IN THE SUPREME COURT OF MISSOURI

SHARON NEWTON and BRIAN NEWTON,	)	
	)	**Supreme Court No. SC97687**
Plaintiffs/Appellants,	)	
	)	**Circuit Court No. 16SL-CC02003**
vs.	)	
	)	**Circuit Court for St. Louis County**
MERCY CLINIC EAST COMMUNITIES, dba MERCY CLINIC OB/GYN, and CHRISTINA KAY MEDDOWS-JACKSON, MD,	)	***Div. 12 Hon. Stanley J. Wallach***
Defendants/Respondents.	)	

PLAINTIFFS/APPELLANTS' CORRECTED SUBSTITUTE REPLY BRIEF

Respectfully Submitted,

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REPLY TO REPONDENTS' JURISDICTIONAL STATMENT

Appellants agree to Respondents' Jurisdictional Statement and state that this Substitute Reply Brief is timely pursuant to Rule 83.08 as it is being filed on 5/22/19 which is within 50 days of this Court's Order of Transfer dated 4/2/19.

REPLY TO RESPONDENTS' STATEMENT OF FACTS

Plaintiffs/Appellants Sharon and Brian Newton (Sharon and Brian) object to Respondents Mercy Clinic East Communities dba Mercy Clinic OB/GYN and Christina Kay Meddows-Jackson, MD's (Respondents') presentation of the facts in the light most favorable to Respondents' positions. Respondents' Statement of Facts is contrary to the requirement that on appeal from summary judgment, evidence in the record is viewed in the light most favorable to the party against whom judgment was entered, along with the benefit of all reasonable inferences. *Brentwood Glass Co., Inc. v. Pal's Glass Serv., Inc.*, 499 S.W.3d 296, 300 (Mo. 2016). The timeline, when viewed in the light most favorable to Appellants, is as follows:

7/5/12: Sharon presented to Respondents for the first time for treatment of an ovarian cyst. LF#42, p.1.

7/10/12: Respondents operated on Sharon to remove the ovarian cyst. LF#42, p.1. The operation involved opening Sharon's abdominal cavity and placing instruments and sponges inside it, manipulating her bowels, examining her ovaries, manipulating the right ovary and removing a cyst on the right ovary. LF#49, p.4.

7/16/12-8/1/12: Sharon saw Respondents for three post-operative care visits on 7/16/12, 7/24/12, and 8/1/12. LF#42, p.2. At these visits Sharon was showing signs and

symptoms of an infection that was from Respondents' 7/10/12 surgery. LF#48, p.31. On 7/16/12, Respondents knew Sharon had drainage from her incision site and fever. LF#42, p.2. Respondents did not culture the wound until 7/24/12, and did not change the antibiotics in response to the culture until 8/1/12. *Id.* The first amended petition alleges that during these visits Respondents negligently treated Sharon's post-operative infection by failing to perform timely blood testing, failing to timely culture the wound and failing to timely order the correct antibiotics and that as a result, Sharon's intra-abdominal area was scarred by infection resulting in the loss of her ability to have children without In Vitro Fertilization (IVF).[1] LF#31, ¶¶3, 4. Appellants' expert testified that the damage was done to Sharon's fallopian tube in 2012. LF#44.

8/15/12-8/17/12: Respondents admitted Sharon to Mercy Hospital, first sought consultation with an infectious disease specialist, and treated Sharon for a pelvic abscess. LF#42, pp. 2-3; LF#49, pp. 8-11. Appellants make no allegation of negligence concerning any treatment during this admission. LF#31. Appellants' expert testified the damage to Ms. Newton's fallopian tubes was sustained in 2012. LF#44. From the allegations of the First Amended Petition and the submitted testimony of Appellants' expert, it is clear that Sharon and Brian are claiming that Respondents' negligence delayed the appropriate treatment of the infection so that by time of the admission and consultation with the infectious disease doctor on 8/15/12, the treatment was too late to avoid the resulting damage to the Sharon's fallopian tubes and her inability to conceive

[1] The petition says "inability to have children" but depositions made clear the injuries include the inability to conceive with intercourse due to the damaged fallopian tubes. Sharon and Brian are able to have children using in-vitro fertilization.

through intercourse. LF#31; LF#44.

9/11/12: Respondents saw Sharon in the office for follow-up of the post-operative infection, including the pelvic abscess, and released her to return to work. LF#49, pp. 26-27. Respondents' diagnoses included pelvic abscess. LF#49, p. 27. Respondent Meddows-Jackson testified that as of this visit she thought the care for the ovarian cyst and the infection were complete. LF#42, p.4.

10/2012: Sharon last saw the infectious disease specialist for treatment of her post-operative wound infection. LF#42, p.4.

2/5/13: Sharon saw Respondent Meddows-Jackson in follow-up regarding the cyst removal and was treated for seepage from the incision. LF#49, pp.28-29. This was Sharon's last visit to Respondent Meddows-Jackson until 1/29/15. LF#43; LF#49.

