice requires comparing the weight of holding out against the information communicated to the patient and how a patient reasonably understands that information. Whether circumstances put the patient on notice is ordinarily a question of fact. *Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d 511, 523–26

(1993). Even clear communications may permit competing reasonable inferences based on their presentation to the patient. *Petrovich v. Share Health Plan of Illinois, Inc.*, 188 Ill. 2d 17, 36 (1999). (explaining that even if HMO did send a disclaimer of an agency relationship to the plaintiff within a “whole stack” of information, this fact would not conclusively resolve the claim). A signed or accessible disclosure is evidence, but it is not automatically dispositive. *Sword v. NKC Hospitals, Inc.*, 714 N.E.2d 142, 151–53 (Ind. 1999). The factfinder must consider what the disclosure said about the particular provider, how and when it was presented, and whether it dispelled the appearance created by the institution’s other patient-facing conduct.

The stronger the hospital’s presentation of care as its own, the clearer its notice of an independent provider must be to dispel that impression. A brief disclosure may carry more weight where the hospital has done little to suggest an agency relationship than where its presentation consistently points the other way. Here, MHS’s unified, institutional appearance was not easily undone. The Terms referred to software “developed by another company,” but did not name CCS or explain that the software acted as a non-human substitute for a diagnostic provider, which would at least support the inference that Cyber MD was being disclaimed. The pop-up did not cure the deficiency in clarity. It identified Cyber MD as AI and not a medical professional, but did not identify CCS as the non-MHS entity furnishing the diagnostic care. Without connecting the dots, the record does not support notice sufficient enough to end Miller’s claim as a matter of law. A reasonable juror can find that MHS failed to dispel the appearance it created.

1. Neither communication disclosed that CCS independently furnished Miller's diagnostic care

Knowing CCS is not part of MHS generally requires knowledge that CCS exists at all. MHS's seamless telehealth experience prohibited CCS's name or branding from ever being seen by a patient. It is hard to dispel something never identified. MHS's disclaimers similarly omit references to the independent software company. The Terms neither identify or distinguish CCS from Cyber MD. They also never explain that the disclaimed software actually provides care and does more than background processing or administrative tasks. Referring to software "developed by another company" identifies a product's origin without identifying the company furnishing diagnostic care through the portal. Also, stating that "software" is not an employee or agent does not resolve whether CCS, the company behind that software, was held out as acting for MHS, since the software could never be an agent in the first place. MHS only disclaimed an impossibility.

The second attempt at notice, the pop-up, was prominent, frequent, and more interactive. This certainly provided meaningful notice to a user that they were not talking to a human doctor with a medical license, but it did not dispel holding out. Again, MHS failed to name or disclaim CCS. It failed to state that CCS furnished the evaluations and interpretations, or describe CCS's relationship with MHS in order to dispel misconceptions arising from the interface. A patient could understand both that Cyber MD was AI and that MHS had selected and integrated that AI to deliver MHS's diagnostic service.

Notice is not meaningful if it fails to identify the provider to which it applies. In *Solorzano v. Magnani*, the patient was treated by Dr. Romano and signed a form repeatedly naming Romano Orthopaedics, LLC, as the practice providing care. The form still did not explain Dr. Romano's relationship with the hospital or expressly disclaim hospital employment. The court declined to assume that the patient understood that relationship from the practice's name and corporate designation, particularly given the hospital's website, referral materials, and medical complex. 2024 IL App (1st) 221169, ¶¶ 9–10, 25–30. MHS's Terms supplied less identifying information: they did not name the separate company at all.

The same difficulty arose in *Soule v. Blessing Hospital*. The signed hospital form listed radiologists, pathologists, and anesthesiologists as examples of providers whose services might come from outside entities. It also stated that other physicians' services might be supplied by Blessing Physician Services, Quincy Medical Group, or other groups. The providers at issue were a hospitalist and two neurologists, one of whom ultimately consulted patients by telemedicine. The court denied summary judgment because the form did not clearly establish that the patient knew those particular treating physicians were independent. No. 20-cv-1398, 2025 WL 2625337, at *1–5 (C.D. Ill. Sept. 11, 2025). These cases do not impose an invariable rule that a disclosure must name every contractor, but they demonstrate the granularity with which a court must ask whether this patient, receiving this care through this institutional presentation, was adequately informed of the provider's independent role. If any inference supports Miller, the question of notice must go to a jury.

2. The Terms' placement and Miller's encounter with them did not make the missing information clear

In addition to the specific language and overall thrust of the disclaimer, the circumstances surrounding its presentation are relevant to its adequacy. The pop-up was presented conspicuously, but it did not address agency. Conversely, MHS's first disclosure, while far more in depth, was "the antithesis of conspicuous." *Berman v. Freedom Fin. Network, LLC*.³⁰ F.4th 849, 856 (9th Cir. 2022) (tiny font that is smaller than the surrounding website elements and designed to "draw the user's attention away from the barely readable critical text"). Similarly to *Berman*, MHS's Terms and Conditions appeared approximately three-quarters down a 34-line, single-spaced, unformatted Terms page in a font noticeably smaller than the rest of the website. The page was accessible through a "Terms and Conditions" hyperlink that was optional to review, and the text beside the login did not indicate that the link contained information about who furnished diagnostic care. R. at 3–4.

