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## The Continuing Care Exception: Is This Bubble About to Burst? Montgomery v. South County Radiologists, Inc.

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**THE CONTINUING CARE EXCEPTION: IS THIS BUBBLE ABOUT  
TO BURST?  
*MONTGOMERY v. SOUTH COUNTY RADIOLOGISTS, INC.***

I. INTRODUCTION

Over the last couple of decades, the number of medical malpractice claims has been on the rise.<sup>1</sup> In response to the perceived medical malpractice crisis this has created, a number of state legislatures have promulgated statutory provisions intended to deal with the problems posed by frivolous malpractice actions and exorbitant damage awards.<sup>2</sup> Often these provisions shorten the statute of limitations for filing a medical malpractice action.<sup>3</sup>

In contrast to these states, Missouri's existing medical malpractice statute was already suited to accomplish this objective. Rather, in Missouri, the same statute has been in force for at least seventy years, and has changed very little in recent years as a result of this quandary. Section 516.105 of the Missouri Revised Statutes provides that:

All actions against physicians, hospitals, dentists, registered or licensed practical nurses, optometrists, podiatrists, pharmacists, chiropractors, professional physical therapists, and any other entity providing health care services and all employees of any of the foregoing acting in the course and scope of their employment, for damages for malpractice, negligence, error or mistake related to health care shall be brought within two years from the date of occurrence of the act of neglect complained of. . . .<sup>4</sup>

Section 516.105 effectively reduces the number of medical malpractice suits because the statute of limitations commences from the date the negligent act occurs and not from the date of discovery. Moreover, this statute has been construed very strictly in favor of physicians in order to bar malpractice actions.<sup>5</sup> While many jurisdictions have instituted a discovery rule, in which

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1. George L. Blum, Annotation, *Medical Malpractice: Who Are "Health Care Providers," or the Like, Whose Actions Fall Within Statutes Specifically Governing Actions and Damages for Medical Malpractice*, 12 A.L.R.5d 1 (1993); James Bartimus et al., *Protecting Plaintiff's Rights in the Medical Malpractice Crisis*, 53 U. MO. K.C. L. REV. 27, 28 (1984).

2. Blum, *supra* note 1, at 1.

3. *Id.*

4. MO. REV. STAT. § 516.105 (2000).

5. Howard Schwartz, *The Law of Medical Malpractice in Missouri*, 28 ST. LOUIS U. L.J. 397, 430 (1984).

the statute of limitations is not tolled until actual discovery of the negligent act, Missouri courts and the Missouri Legislature have rejected such a proposal and instead have continued to carve out narrow exceptions to section 516.105.

The “continuing care rule” is one such exception. The continuing care rule refuses to treat a negligent act as a discrete occurrence when a patient is in an on-going relationship with a physician. Rather, the wrong is treated as if recommitted each time the doctor treats the patient and fails to find the previously ignored medical condition.<sup>6</sup> The underlying theory behind this rule is that the physician is guilty of malpractice during the entire physician-patient relationship because he did not properly diagnose the illness.<sup>7</sup> While the continuing care rule has been applied in multiple cases to toll the statute of limitations against an individual physician, before *Montgomery v. South County Radiologists, Inc.*,<sup>8</sup> Missouri courts had never extended the application of this exception to a health care entity.<sup>9</sup>

In *Montgomery*, the Missouri Supreme Court continued to “chip away” at section 516.105 by expanding the “continuing care exception” and applying it not only to physicians, but to diagnostic health care entities as well.<sup>10</sup> Missouri courts handled similar situations in the past, but chose to not extend the continuing care rule.<sup>11</sup> *Montgomery*, however, provided the ideal opportunity to extend this exception. In *Montgomery*, two years and eight months after the radiology services prescribed by his neurosurgeon began, plaintiff Evan Montgomery and his wife filed suit against South County Radiologists (“SCR”), which failed to recognize a cancerous spinal tumor after reviewing three films on three occasions, eight months apart.<sup>12</sup> Montgomery also filed suit against Dr. Szoko, an individual radiologist working for the group who negligently reviewed Montgomery’s first film more than two years earlier. The circuit court awarded summary judgment to Dr. Szoko and awarded partial summary judgment to SCR.<sup>13</sup> The Montgomerys appealed and the Eastern District reversed and remanded both grants of summary judgment, holding that Montgomery presented sufficient evidence of continuing care by both Dr.