5/23/13 and 6/18/13: Medical records indicate that Sharon returned to Respondent Mercy Clinic for a follow-up on her wound infection.LF#49, pp.29-30. On 6/18/13, the wound was "well healed and no longer open." LF#49, p. 30. Respondents testified at deposition that between 5/23/13, and 1/29/15, Sharon had not had any contact with the office, nor had any appointments scheduled and that in 2014, Respondents did not expect Sharon to return for infection related care, although they admitted Sharon might have said she would return for well woman exam. LF #48, pp.150-151.

1/29/15: Sharon presented to Respondent Meddows-Jackson at Respondent Mercy Clinic. LF#49, pp.31-35. The medical record states that she "presents for annual routine Pap and checkup" and "she is not currently having problems," "would like to get pregnant," and "would like to proceed with testing." LF#49, pp. 31, 34. At this visit Respondent

Meddows-Jackson ordered fertility testing. *Id, at 31.* At her deposition, Sharon testified that at this visit she "expressed that my husband and I had tried to get pregnant and were having trouble, and she [Respondent Meddows-Jackson] ordered an HSG [infertility test], and at that time they found my tubes were—the liquid that they put in didn't go through." LF#47, p. 45. Appellants' expert testified that Sharon's infection was over and done being treated in 2012. LF#44. Sharon testified that by 1/29/15, she and Brian had been trying to get pregnant since mid to late 2013. LF#47, p.38. Respondents, at their deposition, testified that fallopian tube blockage like Sharon's is commonly caused by intra-abdominal infections and that it was possible Sharon's tube damage was from the infection in 2012. LF#48, pp. 12, 19.

4/28/15: Sharon saw Respondents for fallopian tube damage from the "previous florid abdominal infection." LF#43, p.7. At this point, Respondents advised that Sharon undergo a tube blockage procedure ("Essure") in the damaged fallopian tube to minimize the risk of ectopic pregnancy, which in her case, because of scarring, would carry a much higher than normal risk of morbidity. LF#43, p.7.

5/11/15: Sharon presented to Respondents for follow-up of the fallopian tube damage. LF#43, p.1. Respondents again recommended the Essure procedure to prevent a life-threatening ectopic pregnancy. LF#43, p.4. Respondents stated in their records on 5/11/15, that "both of her fallopian tubes are abnormal from the pelvic abscess." LF#43, p.1.

6/9/15: Sharon presented to Respondents for follow-up of the Essure procedure. LF#49, p. 36. Sharon declined IVF at that time due to cost. *Id.* This was Sharon's last visit with

Respondents. LF#49; LF#43.

6/1/16: Sharon and Brian filed suit against Respondents.

REPLY ARGUMENT

I. THE SUMMARY JUDGMENT RECORD RAISED GENUINE ISSUES OF MATERIAL FACT AS TO THE APPLICATION OF THE CONTINUING CARE DOCTRINE.

Reply to Respondents' Introduction

In their introduction and throughout their brief Respondents state that when Newton returned on 1/29/15, it was for a "new condition" (*see* pp.13, 16, 21, 22, 40) that "may be" (*see* pp. 8, 9, 16, 21, 40) related to Respondents' earlier care. The notion that the infertility was a new condition (as opposed to a new diagnosis) is a factual contention that was not contained in Respondents' Statement of Uncontroverted Fact, or Appellants' Response. LF#42. Further, an assumption that the infertility was a new condition, or that it was only possibly-related to the infection, fails to afford Appellants the benefit of all reasonable inferences from the facts. When viewing the facts in Appellants' favor as mandated by Missouri law, it must be taken as true that Sharon returned to Respondents on 1/29/15 – within two years of Respondents' last treatment for the infection – complaining of symptoms (infertility) that Respondent knew or should have known were from the infection in 2012. Finally, contrary to Respondents' repeated assertions, Appellants are not and have never based their statute of limitations argument on the discovery of the fallopian tube damage. Appellants' position would be the same if the

fallopian tube damage was known and treated on 2/5/13, and next treated on 1/29/15. Appellants are basing their statute of limitations argument on the evidence that Sharon returned for and received infection-related medical care within 2 years of prior infection-related medical care under circumstances in which Respondents knew or should have known that further medical care was required to treat the results of their earlier negligent management of the infection. As shown below, these facts are sufficient for the statute of limitations to be tolled while Appellants were under the continuing care of Respondents.

Reply to Standard of Review

Respondents correctly state that the standard of review is a *de novo* review by this Court to determine whether Respondents established their right to summary judgment in the trial court as a matter of law. Respondents, however, fail to note and fail to apply the requirement the evidence be viewed in the light most favorable to Appellants while giving Appellants the benefit of all reasonable inferences from the evidence. *Brentwood Glass Co., Inc. v. Pal's Glass Serv., Inc.,* 499 S.W.3d 296, 300 (Mo. 2016).

IA. The Summary Judgment Record Shows Facts That Support The Application Of The Continuing Care Doctrine.