Vague and internally inconsistent language does not foreclose an agency claim, especially when it is presented so inconspicuously. The *Berman* court reiterated that website users are entitled to assume that important provisions, including those that disclose the existence of proposed contractual terms, will be "prominently displayed, not buried in fine print." *Id.* Courts routinely hold that the onus of website owners to put users on notice of the terms to which they wish to bind consumers falls onto those with "complete control over the design of their websites," See *Sellers v. JustAnswer LLC*, 73 Cal.App.5th 444, 289 Cal. Rptr. 3d 1, 16 (2021); *Nguyen v. Barnes & Noble Inc.*, 763 F.3d 1171, 1179 (9th Cir. 2014). MHS chose to hide the disclaimer, and the

deficiencies in its actual language make it impossible for a reasonable patient to find it meaningful notice of independence.

MHS's disclosures did not and could not, as a matter of law, resolve the contested holding-out issue. The Terms referred to independent physicians and outside-developed software without identifying CCS; the pop-up disclosed AI status without addressing CCS's independence. Their wording and placement, considered alongside MHS's branded portal, permit a factfinder to conclude that Miller was never meaningfully informed that CCS independently furnished his diagnostic care.

D. Even If MHS's Disclosures Supplied Meaningful Notice, Their Terms Cannot Be Enforced as a Contractual Bar to Apparent-Agency Liability

The record supports findings of both procedural and substantive unconscionability based on the presentation and circumstances of the attempted waiver which would preclude enforcement. Courts recognize that procedural unfairness, substantive unfairness, or both may support nonenforcement of a contract. *Kinkel v. Cingular Wireless LLC*, 223 Ill. 2d 1, 21 (2006). Procedural unconscionability concerns how assent was obtained, whether a person had a meaningful opportunity to find and understand the challenged term, and a realistic choice about accepting it. *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 340 (2011). Relevant circumstances include bargaining positions, whether terms were explained or negotiable, their conspicuousness and comprehensibility, and practical alternatives. *Id.* Substantive unconscionability concerns what the term does: whether

its allocation of obligations, remedies, and risks is oppressive, unfairly surprising, or markedly one-sided. *Id.*

The trial court relied on *Hines v. National Entertainment Group, LLC*, 140 F.4th 322 (6th Cir. 2025), and *Payne v. Savannah College of Art & Design, Inc.*, 81 F.4th 1187 (11th Cir. 2023), in discussing bargaining power and choice. R. at 8–9. Those cases applied Ohio and Georgia law to employment arbitration agreements. In *Hines*, the employee signed the same single-page agreement three times, the arbitration clause occupied much of the page, bore an all-caps heading, and *expressly* identified the jury-trial right surrendered. 140 F.4th at 328–30. In *Payne*, the employee signed a handbook acknowledgment expressly referencing an arbitration policy that set out procedures and costs. 81 F.4th at 1189–90. Both opinions included scenarios where far more notice was afforded to the employee than to Miller. They are persuasive only to show that more fairly presented contracts are not unconscionable. Neither opinion permits an unstated wrongful death release to be inferred from tiny, unformatted language on a nondescript hyperlink.

Worse than the presentation of the supposed contract were the rights implicitly waived. Neither notice calls attention to a purported surrender of MHS's liability for wrongful death or medical malpractice. Despite having the onus to warn website users about the contract, MHS kept the important terms hidden in a Terms and Conditions hyperlink. MHS did not even call it a medical consent or negligence waiver, which would prompt a user to realize that the rights they are agreeing to waiving are more than data privacy or patient confidentiality. Expecting a reasonable

patient who is struggling to breathe to parse through legal implications of a dense, internally inconsistent waiver, without any signal as to the significant rights waived, is neither procedurally nor substantively fair. The court cannot enforce a consequence MHS never clearly stated and never clearly presented. *Kinkel* illustrates the point. The customer signed a standard cellular-service agreement with small-print terms on the back, but the court found a degree of procedural unfairness because the agreement did not disclose the cost she would bear to pursue arbitration, which was information material to the restriction on her remedy. 223 Ill. 2d at 22–27.

Miller had no meaningful choice to decline medical care offered through MHS. The trial court reasoned that Miller had other options for care because he could travel to Goshen, but this was impracticable. He was an elderly man struggling to breathe, located three hours away from any hospital. R. at 9. There were no meaningful alternatives, so Miller had no choice. And if he had no choice, there was no meaningful assent, so enforcement would be unconscionable.

Giving the Terms the effect MHS seeks imposes a one-sided transfer of fatal risk. The substantive question is not whether contracting with CCS or using AI to reach underserved patients was unfair, but whether MHS may present a diagnostic service exclusively under its brand, prevent CCS's identity from appearing on patient-facing pages, and then invoke general language about outside-developed software to shift the risk of delegated diagnostic negligence beyond MHS's apparent-agency responsibility. On MHS's reading, the institution receives the benefit of

presenting the service as its own while escaping the potential consequence of that presentation.