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6. Gerald D. McBeth, *Medical Malpractice: When Does the Statute of Limitations Begin to Run?*, 35 MO. L. REV. 559, 562 (1970).

7. *Id.*

8. *Montgomery v. S. County Radiologists, Inc.*, 49 S.W.3d 191 (Mo. 2001).

9. *Id.*

10. *Id.*

11. *See Shah v. Lehman*, 953 S.W.2d 955 (Mo. Ct. App. 1997); *Dunagan v. Shalom Geriatric Ctr.*, 967 S.W.2d 285 (Mo. Ct. App. 1998). Both courts declined to extend the “continuing care” exception to health care entities. However, the facts of both cases made it unnecessary to reach this issue. For a discussion of these cases, see *infra* notes 89-107 and accompanying text.

12. *Montgomery*, 49 S.W.3d at 192.

13. *Id.*

Szoko and SCR to satisfy the continuing care rule.<sup>14</sup> Upon transfer, the Missouri Supreme Court held that the continuing care rule applied to toll the statute of limitations against the radiology group.<sup>15</sup>

Before *Montgomery*, many Missouri courts stretched the continuing care exception to toll the malpractice statute in circumstances dealing with the physician-patient relationship framework. *Montgomery* adds a new dimension to the equation: the relationship between the patient and diagnostic entity. After *Montgomery*, one issue to be discussed is whether the court has gone too far in applying this exception to a health care entity or whether this a necessary change.

In Parts II through V, this Note will discuss the history of the continuing care exception, the policies behind it, its limitations and the extent to which the *Montgomery* holding expands the exception almost to the breaking point. Part VI will explore the implications of the *Montgomery* holding on patients, physicians and health care entities. Finally, the author will discuss why the *Montgomery* court's sizeable stretch of the continuing care rule to toll the statute of limitations is inappropriate given the longstanding rationale behind the exception in Missouri. As part of this discussion, an alternative rule is considered.

## II. HISTORICAL DEVELOPMENTS OF MISSOURI'S CONTINUING CARE EXCEPTION

The Missouri continuing care exception began in *Thatcher v. DeTar*.<sup>16</sup> In *Thatcher*, the doctor performed surgery on the patient for appendicitis and negligently left a surgical needle in her body.<sup>17</sup> Following the operation, the patient experienced pain and continued treatment with her doctor.<sup>18</sup> After two years of continuing treatment, the patient terminated her relationship with that doctor and began seeing a new physician who discovered the surgical needle.<sup>19</sup> Upon discovery, more than two years after the act of negligence, the patient filed suit against her physician.<sup>20</sup> The Missouri Supreme Court found that the "act of neglect complained of" was not only the leaving of a foreign object in plaintiff's body, but also the subsequent treatment of symptoms caused by the failure to discover a needle in plaintiff's body.<sup>21</sup> However, the court held that

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14. *Montgomery v. S. County Radiologists*, No. ED 77285, 2000 WL 1846432, at \*13 (Mo. Ct. App. Dec. 19, 2000).

15. *Montgomery*, 49 S.W.3d at 192.

16. *Thatcher v. DeTar*, 173 S.W.2d 760 (Mo. 1943); *see also* *RCA Mut. Ins. Co. v. Sanborn*, 918 S.W.2d 893, 896 (Mo. Ct. App. 1996).

17. *Thatcher*, 173 S.W.2d at 761.

18. *Id.*

19. *Id.*

20. *Id.*

21. *McBeth*, *supra* note 6, at 563.

the presence of the physician-patient relationship tolled the statutory two-year period of limitations until treatment by the health care provider ceased.<sup>22</sup> The *Thatcher* court defined the continuing care rule by declaring that “the statute does not commence running until treatment by the physician or surgeon has terminated, where the treatment is continuing and of such a nature as to charge the medical man with the duty of continuing care and treatment which is essential to recovery until the relation ceases.”<sup>23</sup>

Since *Thatcher*, few decisions have provided more depth to the framework of the continuing care relationship, nor have the courts set forth any bright line rules. The end result is that the applicability of the continuing care exception depends largely on the circumstances of each individual case. In a few cases, however, Missouri courts have attempted to clarify what factors will trigger the continuing care rule.