Respondents suggest (p. 13) that Appellants are claiming "a new condition discovered years later that was purportedly related to the initial course of treatment." Again, this assertion that the infertility was a new condition (as opposed to a new diagnosis) is a factual contention that was not contained in Respondents' Statement of Uncontroverted Fact, or Appellants Response. LF#42. Further, Appellants' evidence indicates that the fallopian tube damage was not new, it happened in 2012, but was not

diagnosed until 2015. LF#44. Secondly, the relationship of the injury to Respondents' earlier medical care for infection is not "purported" but was acknowledged by Respondents in their medical records. LF#43, p.1.

Appellants agree with Respondents' general discussion of *Thatcher v. De Tar,* 173 S.W.2d 760, 761 (Mo. 1943), *Weiss v. Rojanasathit*, 975 S.W.2d 113, 119-20 (Mo. banc 1998) and *Montgomery v. S. Cty. Radiologists, Inc.*, 49 S.W.3d 191, 193 (Mo. 2001) on page 14 of their brief. The suggestion, however, that the doctor's and patient's subjective (and erroneous) belief at one point that care was no longer required somehow terminates the physician-patient relationship, or the continuing nature of the care when the patient returns, is not found in these or any Missouri cases. Respondents' statement that the exception is intended to apply "only to extent that further care and treatment should be anticipated proactively" (p. 16) is made without citation to any authority.

If it were true that the parties' prior subjective, but erroneous, belief that no further treatment is required somehow operates to cut off the application of the continuing care doctrine to return visits, then *Thatcher,* 173 S.W.2d 760, itself would have been decided differently. After all in *Thatcher,* it would have been impossible for the patient or the defendant surgeon to have anticipated the need for continuing treatment from a needle being left in the abdomen since the needle was not discovered for years, and then by a different doctor. *Id.*

Most malpractice cases involve an unexpected outcome. If things turned out as expected there would be no injury and no case. Cutting off the application of the continuing care doctrine because there was a time the patient and doctor thought

everything was fine would make the doctrine largely meaningless, and make the determination of when the statute of limitations ran dependent on discovery of the subjective belief of the doctor and patient at the crucial times. Under Respondents' interpretation, patients and their lawyers could not know when the limitations period expires without knowing, or perhaps without having a jury determine, the subjective beliefs of the health care providers.

Rather than focusing on what the patient and doctor thought before the problems became apparent, *Weiss,* 975 S.W.2d 113, focuses on what the physician knew or should have known at the time the patient comes back. As this Court stated: "Absent good cause to the contrary, where the doctor knows or should know that a condition exists that requires further medical attention to prevent injurious consequences, the doctor must render such attention or must see to it that some other competent person does so until termination of the physician-patient relationship…." *Id.* at 120 (citations omitted).

The factual record submitted by Appellants in opposition to summary judgment includes deposition testimony by Respondents that the kind of fallopian tube damage Sharon sustained is most commonly caused by intra-abdominal infections and could have been from the 2012 intra-abdominal infection. LF#48, pp. 12, 19. Reviewing this evidence in the light most favorable to Appellants and giving Appellants the benefit of all reasonable inferences, *Brentwood Glass Co., Inc. v. Pal's Glass Serv., Inc.,* 499 S.W.3d 296, 300 (Mo. 2016), this evidence supports a conclusion that when Sharon came back complaining of an inability to get pregnant in on 1/29/15, Respondents, having treated Sharon for an intra-abdominal infection in 2012 & 2013, knew or should have known that

the infection could have caused her problems getting pregnant. It is also reasonable to infer that, under these circumstances, Respondents knew or she have known that Sharon, a woman who was actively trying to get pregnant, could require continuing medical care including a need for Essure in order to prevent a life-threatening ectopic pregnancy. Respondents therefore had a duty of continued care under *Weiss*, 975 S.W.2d 113, at the 1/29 and other 2015 visits.

Respondents also seem to suggest that the tolling of the limitations period until "the treatment of plaintiff's ailment by the defendant ceases" in *Thatcher,* 173 S.W.2d 760, means that the continuing care doctrine does not apply when Sharon came back on 1/29/15, because the visit did not have enough of a relationship to the infection. This argument, again, does not accept as true the evidence submitted by Appellants in opposition to summary judgment, or give Appellants the benefit of all reasonable inferences from the evidence.