The Court should not give MHS's Terms a broader exculpatory effect than their words express and should not enforce that inferred effect without considering how it was presented and whose risks it shifts. In *Tunkl v. Regents of the University of California*, 60 Cal. 2d 92, 98–101 (1963), a hospital conditioned admission on an express release of liability for employee negligence. The California Supreme Court refused to enforce it, emphasizing the importance of medical services, standardized admission terms, unequal bargaining strength, and the patient's inability to bargain for protection against negligent care. *Id.* *Tunkl* featured an actual release and still failed. MHS had a hyper link. MHS asks for an even more consequential inference from language that never says Miller released MHS at all.

The Supreme Court's acknowledgement that there is no public policy against remedy for wrongful death reinforces this outcome. *Moragne v. States Marine Lines, Inc.*, 398 U.S. 375, 390–91 (1970). Resolving accountability gaps in common law can “reinforce and make more effectual well-understood primary obligations.” *Id.* at 403–04. When a hospital asks a court to give a patient-facing form the effect of shifting medical-negligence risk, the public interest, presentation, and the patient's practical alternatives matter.

The Court should reject MHS's contractual defense. No term expressly bars Miller's apparent-agency claim. If the Terms are nevertheless construed to impose

that result, their presentation, the practical constraints on Miller's choice, and the one-sided effect MHS asserts supply a substantial unconscionability objection. Either way, the Terms do not justify summary judgment for MHS.

E. Apparent-Agency Liability Preserves Access to AI-Assisted Care Without Excusing Institutions From Responsibility for Care They Present as Their Own

AI-assisted medical software can markedly help Shawnee. At the same time, allowing hospitals to outsource all malpractice liability to a third-party AI developer will lead to lower quality of care and more uncompensated victims of medical negligence. Courts should not assume that basic accountability makes AI-assisted care economically unworkable. Access should not come at so high a cost.

AI-assisted care is not just altruistic, it is very profitable. Autonomous AI care is reimbursed much higher for the same procedure done by a human, but does not require paying for costly provider salaries, benefits, sick time, insurance, or vacation. Two CPT codes for the same remote retinal-screening services illustrate just how much payment can differ between AI and human-interpreted workflows. The Medicare national average reimbursement for autonomous AI point-of-care diabetic retinal screening under CPT code 92229 is approximately \$57.12, nearly four times higher than the reimbursable rate of \$17.14 for human-interpreted remote diabetic retinal screening under CPT code 92227. *See* Centers for Medicare & Medicaid Services, Physician Fee Schedule Search, U.S. Dep't of Health & Hum. Servs., cms.gov. Expanding liability to cover accountable actors will not stop hospitals from

using a tool significantly cheaper and more efficient, it only ensures that they weigh risks with rewards.

Law and economics perspectives similarly suggest that extending the doctrine to modern delivery creates incentives for the hospital to provide high-quality health care, maximizing profit and minimizing risk. When hospitals incurred no liability for the actions of its independent-contractor physicians, they had little financial incentive to ensure that those physicians were more than minimally competent. Spreading the risk of malpractice liability prompts cost-conscious hospital administrators to do what they can to ensure quality care and the absolute minimum of malpractice awards. *Kashishian v. Port*, 167 Wis. 2d 24, 46–47 (1992) (quoting *Pamperin v. Trinity Memorial Hospital and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency*, 1990 WIS.L.REV. 1127, 1151 (1990)).

Concerns over potential insurance burdens to hospitals were not persuasive when apparent agency extended to doctors and is even less persuasive now. When Connecticut considered apparent-agency liability for physicians, the Connecticut Hospital Association warned that it would “transmute hospitals into excess insurers” for independent practitioners. *Cefaratti v. Aranow*, 321 Conn. 593, 611 (2016). The court swiftly rejected that objection, noting that a hospital held vicariously liable may have a claim for indemnification, insurers routinely cover complex enterprises, and the association identified no insurance crisis in jurisdictions that already recognized agency doctrine. *Id.* The insurance market is already developing products for AI-related errors and liability, including specialized coverage for AI vendors and

organizations that deploy AI. See Anat Lior, *The Evolving Landscape of AI Insurance: Empirical Insights into Risks and Policy Gaps*, 55 The Brief 18 (Fall 2025). The premise that AI risk is beyond the reach of underwriting and insurance is without merit.

Failing to extend agency law to AI-provided care distorts incentives for patient safety, fails to protect the doctrine's compensatory and deterrent functions, and insulates institutions from the harm they cause. Because a reasonable juror could find MHS vicariously liable for holding out CCS-furnished services, the analysis now turns to whether Miller's claims are timely under Shawnee's limitations and repose provisions.