In 1980, the Western District articulated the underlying rationale for the continuing care rule in *Shaw v. Clough*, illustrating the depth and importance of the physician-patient relationship.<sup>24</sup> In *Shaw*, the plaintiff employed a physician after sustaining an injury to her cervical area.<sup>25</sup> After the defendant physician performed a medical test that revealed cervical disease, the defendant performed corrective surgery.<sup>26</sup> Subsequent to the surgery, however, the plaintiff began to experience pain and loss of sensation in a portion of the body used as the donor site of infusion material during the surgery.<sup>27</sup> Plaintiff continued under the care of defendant physician, who eventually performed a second exploratory surgery and found that a nerve had been entrapped during the initial surgery.<sup>28</sup> Plaintiff thereafter filed suit, alleging that the physician was negligent and lacking in requisite skill or knowledge.<sup>29</sup>

In *Shaw*, the court began its opinion by stating that “[b]y its very nature, the tolling exception to the bar of limitation rule rings out with logic, with

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22. *Thatcher*, 173 S.W.2d at 763.

23. *Id.* at 762. The court also recognized that a discovery rule was another possible way of remedying the situation, stating:

[I]t has been held, too, that where injury does not immediately become apparent to the patient, the statute begins to run in favor of the physician when the injury so appears as to put the patient on notice and inquiry and not at a later period when a malignant condition develops there from, or the injury becomes permanently fixed.

*Id.*

24. *Shaw v. Clough*, 597 S.W.2d 212, 215-16 (Mo. Ct. App. 1980).

25. *Id.* at 214.

26. *Id.*

27. *Id.*

28. *Id.*

29. *Shaw*, 597 S.W.2d at 214.

morality, and with ‘common sense’ as recognized in *Thatcher*.<sup>30</sup> The court found that:

The doctor-patient relationship is in most instances a highly personal and close one, encompassing on the part of the patient a basic confidence and reliance upon the skills and judgment of the doctor with a reasonable expectation that such will be met by a deep sense of obligation and proper exercise by the doctor of his incomparable superior knowledge and the dedicated use of his best talents and judgment.<sup>31</sup>

The court further stated that the rationale of *Thatcher* stems primarily from the nature of the relationship, and that the treatment obligations arising therefrom should be considered as a whole until treatment ceases.<sup>32</sup>

Almost twenty years later in *Weiss v. Rojanasathit*, the Missouri Supreme Court articulated four ways in which the physician-patient continuing treatment relationship may end, thus terminating the duty of continuing care and beginning the statutory limitations period.<sup>33</sup> In *Weiss*, the plaintiff brought a medical malpractice action against her gynecologist who failed to inform her that her medical tests showed the presence of either a pre-cancerous or cancerous condition.<sup>34</sup> After employing a different physician and undergoing another test almost four years later, the plaintiff was diagnosed with cervical cancer.<sup>35</sup> The court noted that the duty to treat continues until the physician-patient relationship is ended by: (1) mutual consent of the parties; (2) the physician’s withdrawal after reasonable notice; (3) the dismissal of the physician by the patient; or (4) the cessation of the necessity that gave rise to the relationship.<sup>36</sup> *Weiss* added that absent good cause to the contrary, where the doctor knows or should know that a condition exists which requires further medical attention to prevent injurious consequences, the doctor must render such attention himself or ensure that some other competent person does so until termination of the physician-patient relationship.<sup>37</sup> In *Weiss*, because the plaintiff failed to keep a follow-up visit three months after defendant

30. *Shaw*, 597 S.W.2d at 215; *Thatcher v. DeTar*, 173 S.W.2d 760, 762 (Mo. 1943).

31. *Shaw*, 597 S.W.2d at 215. The court found that the relationship between the plaintiff and physician existed by reason of the plaintiff’s traumatic injury, and that the physician accepted this relationship and the responsibilities that ensued, namely, the resulting treatment for the plaintiff’s subsequent right leg condition. *Id.* at 216.

32. *Id.* at 215-16; *Thatcher*, 173 S.W.2d at 762. While the defendant physician sought to avoid the *Thatcher* rule by arguing that a foreign object had been left in the plaintiff’s body, the court explicitly rejected the defendant’s argument by way of reference to *Laughlin v. Forgrave*, 432 S.W.2d 308, 314 (Mo. 1968), and distinguished the case from *Laughlin*, which the court noted was not a continuing care case. *Shaw*, 597 S.W.2d at 216.

33. *Weiss v. Rojanasathit*, 975 S.W.2d 113, 119 (Mo. 1998).

34. *Id.* at 116.

35. *Id.*

36. *Id.* at 119-20.