According to Appellants' evidence, Sharon came back before two years from Respondents' last treatment for the infection, complaining of symptoms which Respondent knew could be caused by the infection, and for which Respondents ordered the test that showed the fallopian tube damage and recommended an Essure procedure to prevent a life-threatening ectopic pregnancy. Respondents fail to explain how this is not treatment for the "ailment" under *Thatcher.* It cannot be reasonably suggested that treatment for injuries as result of a doctor's negligence is not treatment of the "ailment." A number of cases, including *Thatcher*, so hold. *Thatcher v. DeTar*, 173 S.W.2d 760, 762 (Mo. 1943); *Brickey v. Concerned Care of Midwest, Inc.*, 988 S.W.2d 592, 597-598

(Mo. App. E.D. 1999)(the continuing care exception provides that the statute begins to run when the defendant ceases to treat the injury caused by the alleged act of negligence or neglect*); Dunagan By & Through Dunagan v. Shalom Geriatric Ctr.,* 967 S.W.2d 285, 289 (Mo. App. W.D. 1998); *Hill v. Klontz*, 909 S.W.2d 725, 726 (Mo. App. S.D. 1995). While it is true that neither *Montgomery,* 49 S.W.3d 191, nor *Weiss*, 975 S.W.2d 113, involved a claim of continuing care based on treatment of the injury, there is nothing in the cases that precludes it.

Montgomery, 49 S.W.3d 191, claimed continuing care against a radiology corporation based on a failure to diagnose a lung mass by a series of different employees. *Weiss*, 975 S.W.2d 113, claimed continuing care based on a continuing failure to tell the patient of an abnormal pap smear. *Montgomery*, found the statute tolled for the corporation by the continuing care of their employed radiologists, but found no tolling as to individual radiologists who had not seen the patient in the two years before filing suit. *Weiss* found that the plaintiff's failure to follow her doctor's instructions to come back precluded tolling, a fact not present here. Neither case says that continued treatment of an injury cannot toll the statute of limitations, nor do they discuss the issue. *Montgomery*, 49 S.W.3d 191; *Weiss*, 975 S.W.2d 113. Respondents' argument that the holding in *Montgomery* with regard to the individual radiologists somehow supports the denial of continuing care tolling in this case is misplaced. *Montgomery* held that there could be no continuing care tolling as to individual radiologists who had not seen the patient within two years of filing suit. As to the individual radiologists, the difference between *Montgomery* and the present case, of course, is that Sharon went back to

Respondents before two years since her last visit and within two years of filing suit.

IB. The Cases Relied On By Appellants Support The Application Of The Continuing Care Doctrine.

As previously discussed, Respondents present the 1/29/15, visit in the light most favorable to them describing it as presenting a "new condition that may be related to prior care" but the notion that the infertility was a new condition (as opposed to a new diagnosis) is a factual contention that was not contained in Respondents' Statement of Uncontroverted Fact, or Appellants' Response. LF#42. Giving Appellants the required beneficial construction of the evidence, the 1/29/15, visit was the patient coming back to get medical treatment for a condition that Respondents knew or should have known was related to the prior infection and their care of it.

Respondents also incorrectly argue that *Weiss,* 975 S.W.2d at 120, focuses on the doctor's knowledge prospectively from the time of the last visit before the patient returned, as opposed to the doctor's knowledge at the time of that return. "Absent good cause to the contrary, where the doctor knows or should know that a condition exists that requires further medical attention to prevent injurious consequences, the doctor must render such attention or must see to it that some other competent person does so until termination of the physician-patient relationship...." *Id. (citations omitted).* Appellants suggest that Respondent undertook continuing treatment of the consequences of the infection on 1/29/15, because Respondents knew, as they acknowledged in their deposition, that fallopian tube damage commonly results from infection and infection

could be the cause of the infertility Sharon presented with, and which Respondents tested for, on 1/29/15. The recommendation regarding the Essure procedure was also necessary medical care to prevent a life-threatening ectopic pregnancy which also resulted from Respondents' negligence. This is the precisely the circumstance, under *Weiss,* to which the continuing care doctrine applies.

Appellants agree with Respondents' general discussion of foreseeability as the touchstone of duty. Appellants, however, would point out that Respondents, knowing that fallopian tubes can be made dysfunctional by a pelvic infection, and knowing that Sharon had a pelvic infection, knew or could have known in 2012 or 2013 that Sharon's fallopian tubes may have been damaged. Respondents certainly knew, when Sharon returned on 1/29/15, unable to get pregnant after over a year of trying, that the issue could be from the infection. By 5/11/15, Respondents were writing in their medical records that "both of her fallopian tubes are abnormal from her pelvic abscess." LF#43, p.1.

Respondents' attempt to distinguish *Thatcher,* 173 S.W.2d 760, by saying that in *Thatcher,* unlike here, a surgeon unknowingly left a needle in the patient's abdomen and after that, unlike here, the patient continued to complain of the same condition – abdominal pain –before the appendectomy and during the continued care. Respondents argue that these facts limit *Thatcher's* application to situations where the continuing care involves treatment of the exact same symptoms the patient originally presented with, regardless of whether those symptoms are related to or caused by the doctors' earlier care. The argument is apparently that if Sharon had returned with abdominal pain like she had when she first went to Respondents, then *Thatcher* would apply. But, so the

argument goes, continuing care does not apply when Sharon returned with infertility problems even though those problems resulted from Respondents' earlier treatment of the infection simply because infertility was not a symptom at the first visit.