II. CYBER MD'S LATENT ALGORITHMIC DEFECT SATISFIES THE EXCEPTION TO SHAWNEE'S FOUR YEAR PRODUCT LIABILITY REPOSE PERIOD BECAUSE IT WAS NOT DISCOVERABLE BY A REASONABLY PRUDENT SOFTWARE USER

Shawnee's four-year repose period or two-year limitations period in § 12-410 does not bar Mr. Miller's product liability claim because the algorithmic flaw that failed to diagnose Mr. Miller's lung cancer was not discoverable by an ordinary reasonably prudent person. Mr. Miller participated in four diagnostic and treatment sessions with Cyber MD between April 2018 and June 2021. In these sessions, Mr. Miller was misdiagnosed with asthma and was assured by Cyber MD's AI tool that

there was no malignancy in his scans. In October 2023, Mr. Miller suffered a spontaneous pneumothorax and was found to have Stage IV lung cancer.

Mr. Miller was treated by the 2017 version of Cyber MD, which consistently failed to identify his lung lesions. When Cyber MD was approved by the FDA and integrated into MHS's telehealth portal in 2017, the software had been trained on a dataset of 40,000 images and was found to have a 97% accuracy rate in classifying lung lesions. In October 2022, well after the patient-provider relationship between Mr. Miller and Cyber MD had ceased, CCS found that Cyber MD's diagnostic accuracy dropped to 85% when asked to identify lung lesions when evaluating the scans of patients with prior occupational asbestos exposure. Due to the severity of the issue, CCS retrained Cyber MD using 10,000 asbestos-exposed image sets and released a new version of the software to clients in December 2023.

Applying the repose or limitations periods to Miller's case without giving effect to the express statutory exceptions enacted by the Shawnee legislature would undermine the public policy goals underlying those provisions. The discovery rule is grounded in the principle that it would be unfair to allow a plaintiff's opportunity for relief to expire before they could reasonably discover an inherently undiscoverable defect. *William A. Graham Co. v. Haughey*, 646 F.3d 138, 150 (3d Cir. 2011). Allowing such unfair expiration of claims would create an incentive for defendants to conceal their tortious or otherwise illegal acts. *Id.*

A. Shawnee's Statutory Framework Does Not Require Complete Repose And Expressly Accommodates Latent-Defect Claims Like Mr. Miller's

The Shawnee legislature has established separate statutes of limitations and repose governing product liability claims, both of which Miller satisfies to maintain her lawsuit. These filing deadlines protect individuals from defending themselves from claims where basic facts may have become obscured by the passage of time. *United States v. Smith*, 373 F.3d 561, 563 (4th Cir. 2004). Statutes of repose begin to run on the date of “the last culpable act or omission of the defendant,” whereas statutes of limitations begin to run “when the cause of action accrues.” *Cal. Pub. Emps.’ Ret. Sys. v. ANZ Sec., Inc.*, 582 U.S. 497, 137 S. Ct. 2042 (2017). A statute of repose starts its clock at an event like manufacturing or sale, while a statute of limitations begins when an injury or harm occurs. Unlike statutes of limitations, statutes of repose are typically strict deadlines that cannot be extended, even in extraordinary circumstances. *CTS Corp. v. Waldburger*, 573 U.S. 1, 134 S. Ct. 2175 (2014). However, federal courts have permitted tolling where the legislature clearly indicates they did not intend the statute to provide complete repose, including where the statute contains an express exception. *ANZ Sec., Inc.*, 582 U.S. 497. Courts must give effect to the legislative policy choices embodied by such express statutory exceptions. *CTS Corp. v. Waldburger*, 573 U.S. 1, 10 (2014).

Under Shawnee statute, product liability claims are subject to a four-year statute of repose running from the date of the product’s first sale, lease, or delivery of possession to its initial user or consumer. Sn. Rev. Stat. §12-410(a). The Shawnee legislature created an express exception to this four-year period of repose under §12-

410(b)(3) to accommodate situations where the injury-causing aspect of the product, that existed at the time of delivery, was not discoverable by an ordinarily reasonably prudent person until more than four years after delivery, or when harm caused within four years of delivery did not manifest until after that period.

Such product liability claims must also satisfy Shawnee's limitations statutes governing personal injury and wrongful death. Sn. Rev. Stat. §12-402. Under § 12-402(a), an action for damages for personal injury caused by the wrongful act, neglect, or default of another must be commenced within two years after the cause of action accrues. The Shawnee legislature carved out an exception under the § 12-402(c) discovery rule, where when the cause of an injury is not immediately discoverable, the two-year personal injury limitation period does not begin to run until the claimant knows, or through reasonable diligence should have known, of the injury and the tortfeasor's identity. Additionally, § 12-402(b) provides that a wrongful death action must be commenced within two years of death.

B. Miller's Product Liability Claim Falls Within the Statute of Repose's Express Latent Defect Exception

Although Shawnee Revised Statutes § 12-410(a) generally bars product liability claims brought more than four years from a product's first sale, lease, or delivery to its initial consumer, § 12-410(b)(3) expressly exempts claims involving latent defects that could not have been discovered by a reasonably prudent person within the repose period or if the harm did not manifest until after that period. As the algorithmic flaw within Cyber MD's source code could not have been discovered

through ordinary use by Mr. Miller or his treating providers, Miller's claim falls squarely within § 12-410(b)(3). Federal courts have recognized that tolling a statute of repose is permissible only where the legislature clearly did not intend for the statute to provide complete repose. *ANZ Sec., Inc.*, 582 U.S. 497. An express exception written into the statute of repose demonstrates the requisite legislative intent to permit the alteration of the statutory period in certain circumstances. *Id* at 507.