37. *Id.* at 120.

performed the medical tests, and because she failed to return at any reasonable time thereafter, the court found that the physician-patient relationship had terminated long before suit was filed.<sup>38</sup>

Missouri courts developed the continuing care exception in only these few cases. The application of the continuing care rule is very case-specific. As such, the facts and outcomes of different cases in which the rule was applied are instructive in an effort to truly grasp what falls within the boundaries of the continuing care rule.

### III. HOW FAR-REACHING IS THE “CONTINUING CARE” EXCEPTION IN MISSOURI?

Although the applicability of the “continuing care” exception depends largely on the unique circumstances of each case, Missouri courts have nevertheless expressed limitations and extensions on the application of this rule. At this point, it is important to take an in-depth look at the court’s analysis in each individual case, as each holding adds a small piece to the framework of the continuing care exception. This part first looks at cases in which Missouri courts have extended the continuing care exception, and then discusses Missouri opinions in which the court refused to apply this exception. Additionally, Missouri opinions involving the application of the exception to a health care entity are examined.

#### A. *Extensions of the Continuing Care Exception*

In *Lorsbach v. Plastic Surgery Consultants, Ltd.*, the Eastern District extended the continuing care exception to include post-operative care after a physician performed a surgical procedure.<sup>39</sup> The plaintiff in *Lorsbach* had a history of breast lumps, and after having several lumps surgically removed, she eventually decided to have a breast stripping procedure performed to eliminate the risk of breast cancer.<sup>40</sup> Immediately after surgery, and for months following the surgery, the plaintiff consulted her physician several times regarding the unsatisfactory appearance of her breasts and various complications from the surgery.<sup>41</sup> Eight months after the operation, the

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38. *Weiss*, 975 S.W.2d at 120. The court explicitly rejected the plaintiff’s argument that the statute of limitations was tolled until damages could be ascertained when the plaintiff’s pre-cancerous condition developed into a cancerous condition, noting that the plaintiff’s argument read “damages” in section 516.105 in a vacuum. *Id.* at 117. The court stated that the word “damages” merely specified the type of action subject to the statute of limitations in section 516.105, but “[did] not alter the plain and unequivocal limitation in the statute that such actions be brought within two years from the date of the act of neglect.” *Id.* at 118.

39. *Lorsbach v. Plastic Surgery Consultants, Ltd.*, 745 S.W.2d 220, 221 (Mo. Ct. App. 1987).

40. *Id.*

41. *Id.*

plaintiff again contacted her physician, who informed her that another surgery had to be performed.<sup>42</sup> Plaintiff did not authorize the second surgery, but sought professional opinions from two other physicians.<sup>43</sup> The court held that the plaintiff was under the care and treatment of her physician for several months after the operation due to complications from the operation itself, and therefore the statute was tolled until the plaintiff terminated the relationship to seek another opinion.<sup>44</sup>

Almost ten years later, the Southern District, in *RCA Mutual Insurance Company v. Sanborn*, applied the continuing care exception to toll the statute of limitations where one physician negligently performed a patient's initial surgery as well as two subsequent unsuccessful revision surgeries.<sup>45</sup> In this case, the plaintiff visited a physician for an evaluation of pain in his right hip.<sup>46</sup> After concluding that arthritis caused the pain, the physician performed a total hip replacement surgery, using a prosthesis.<sup>47</sup> Six months later, an x-ray revealed dislocation of the prosthesis and a revision surgery followed.<sup>48</sup> Two months after the revision, the plaintiff complained of pain and swelling in his right leg, and thereafter the physician performed another revision.<sup>49</sup> Post-operative x-rays showed that the physician placed the prosthesis four to five inches too high, resulting in the shortening of the plaintiff's right lower extremity and a permanent functional impairment.<sup>50</sup> The plaintiff filed suit, alleging that he was under the continuing treatment of the physician from the time of the initial surgery until the end of treatment following the last revision surgery.<sup>51</sup> The court recognized the striking similarity to *Shaw*, holding that the second and third surgeries were negligently performed revisions of the negligently performed first surgery. In *RCA*, the treatment was viewed as a whole, thus tolling the statute due to continuous treatment.<sup>52</sup>

In *Adams v. Lowe*, the Eastern District held that despite a seven-month time span between the patient's surgery and follow-up visit, there was a

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42. *Id.*

43. *Lorsbach*, 745 S.W.2d at 221.

44. *Id.* at 220-21.

45. *RCA Mut. Ins. Co. v. Sanborn*, 918 S.W.2d 893 (Mo. Ct. App. 1996).