Respondents also attempt to distinguish *Thatcher,* 173 S.W.2d 760, because the Court there noted a continuous failure to diagnose the needle at all visits, and point out that there is no allegation of continuing negligence at the 2015 visits here. Again, Respondents are trying to graft requirements onto the continuing care doctrine that do not exist. It should first be noted that despite Respondents' implication that the post-operative visits in *Thatcher* found to constitute continuing care were frequent, there is no description of the frequency of these visits in the Opinion, only that they occurred between 1937-1939. Surely if the Missouri Supreme Court in *Thatcher*, 173 S.W.2d 760 (Mo. 1943), and later in *Weiss*, 975 S.W.2d 113, intended to require that the continuing care involve the same symptoms as the first visit, as well continuing negligence, the Court would have said so. Instead, in *Thatcher*, the Court for the first time applied the doctrine by saying 'Thus, it has been held that the statute does not commence running until treatment by the physician or surgeon has terminated, where the treatment is continuing and of such nature as to charge the medical man with the duty of continuing care and treatment which is essential to recovery until the relation ceases." *Thatcher,* 173 S.W.2d 760 (Mo. 1943).

In *Weiss*, 975 S.W.2d 113, 120 (Mo. banc 1998), 45 years later, this Court defined the doctor's obligation of continuing care as when, "Absent good cause to the contrary, where the doctor knows or should know that a condition exists that requires further

medical attention to prevent injurious consequences, the doctor must render such attention or must see to it that some other competent person does so until termination of the physician-patient relationship…." What this Court's descriptions of the continuing care doctrine does not contain is any requirement of an identity between the symptoms at the first visit and symptoms present during the continuing care, or any requirement of continuing negligence. *Id.* Rather, this and the appellate courts' opinions have made it clear that the duty to continue to treat is broader than the specific facts of any case, and applies to return visits that are related to the earlier care.

Respondents similarly suggest that *Montgomery*, 49 S.W.3d 191, contains a requirement that for continuing care to apply, the patient must return with exact same symptom as on their first visit. Again, Respondents are picking out factual differences and calling them requirements. While it is true that in *Montgomery* this Court applied the continuing care doctrine in a situation where the return visits were for the same symptom as the first visit, there is nothing in the opinion that requires such an identity of symptoms. *Id.*

This suggestion that the continuing care must be for the same symptom for which the patient originally presented is a another version of Respondents' position that continuing care cannot be for an injury from the treatment of the original condition but must be for the original condition itself. A number of cases, however, including *Thatcher*, hold that continuing treatment of an injury is sufficient. *Thatcher v. DeTar*, 173 S.W.2d 760, 762 (Mo. 1943); *Brickey v. Concerned Care of Midwest, Inc.*, 988 S.W.2d 592, 597-598 (Mo. App. E.D. 1999)(the continuing care exception provides that the

statute begins to run when the defendant ceases to treat the injury caused by the alleged act of negligence or neglect); *Dunagan By & Through Dunagan v. Shalom Geriatric Ctr.*, 967 S.W.2d 285, 289 (Mo. App. W.D. 1998); *Hill v. Klontz*, 909 S.W.2d 725, 726 (Mo. App. S.D. 1995). In fact in *Montgomery*, the Court stated: "The necessity that gives rise to the relationship is the patient's ailment or condition. 'When the physician takes charge of a case and is employed to attend a patient, the relation of physician and patient continues until ended by the consent of the parties, or revoked by the dismissal of the physician, or until his services are no longer needed.'" *Montgomery*, 49 S.W.3d at 194, *citing Cazzell v. Schofield*, 8 S.W.2d 580, 587 (1928) and *Weiss*, 975 S.W.2d at 120. The cessation of the relationship is thus determined by the cessation of the need for the services related to the ailment or condition, defined by the case law as including the injuries resulting from the negligence. Respondents' suggestion that *Montgomery's* refusal to apply continuing care to an individual radiologist who had not seen the patient at all within two years of filing, means that Respondents, who did see their patient within two years of filing for an issue related to their earlier care, cannot be charged with a continuing duty of care is not a reasonable interpretation and shows the strained nature of Respondents' arguments.

In their discussion of *Shaw v Clough*, 597 S.W.2d 212 (Mo.App. W.D. 1980), Respondents disregard the fact that continuing care extended to the patient's visit for care-related symptoms in his thigh, even though he originally presented for neck pain. Respondents distinguish the case by saying that in *Shaw* the post-operative complications appeared immediately, and the continuing care for them was immediate, and that, when

Sharon came back it was more of an "indirect injury." Immaterial factual differences from Sharon's situation does not equate to establishing narrow legal requirements which prevent application of the continuing care doctrine. Sharon's infertility did not show immediately because she had to try for awhile to get pregnant before she knew she couldn't. The damage to Sharon's fallopian tubes from an abdominal infection after abdominal surgery are no more indirect than *Shaw's* thigh pain following his neck surgery. *Shaw*, 597 S.W.2d 212. The lesson of *Shaw* is that the continuing care doctrine "stems primarily from the nature of the relationship and that the obligation and treatment be considered as a "whole" until it ceases and the obligations arising therefrom should not be conceptually fragmented." *Id.* at 215–16. Contrary to this instruction, Respondents' brief and summary judgment pleadings fragment Respondents' treatment into many different parts: Treatment for the ovarian cyst is different from treatment for the abdomen, or different from treatment for the fallopian tubes, or different from treatment for the incision; Treatment for the infection in the incision is different from the treatment for the infection inside the abdomen, treatment for abdominal pain is different from treatment for infertility from an abdominal infection.