Kansas's nearly identical product liability repose period statute and related case law provide guidance for interpreting Shawnee statute. The Kansas Product Liability Act creates an exception to its repose period when harm results from prolonged exposure to a defective product, where the product's injury-causing aspect was not discoverable by a reasonably prudent person until after the repose period, or where harm caused within that period does not manifest until afterward. Kan. Stat. Ann. § 60-3303(b)(2)(D). Although Kansas's product liability repose period is ten years, compared with Shawnee's four years, the difference in duration does not diminish the statute's interpretive value. Both states make explicit that a repose period should not prematurely bar claims arising from inherently undiscoverable defects before the resulting injury can reasonably be detected.

In *Ehrenfelt v. Janssen Pharm., Inc.*, the Sixth Circuit applied the latent defect exception under the Kansas Product Liability Act, demonstrating that a statute of repose should not bar a claim when critical information necessary to identify a product defect was unavailable to the consumer when the product entered the market. 737 F. App'x 262, 263 (6th Cir. 2018). In *Ehrenfelt*, the plaintiff sued a

pharmaceutical manufacturer for side effects allegedly caused by the drug Risperdal. When Ehrenfelt began taking Risperdal, the drug indicated that gynecomastia, the abnormal enlargement of breast tissue in males, was rare and had occurred in fewer than 0.1% of patients. *Ehrenfelt* at 264. After Ehrenfelt was diagnosed with gynecomastia and his Risperdal usage ceased, the drug's label was revised to state that gynecomastia was reported in 2.3% of patients in clinical trials. *Id.* Therefore, when Ehrenfelt and his treating providers used the drug, they lacked critical information concerning the magnitude of defect risk associated with its use.

Similarly, Miller and his treating provider, MHS through Cyber MD, lacked critical information about Cyber MD's algorithm's performance. At the time of Miller's care, Cyber MD represented that its algorithm was 97% accurate in classifying lung lesions, but the algorithm actually performed with only 85% accuracy when evaluating scans of patients with prior occupational asbestos exposure. As in *Ehrenfelt*, this limitation in the product's application to patients with Miller's medical history was unknown to both Miller and his treating providers and could not reasonably have been detected through ordinary use.

A central element of the latent defect exception in § 12-410(b)(3) is that the alleged defect is not discoverable at the time of delivery. That requirement is satisfied here because the alleged defect was concealed within Cyber MD's algorithm, which operated exclusively within CCS's proprietary cloud infrastructure. Nothing about Miller's treatment would have alerted him or his treating providers that Cyber MD's baseline algorithm could perform differently when applied to the lungs of patients

with prior occupational asbestos exposure. Even if Miller or his treating providers had suspected such a defect, they lacked access to the source code or the technical expertise necessary to examine the algorithm, leaving them with no reasonable means of discovering it.

Not only was the defect in the algorithm undiscoverable to Miller and his providers, but it was also unknown to CCS. It was not until Miller experienced a spontaneous pneumothorax in October 2023, resulting in the discovery of his Stage IV lung adenocarcinoma, that CCS hired oncology experts to perform a retrospective examination of Cyber MD's baseline algorithm. That review ultimately uncovered the alleged defect and led to the retraining of the Cyber MD algorithm in 2023. The fact that the defect could not be identified by CCS without hiring experts in the field further demonstrates that the defect was not discoverable by an ordinary, reasonably prudent person, satisfying § 12-410(b)(3).

C. Miller's Product Liability Claim Was Timely Filed Under The Personal Injury and Wrongful Death Limitations Period in § 12-402

The pivotal question in determining whether Miller's personal injury claim is timely under the statute of limitations is when the cause of action accrued. Under Shawnee § 12-402(a), the two-year limitations period begins to run upon accrual of the cause of action. Accordingly, for Miller's claim to be timely, the cause of action must have accrued on or after July 2022, two years before Miller filed suit. Typically, a cause of action for personal injury accrues when the actual injury occurs. *CTS Corp. v. Waldburger*, 573 U.S. 1, 8 (2014). However, the Shawnee legislature expressly

intended to preserve claims in circumstances like Miller's by protecting plaintiffs from losing their right to sue before they discover they have been injured. That policy is codified in the discovery rule in § 12-402(c). This provision is particularly important in cases involving latent or hidden harms, such as medical malpractice or toxic environmental exposure, where the resulting injury may not manifest until well after the underlying exposure or wrongful conduct occurs. *Id* at 4. By delaying accrual in appropriate circumstances, the § 12-402(c) discovery rule promotes fairness and prevents the injustice of barring a plaintiff's claim before the plaintiff could reasonably know that an injury had occurred.