46. *Id.* at 894.

47. *Id.*

48. *Id.*

49. *Id.* at 894-95.

50. *RCA*, 918 S.W.2d at 895.

51. *Id.* at 896.

52. *Id.* The only difference between *Shaw's* and *Sanborn's* medical treatment was a third negligently performed surgery. Therefore, the court held that *Shaw* dictated the result reached. The court discussed the importance of viewing the treatment as a whole due to the fact that *Shaw* had separately argued that the case be fragmented for purposes of payment by the insurance company for damages. *Id.* The court refused to fragment the case, limiting payment of damages for only one "whole" claim. *Id.* at 897.



sufficient nexus to constitute continuing care by a patient's dentist.<sup>53</sup> The plaintiff's dentist performed a root canal.<sup>54</sup> Following the surgery, the dentist told the plaintiff that his teeth "would be tender for a while."<sup>55</sup> Seven months later, the plaintiff revisited his dentist complaining that his teeth were still tender and his dentist informed him that there were some problems with the root canal and suggested further surgery.<sup>56</sup> The plaintiff then sought a second opinion from another dentist and filed suit.<sup>57</sup> The court, citing *Thatcher v. DeTar*, stated that the continuing care exception applied to treatment that is essential to recovery.<sup>58</sup> Because the dentist did not terminate care with the plaintiff, the court held that the plaintiff's claim was timely.<sup>59</sup>

In another surgery-related case, *Reynolds v. Dennison*, the plaintiff prevailed in applying the continuing care exception to toll the statute of limitations against a physician who negligently performed sinus surgery to remove the plaintiff's nasal polyps.<sup>60</sup> Nearly one year later, the plaintiff was admitted to the hospital with meningitis, where a hospital physician called the plaintiff's physician to examine the patient, and to look for a complication from the previous surgery.<sup>61</sup> While the plaintiff's physician did not discover any sinus leakage as a result of the surgery he performed, another physician did detect it and subsequently corrected it.<sup>62</sup> The plaintiff filed suit against his physician alleging negligent performance of the nasal polyp surgery.<sup>63</sup> The court noted that "treatment" includes measures necessary for the physical well-being of the patient.<sup>64</sup> The court found that the plaintiff and his physician had agreed to continue their relationship through "complications," and even though the physician did not detect the problems and was, therefore, unaware that any existed, the relationship had not been terminated by either party.<sup>65</sup> Therefore, the continuing care exception applied and the plaintiff's suit was not time-barred.

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53. *Adams v. Lowe*, 949 S.W.2d 109 (Mo. Ct. App. 1997).

54. *Id.* at 110.

55. *Id.*

56. *Id.*

57. *Id.*

58. *Adams*, 949 S.W.2d at 110 (citing *Thatcher v. DeTar*, 173 S.W.2d 760, 762 (Mo. 1943)).

59. *Adams*, 949 S.W.2d at 111. The court rejected the defendant dentist's argument that this case was similar to *Swallows v. Weathers*, 915 S.W.2d 763, 764 (Mo. 1996), holding that *Swallows* was not applicable, as the "continuing course of treatment theory was untimely presented and thus not considered by either the trial court or the supreme court [in *Swallows*]." *Adams*, 949 S.W.2d at 111.

60. *Reynolds v. Dennison*, 981 S.W.2d 641 (Mo. Ct. App. 1998).

61. *Id.* at 643.

62. *Id.*

63. *Id.* at 642.

64. *Reynolds*, 981 S.W.2d at 642 n.1.

65. *Id.* at 643.

*B. Missouri's Refusal to Apply the Continuing Care Exception*

The Western District, in *Shroyer v. McCarthy*, refused to extend the continuing care rule to toll the statute of limitations during the plaintiff's attempts, or failed attempts, to discover the identity of his allegedly negligent treating physician.<sup>66</sup> In *Shroyer*, the plaintiff filed suit, alleging that he sustained burns on his wrist and was permanently injured when his employer's physician improperly and negligently operated an electrical muscle stimulation unit.<sup>67</sup> The plaintiff raised the issue of identity of the treating physician more than two years after the date of the alleged injury during a hearing on the employer's motion to dismiss.<sup>68</sup> At that hearing, the name of the allegedly negligent physician was revealed to the plaintiff and, thereafter, the plaintiff added the physician as a defendant.<sup>69</sup> The court, strictly applying *Thatcher's* continuing care rule,<sup>70</sup> held that the date upon which the plaintiff sustained burns from the physician's allegedly negligent act was the only occurrence of negligence complained of and, therefore, the date on which the physician's treatment of the plaintiff ceased.<sup>71</sup> Because treatment did not continue past the date of the negligent occurrence, which was more than two years prior to the plaintiff adding the physician as a defendant, the suit was barred.<sup>72</sup>