Similarly, Respondents assert that *Adams v. Lowe*, 949 S.W.2d 109 (Mo.App. E.D. 1997), includes a requirement that the return visits had to have been pre-arranged and must concern the same symptoms as at the first visit. Although those facts are in the Court's initial overview of the case, there is nothing in the opinion that establishes those facts as requirements for other cases. *Id.* In fact, neither the prearranged nature of the

return appointment nor the similarity of symptoms to the first appointment were mentioned by the Court in the facts it found determinative. As stated by the Court:

> In the case before us, patient returned to see dentist seven months after the root canal therapy. In making the follow-up appointment, he notified the office staff that he was having continual problems. He continued to express these complaints at the actual visit. After dentist discussed these complaints with the dental assistant, he told patient that there were "still some problems," and that he "may have to open up one or both of [the] teeth and get back in there." Another appointment was then made for patient to return.
> Assuming these facts to be true, dentist had not terminated his treatment of patient's root canal problem. Rather, dentist continued to treat this problem at least until November 2, 1993. Thus, the petition filed in May 1995 would be timely.

Id. at 111. This quote shows that what was determinative was that within two years of filing, the patient had been back to the dentist for problems with injuries resulting from the negligence and continued treatment was undertaken. These facts are also present in Sharon's treatment: She went back on 1/29/15, for a continued inability to get pregnant as a result of Respondents' earlier negligence and the doctors undertook treatment of that problem.

Norman v. Lehman, 347 S.W.3d 611 (Mo.App. E.D. 2011), is discussed by Respondents as support for a requirement that for a doctor visit to count as continuing care, the doctor must be aware that the original condition for which the patient presented had not resolved, and both the doctor and the patient must expect future care for the unresolved, original condition. No such requirement is expressed in the opinion. *Id.* Respondents similarly suggest *Cole v. Ferrell-Duncan Clinic*, 185 S.W.3d 740 (Mo.App. S.D. 2006), mandates that for Sharon, Respondents' care in 2012 and 2013 must be

considered separate from Respondents care from in 2015 based on minor differences from the facts in the case law and Sharon's treatment. The lesson of *Cole* is not, as Respondents suggest, that the symptoms on the return visit must be identical to the symptoms on the first visit but the opposite. *Cole* reaffirmed *Shaw's* admonition against conceptually fragmenting a course of treatment and reasserted *Shaw's* instruction that testing for problems resulting from negligence amounts to "treatment" for purposes of the continuing care doctrine. *Cole v. Ferrell-Duncan Clinic*, 185 S.W.3d at 743–44 (Mo.App. S.D. 2006); *Shaw v Clough*, 597 S.W.2d 212 (Mo.App. W.D. 1980).

Respondents next suggest that *Brickey v. Concerned Care of Midwest, Inc.*, 988 S.W.2d 592, 597-598 (Mo. App. E.D. 1999), and *Dunagan By & Through Dunagan v. Shalom Geriatric Ctr.*, 967 S.W.2d 285, 289 (Mo. App. W.D. 1998), establish that an "indirect relationship" between the return visits and the original care is not enough to apply continuing care. How the damage to Sharon's fallopian tubes have only an "indirect relationship" to the abdominal infection treated by Respondents in 2012 and 2013 is not explained. Notably, this argument also fails to address Respondents acknowledgment in the medical records that the damage to the fallopian tubes was from infection, LF#43, p.1, and Respondents' admission in in their deposition that fallopian tube damage is commonly caused by infection. LF#49, pp.12, 19.

Even if, despite the evidence, fallopian tube damage is somehow considered an indirect result of an infection inside the abdomen, it is irrelevant to the law as set forth in *Brickey* and *Dunagan* as those opinions did not reject application of the continuing care doctrine because of an indirect relationship to the prior treatment. *Brickey*, 988 S.W.2d at

597-598; *Dunagan*, 967 S.W.2d at 289. These cases rejected application of the continuing care doctrine because they found the treatment claimed to constitute continuing care had no relationship to the prior care. *Id.* Respondents first assume, contrary to the courts' holdings, that the treatment within two years of filing in those cases "undoubtedly involved some ongoing, indirect care" for the claimed injuries. Respondents then assert that these assumed facts establish a rule that indirect, generalized care, is not, as a matter of law, enough. Again, even if there was such a rule, how Respondents' testing for and treatment of the fallopian tube damage between 1/29/15, and 6/9/15, is only generalized care, or how that is somehow an indirect consequence of Respondents' treatment, is not explained and cannot be accepted in light of the requirement that Appellant be given the benefit of all reasonable inferences from the evidence. Respondents' further suggestion that the care provided by them for the fallopian tube damage was not essential to recovery from the infection, is not consistent with notations in Respondents' records that the care was necessary to avoid a life threatening ectopic pregnancy. LF#43, pp.1,7.