Under the discovery rule in § 12-402(c), the two-year limitations period for Miller's claim did not begin to run until Mr. Miller discovered his injury, the failure of Cyber MD to detect his Stage IV lung cancer due to an algorithmic defect, following his spontaneous pneumothorax in October 2023. Prior to this medical incident, Miller reasonably believed that he was receiving sufficient care from Cyber MD for adult-onset asthma. This renders Miller's claim filed in July 2024 as timely.

Additionally, the Shawnee legislature requires wrongful death actions to be filed within two years of the decedent's death. Sn. Rev. Stat. § 12-402(b). Most circuit courts have consistently held that a wrongful death claim accrues upon the decedent's death, while the Ninth Circuit has permitted application of the discovery rule to extend the filing period. *Johnston v. United States*, 85 F.3d 217, 221 (5th Cir. 1996). Here, the claim accrued when Mr. Miller died in April 2024, and his wife filed suit in July 2024, well within the two-year limitations period.

III. PLAINTIFF'S MEDICAL MALPRACTICE CLAIM AGAINST MHS IS TIMELY UNDER A TOLLED STATUTORY REPOSE PERIOD UNDER THE CONTINUOUS TREATMENT DOCTRINE

Miller's medical malpractice claim is preserved under both the applicable statutes of limitation and repose by the Shawnee legislature's adoption of the continuous treatment doctrine. The Court must apply the continuous treatment doctrine to preserve Miller's medical malpractice claim Under Shawnee statute, medical malpractice claims are subject to a two-year discovery limitations period and a four-year absolute repose cap, which may be tolled under the continuous course of treatment exception. Sn. Rev. Stat. § 12-404. The continuous course of treatment doctrine tolls the start of the medical malpractice statutory period until a healthcare provider is no longer treating or monitoring an underlying disease, injury, or condition. See *Castillo v. Emergency Med. Assocs., P.A.*, 372 F.3d 643, 648 (4th Cir. 2004); *Med. Liab. Mut. Ins. Co. v. Alan Curtis LLC*, 519 F.3d 466 (8th Cir. 2008); *Miller v. United States*, 932 F.2d 301 (4th Cir. 1991).

Mr. Miller's interactions with Cyber MD satisfy the requirements for the continuous treatment doctrine because 1) Mr. Miller was undergoing a "course of treatment" between 2018 and 2021 for his adult-onset asthma; 2) the respiratory care Mr. Miller received is sufficiently related to the condition underlying his medical malpractice claim, Stage IV lung adenocarcinoma; and 3) annual visits within a treatment regimen are frequent enough to be considered continuous. Because the continuous treatment doctrine applies, the four-year repose period is tolled until Mr.

Miller's final visit with Cyber MD in June 2021. Accordingly, Miller's July 2024 filing falls within the repose period specified in § 12-404(b).

Miller's claim also satisfies Shawnee's two-year statute of limitations for medical malpractice claims under § 12-404(a). The statutory provision creates a timely filing deadline of two years of the date the claimant knew or, through reasonable diligence, should have known of the injury or death. Here, Mr. Miller's lung cancer was not discovered until his spontaneous pneumothorax in October 2023, and he died in April 2024. Miller filed suit in July 2024, just three months after her husband's death and well within the two-year limitations period.

The public policy rationale also weighs in favor of applying the continuous treatment doctrine to Miller's case. The doctrine protects patients by allowing them to continue receiving care without being forced to interrupt treatment to preserve a malpractice claim before the limitations period expires. It also ensures an avenue for recourse for those harmed by latent defects in artificial intelligence tools whose underlying functionality may be concealed within a "black box" and inaccessible to ordinary patients. Without the doctrine, Miller's medical malpractice claim against Cyber MD would have expired in April 2022, well before the severity of his respiratory illness became apparent in October 2023.

A. The Continuous Treatment Exception Applies Because MHS Continuously Treated Mr. Miller for the Condition Underlying His Malpractice Claim.

The continuous treatment doctrine is most commonly recognized in states through judicial precedent. Few states expressly codify the doctrine by statute, as Shawnee and New York do. The Shawnee legislature specified that the statutory repose period may be tolled “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. § 12-404(b). This language closely mirrors the statutory formulation of the continuous treatment doctrine in New York, which provides that the limitations period does not begin to run until the “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.

New York courts have articulated three requirements for the application of the continuous treatment doctrine: 1) the plaintiff sought and obtained a course of treatment from the defendant provider; 2) the treatment was for the same condition underlying the plaintiff’s medical malpractice claim; and 3) the treatment was continuous. *Ren v. Kuo*, No. 09-CV-1186, 2009 U.S. Dist. LEXIS 87921, at *13 (E.D.N.Y. Sep. 24, 2009). These requirements provide a useful framework for interpreting Shawnee’s analogous similar statutory language. Miller received continuous treatment from a single provider, MHS, through Cyber MD, for the same condition underlying his medical malpractice claim, thereby satisfying the requirements of the continuous treatment exception.