Respondents take exception to Appellants' citation of *Hooe v. Saint Francis Med. Ctr.,* 284 S.W.3d 738, 739 (Mo. App. S.D. 2009), in support of the argument that a gap of less than two years between visits is not too long to be continuing care. In *Hooe*, the Court refused to apply the doctrine to a gap of 6 years, and noted that "what we found, in cases where continuing care tolled the statute, were plaintiffs returning to medical defendants within two years of alleged malpractice. *Id.* at 739. While this may not amount to an affirmative holding that a gap of less then two years is enough, it certainly

suggests it, and cases that have rejected continuing care because of the gap in treatment have done so in the face of gaps significantly longer than the less than two year gap in the treatment here. *Hooe,* 284 S.W.3d at 739 (6 year gap too long); *Shah v. Lehman*, 953 S.W.2d 955, 958 (Mo.App. E.D .1997)(9 year gap too long); *Vilcek v. Lee*, 982 S.W.2d 758, 759 (Mo.App. E.D. 1998)(8 year gap too long).

Respondents also argue that Appellants citation of *Hill v. Klontz*, 909 S.W.2d 725, 726 (Mo. App. S.D. 1995), for the proposition that continuing treatment of an injury from prior treatment counts as continuing care is not supported. However, even if one were to reject the quote from *Hill* to that effect as *dicta*, there are several other cases applying continuing care to visits made for the treatment of injuries resulting from negligence. *See Thatcher v. DeTar*, 173 S.W.2d 760, 762 (Mo. 1943); *Brickey v. Concerned Care of Midwest, Inc.,* 988 S.W.2d 592, 597-598 (Mo. App. E.D. 1999)(the continuing care exception provides that the statute begins to run when the defendant ceases to treat the injury caused by the alleged act of negligence or neglect); *Dunagan By & Through Dunagan v. Shalom Geriatric Ctr.*, 967 S.W.2d 285, 289 (Mo. App. W.D. 1998). Respondents' incorrectly argue that application of the continuing care doctrine to treatment of injuries from prior treatment is contrary to *Weiss,* 975 S.W.2d 113, and *Montgomery,* 49 S.W.3d 191. *Weiss* and *Montgomery* do not refuse to apply the continuing care doctrine to treatment of an injury from negligence. The facts of those cases concerned alleged failures to diagnose cancer, and thus continuing care for treatment of an injury were not claimed or discussed.

Respondents also argue that Appellants incorrectly cite *Shah v. Lehman*, 953 S.W.2d 955, 958 (Mo. App. ED 1997), as rejecting the continuing care exception in the face of a 9 year gap in treatment. The case, however, plainly states that "A 9–year lapse between treatments does not constitute "continuing care." *Id.* Appellants do not argue that any gap of less than two years is acceptable regardless of the connection between the prior treatment and the return visit. Appellants do argue that Sharon returned to Respondents within two years of the 2013 treatment, and within two year of filing the lawsuit, and returned with an injury which was related to the prior treatment and was a result of the earlier negligence. When Sharon returned to Respondents between 1/29/15, and 6/9/15, Respondents knew that continued treatment could be necessary to protect Sharon's life. Appellants assert that that these facts, under *Thatcher*, *Weiss, Montgomery*, and their progeny, warrant the application of the continuing care doctrine.

IC. Appellants Are Not Relying On A Discovery Rule.

Appellants are not basing their statute of limitations argument on the discovery of the fallopian tube damage. Appellants' position would be the same if the fallopian tube damage was known and treated on 2/5/13, and next treated on 1/29/15. Appellants are basing their argument on the evidence that Plaintiff, within two years of Respondents' last treatment of the infection, returned for and received infection related medical treatment under circumstances establishing that Respondents knew or should have known that that medical treatment was needed.

Appellants have always invoked the continuing care doctrine. LF#31, ¶1; LF#45. If Appellants were arguing for application of a discovery-like rule, they would assert that

the statute of limitations did not begin to run until discovery of the injury, regardless of Sharon's return to Respondents' care. *See e.g. Doe v. O'Connell*, 146 S.W.3d 1, 3 (Mo.App. E.D. 2004). Appellants agree that when they discovered their injury is irrelevant to the continuing care doctrine, and are not making such a claim. In arguing that Appellants are trying to back door into a discovery rule, Respondents assert that there was time in 2012 when Sharon knew of sufficient to injury to sue. However, there is nothing in the continuing care case law that forecloses the application of the continuing care because the patient had enough information to file suit before the care continued so these arguments about when or whether Sharon and Brian knew about sufficient injuries should be disregarded.

ID. The Policy Behind The Continuing Care Doctrine.

In discussing the policy behind the continuing care doctrine, Respondents point to policies intended to prevent against stale claims and those in favor of giving finality to defendants. Respondents' brief p. 29. Those policies, of course, are affected to some degree whenever the continuing care doctrine is applied. Respondents assertion that "applying the continuing care exception in the manner requested by Appellants would in essence allow the statute of limitations to be tolled as long as there is a possibility that a patient may one day return to a health care provider for treatment of a new condition that may be remotely related to the prior alleged negligence, in retrospect, regardless of whether the new condition was known or any follow up care was contemplated at the last visit" is also not correct. The continuing care doctrine is not an ever-open window to suit but requires that the patient actually return to the physician *Weiss v. Rojanasathit*, 975

S.W.2d 113, 119-20 (Mo. 1998), for related treatment, *Dunagan By & Through Dunagan v. Shalom Geriatric Ctr.,* 967 S.W.2d 285, 289 (Mo. App. WD 1998)), in a reasonable time, suggested by case law to be within two years. *Hooe v St. Francis Medical Center*, 284 SW3d 738, 739, fn 5 (Mo.App. S.D. 2009). These considerations have created a reasonable tolling period based on the patient and her doctor's efforts to deal with a problem related to the medical care, for the time period that they are trying. The continuing care exception does not put health care providers at undue risk of their treatment reviving stale claims. It rather, as expressed by this Court in *Thatcher, Weiss and Montgomery*, serves the pubic policy of advancing and protecting the physicians' duty to provide continuing care when the patient presents with a problem related to prior treatment.

Respondents' assertions that Sharon does not allege that she had tubal blockage on 2/5/13, or claim that Respondents knew or should have known that Sharon would one day develop this tubal blockage and require treatment is not correct. Under the mandated construction of the evidence in Appellants' favor, it must be taken as true that the fallopian tube damage was not new, it happened in 2012. LF#44. Certainly, Repondents did not show the fallopian tube damage was new in their summary judgment pleadings. LF#42. Respondents testified that the kind of fallopian tube damage Sharon had was commonly caused by infections. LF#48, pp.9, 12. It can, therefore, reasonably be inferred that Respondents knew or should have known that Sharon fallopian tubes may have been damaged by the 2012 infection.

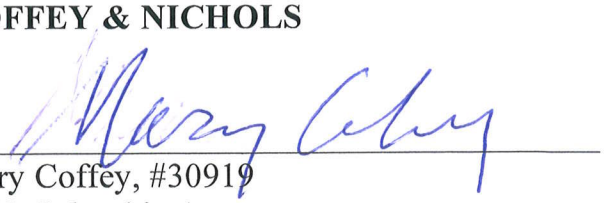
Finally, Respondents repeated claim that the visit of 1/29/15, was only for a well women exam, unrelated to the prior infection, and therefore established a new physician patient relationship, ignores Appellants evidence to the contrary and fails to give Appellants the mandated construction of the evidence in Appellants favor. Under Appellants' evidence, when Sharon returned on 1/29/15, she complained of an inability to get pregnant despite trying since 2013 and Respondents ordered the test that found the fallopian damage causing the infertility and **on** the next visits, recommended an Essure procedure to prevent a life-threatening ectopic pregnancy. Further, Respondents knew that fertility issues and the threat of ectopic pregnancy like Sharon's are commonly caused by intra-abdominal infections. Medical records show that the infection was treated though 2/5/13 specifically by Respondent Meddows-Jackson, and through 6/18/13 by Respondent Mercy Clinic, before Sharon returned on 1/29/15.

Conclusion

As discussed in Appellants' Brief and this Substitute Reply Brief, these facts permit the application of the continuing care doctrine, and warrant reversal and remand for a trial. [W]hen contradictory or different conclusions may be drawn from the evidence as to whether the statute of limitations has run, it is a question of fact for the jury to decide." *Giles v. Carmi Flavor & Fragrance Co., Inc.*, 475 S.W.3d 184, 194 (Mo. App. W.D. 2015).

Respectfully Submitted,

COFFEY & NICHOLS



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Certificate of Compliance under Rule 84.06(c)

Pursuant to Rule 84.06(c), the undersigned certifies that:

1. The brief includes the information required by Rule 55.03, in that it is signed by an attorney of record for the party filing the brief, a signature block including the name, Missouri bar number, address, telephone, fax number and email, and the original signed brief will be maintained by filer throughout the appellate process.

2. The brief was e-filed this 24th day of May, 2019, and served on all counsel of record through Rule 103.8, all of whom are registered users of the electronic filing system.

3. The brief complies with the limitations of Rule 84.06(b) in that all material contained in the brief except the cover, certificate of service, signature block and any appendix, which does not exceed 7,750 words.

4. The brief, exclusive of the parts set forth in 3 above, contains 6,930 words.

5. Pursuant to Rule 84.06(a) the brief is filed in text searchable PDF.

Mary Coffey