1. Mr. Miller Was Undergoing a Course of Treatment for Adult-Onset Asthma from a Single Provider, MHS, through Cyber MD

Several criteria must be met to satisfy the “course of treatment” requirement. First, the treatment must involve specific care directed toward the condition at issue; the mere continuation of a general doctor-patient relationship or the ongoing nature of a diagnosis is insufficient. Additionally, continuing efforts to diagnose a condition are insufficient to be considered a “course of treatment”. *Nykorchuck v. Henriques*, 78 N.Y.2d 255, 259, 573 N.Y.S.2d 434, 436, 577 N.E.2d 1026, 1027 (1991). Some courts require affirmative and ongoing conduct by the physician such as surgery, therapy, or the prescription of medications. *Gomez v. Katz*, 2009 NY Slip Op 1082, ¶ 3, 61 A.D.3d 108, 112, 874 N.Y.S.2d 161, 165 (App. Div.).

Mr. Miller was receiving affirmative, ongoing care from Cyber MD pursuant to an established treatment plan. In April 2018, when Mr. Miller sought care from MHS after experiencing shortness of breath, Cyber MD ordered scans, evaluated them, issued an adult-onset asthma diagnosis, referred Mr. Miller to a local practitioner for inhaler management, and committed to monitoring his condition through a mandatory annual follow-up imaging protocol. Mr. Miller then received annual diagnostic scans from Cyber MD in May 2019, May 2020, and June 2021 and assured Mr. Miller there was “zero evidence” of disease. These mobile scans were not intended to establish an initial diagnosis, as Cyber MD had already diagnosed Mr. Miller with asthma. Rather, these scans were intended to monitor the progression of respiratory abnormalities in light of his heightened respiratory risk after 35 years of heavy occupational asbestos exposure.

Second, the course of treatment must be provided by the same doctor or the same hospital for the relevant period. *Camire v. United States*, 535 F.2d 749, 750 (2d Cir. 1976). Mr. Miller received care solely from MHS through Cyber MD. The fact that Cyber MD referred Mr. Miller to a mobile radiology provider for CT scans and chest X-rays does not sever the continuity of his treatment. Diagnostic radiologists provide consultative services only and therefore critically depend on the guidance of their referring physicians. *Wilk v. Am. Med. Ass'n*, 671 F. Supp. 1465, 1503 (N.D. Ill. 1987), *aff'd*, 895 F.2d 352 (7th Cir. 1990).

Finally, a patient must have knowledge of the medical condition and have reason to expect ongoing treatment for it. *Martinelli v. Fusi*, 290 Conn. 347, 356, 963 A.2d 640, 645 (2009). Mr. Miller was aware of his high-risk respiratory status and asthma diagnosis, albeit inaccurate, and was under the impression that he was in an ongoing clinical management relationship with Cyber MD.

2. Cyber MD's Negligent Interactions with Mr. Miller All Targeted a Single Health Condition, Mr. Miller's High-Risk Respiratory Status from Occupational Asbestos Exposure

Multiple federal circuit courts have recognized that where there has been a course of treatment, "a claim may not accrue until the end of that course of treatment, if the treatment has been for the same illness or injury out of which the claim for medical malpractice arose." *Otto v. Nat'l Inst. of Health*, 815 F.2d 985, 988 (4th Cir. 1987). In *Nykorchuck v. Henriques*, the Court of Appeals of New York found that the continuous treatment doctrine did not apply where the plaintiff alleged that her physician failed to properly diagnose and monitor a lump in her right breast that was

brought to the physician's attention during treatment for endometriosis. The court found no connection between Nykorchuck's breast condition and her treatment for endometriosis, noting that the alleged course of treatment was unrelated to the breast condition underlying her malpractice claim. 78 N.Y.2d 255, 577 N.E.2d 1026 (1991).

Mr. Miller's case can be distinguished from *Nykorchuck v. Henriques*. Mr. Miller sought and received ongoing care from Cyber MD for his high-risk respiratory status following 35 years of heavy occupational asbestos exposure. After Mr. Miller presented with shortness of breath, Cyber MD diagnosed him with adult-onset asthma and continued to treat and monitor his respiratory condition, including through annual scans intended to detect developing abnormalities. Given the interconnected nature of respiratory conditions, this ongoing respiratory care was directly related to the condition underlying Mr. Miller's malpractice claim, Stage IV lung adenocarcinoma. Although Cyber MD initially diagnosed asthma rather than lung cancer, the absence of an initial diagnosis of the ultimate underlying condition does not preclude continuous treatment where the physician continued to treat and monitor symptoms that were ultimately associated with that condition. *Chestnut v. Bobb-McKoy*, 94 A.D.3d 659, 660, 943 N.Y.S.2d 461 (2012).

3. Cyber MD's Recommended Annual Check Ups Qualify as Continuous Care

Mr. Miller's annual visits with Cyber MD were part of an ongoing protocol to monitor his misdiagnosed asthma and detect any further decline in his respiratory health. The trial court characterized the care Mr. Miller received from Cyber MD each

year as “separate, discrete, and independent diagnostic screenings” rather than a continuous course of treatment. The appellate court rejected that narrow interpretation, concluding that Mr. Miller was participating in an annual cancer-surveillance protocol that constituted a single, continuous course of diagnostic monitoring for the same underlying health threat, rather than a series of unrelated encounters.

The Court of Appeals of New York has repeatedly noted that the continuous treatment doctrine does not cover “circumstances where a patient initiates return visits merely to have ... her condition checked.” Routine examinations of a patient who appears to be in good health or diagnostic examinations, even when conducted repeatedly over a period of time, are not “a course of treatment” *Massie v. Crawford*, 78 N.Y.2d 516, 520, 583 N.E.2d 935 (1991). However, the continuous treatment doctrine still applies if periodic diagnostic examinations are prescribed as part of ongoing care for a plaintiff's existing condition. *Ren v. Kuo*, No. 09-CV-1186, 2009 WL 3111721, at *4 (E.D.N.Y. Sept. 24, 2009).

In *Ren v. Kuo*, the defendant physician performed on the plaintiff regular Pap smears and other tests over a two-year period to monitor abnormal cell growth that was the precursor for cancer. When the atypical cell growth progressed to a point at which there was significant concern that it would develop into cancer, the defendant performed a hysterectomy. The District Court of the Eastern District of New York found that these diagnostic tests were part of an ongoing treatment protocol and that

a reasonable fact finder could find that the “continuous” element of the continuous treatment doctrine was satisfied.

Mr. Miller’s case is analogous to *Ren v. Kuo*. Mr. Miller, after 35 years of heavy occupational asbestos exposure, had an elevated risk of respiratory disease. In Mr. Miller’s initial visit, Cyber MD ordered scans, evaluated them, issued an adult-onset asthma diagnosis, referred Mr. Miller to a local practitioner for inhaler management, and committed to monitoring his condition through annual follow-up diagnostic imaging tests. Cyber MD initiated a long-term treatment protocol with Cyber MD in annual increments, thereby satisfying the “continuous” element of the continuous treatment doctrine.

B. Applying the Continuous Treatment Doctrine to AI-Based Care Ensures Patients Can Hold Healthcare Providers Accountable Without Jeopardizing Their Care

The court must rule in favor of Miller to further judicial and legislative intent in adopting the continuous treatment doctrine and to ensure that patients can seek accountability for algorithmic errors by artificial intelligence tools. Few relationships rely on a greater degree of trust and confidence than the one between a patient and their physician. *United States v. Solakyan*, 119 F.4th 575, 585 (9th Cir. 2024), cert. denied, 146 S. Ct. 91, 223 L. Ed. 2d 8 (2025). Recognizing the sensitivities inherent in the physician-patient relationship, courts and legislatures have created the continuous treatment doctrine to preserve a patient’s ability to pursue a medical malpractice claim after the ordinary limitations period would otherwise expire.

This doctrine rests on several concerns. First, the New York Court of Appeals noted that it would be absurd to expect a patient to interrupt treatment with a suit against their providers while under their continuing care. *Ulrich v. Veterans Admin. Hosp.*, 853 F.2d 1078, 1081 (2d Cir. 1988). Second, the doctrine accounts for the possibility that a negligent physician may conceal information about a patient's injury and prevent them from initiating a malpractice claim before the limitations period expires. *Ashley v. United States*, 413 F.2d 490, 493 (9th Cir. 1969). Third, the confidential relationship between a patient and their provider might inhibit the patient from questioning the care they are receiving. *Brown v. United States*, 353 F.2d 578, 580 (9th Cir. 1965). If the continuous course of treatment doctrine does not apply, Miller's claim would have been time-barred by the Shawnee statutes of repose in April 2022, four years after Cyber MD's initial diagnostic act or omission in applying that algorithm to Mr. Miller in April 2018. However, Mr. Miller had no indication that his undiagnosed lung cancer was worsening until he suffered a spontaneous pneumothorax in October 2023. Without application of the continuous course of treatment doctrine, the Shawnee statutes of repose would extinguish Miller's claim before he had any reason to discover his injury or Cyber MD's negligence.

Finally, the doctrine salvages causes of action which otherwise would be time-barred because of the latent nature of the injury. *Barrella v. Richmond Mem'l Hosp.*, 88 A.D.2d 379, 384, 453 N.Y.S.2d 444, 448 (1982). This concern is heightened where artificial intelligence tools are involved, as these technologies often operate as "black

boxes” where the internal mechanisms are not readily available to patients and providers. Nithesh Naik, *Legal and Ethical Consideration in Artificial Intelligence in Healthcare: Who Takes Responsibility?*, Front Surg. (2022). Errors in artificial intelligence technology, such as the latent defect in Cyber MD’s algorithm, may be difficult to detect because patients typically lack the technical expertise necessary to identify them. The continuous treatment doctrine addresses this problem by tolling the statute of limitations in medical malpractice claims while the patient remains under the artificial intelligence tool’s care, allowing the patient an opportunity to discover the injury and its connection to the tool’s negligence.