In 1995, the Western District, in *Kamerick v. Dorman*, held that a telephone conversation after the last date of medical services rendered did not rise to the level of medical care, services or treatment required to trigger the continuing care exception.<sup>73</sup> The plaintiff in *Kamerick* sought treatment with her physician from 1983 through mid-1987, and discovered she was suffering from carcinoma in late 1987.<sup>74</sup> The plaintiff alleged failure to timely diagnose the condition and failure to timely refer the plaintiff to a specialist who could

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66. *Shroyer v. McCarthy*, 769 S.W.2d 156 (Mo. Ct. App. 1989).

67. *Id.* at 157.

68. *Id.* at 157-58. Although the defendant physician remained employed by Ford, also the plaintiff's employer, for almost one year after the date of his alleged injury, the plaintiff failed to add the defendant physician to the lawsuit until approximately two years later. *Id.*

69. *Id.* at 158.

70. *Id.* at 161.

71. *Shroyer*, 769 S.W.2d at 160.

72. *Id.* The plaintiff also unsuccessfully argued that section 516.100 applied, requiring the statute of limitations to commence when damages were capable of ascertainment. The court noted that the Missouri Supreme Court had rejected a similar suggestion in *Laughlin*, holding that the specific statute pertaining to medical malpractice actions prevails over the general statute, section 516.100. *Id.* "The [*Laughlin*] court reasoned that the General Assembly deliberately used the words, 'from the date of the act of neglect,' as an expression of purpose to build into that part of the statute applicable specifically to medical malpractice actions a special provision independent of, and as an exception to, the provisions of section 516.100." *Id.*

73. *Kamerick v. Dorman*, 907 S.W.2d 264 (Mo. Ct. App. 1995).

74. *Id.* at 265.

have properly diagnosed the condition.<sup>75</sup> While the last date on which any act of negligence could have occurred was in mid-1987, the plaintiff claimed that a telephone conversation with the physician in late 1987 constituted continuing care.<sup>76</sup> The court cited *Thatcher*, noting that the plaintiff was not seeking treatment from her physician at the time of the calls, but rather that she was merely relaying complaints about the physician's diagnosis.<sup>77</sup> Therefore, the court held that a telephone call such as this one, made to a physician months after the last treatment, was not sufficient to trigger an extension of the statute of limitations.<sup>78</sup>

The following year, the Western District, in *McCrary v. Truman Medical Center*, refused to apply the continuing care exception to treatment provided by a physician after his recommendation for removal of a painful implant.<sup>79</sup> In *McCrary*, the plaintiff was first examined by her physician in early 1986 concerning complaints of jaw pain, and shortly thereafter the physician surgically placed an implant into the plaintiff's jaw.<sup>80</sup> The plaintiff then returned to her physician's office seven times over a six-month period.<sup>81</sup> A year and a half later, in 1988, the plaintiff returned to her physician's office, again complaining of pain.<sup>82</sup> At this visit, the physician recommended removal of the implant.<sup>83</sup> The plaintiff, however, did not return for the operation until her physician wrote her in 1991 to inform her that the United States Food and Drug Administration had issued a "safety alert" concerning the implant.<sup>84</sup> The plaintiff then filed suit against her physician in 1993.<sup>85</sup> The plaintiff argued that the continuing care exception should apply to toll the statute of limitations from the last date that she visited her physician, in 1991.<sup>86</sup> The court, however, disagreed and found that the treatment was terminated by the

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75. *Id.*

76. *Id.* at 266. The plaintiff claimed that the telephone call created a "reasonable doubt" regarding the date of the plaintiff's last treatment by her physician, citing *Ventimiglia v. Cutter Laboratories*, 708 S.W.2d 772 (Mo. Ct. App. 1986), for support. In *Ventimiglia*, the defendant physician who had treated a young boy for burns had admitted in a deposition that he recalled glancing at the scars at a later date. *Id.* The court held that summary judgment was inappropriate because the date of the physician's last treatment had not been ascertained. *Id.* at 774.

77. *Kamerick*, 907 S.W.2d at 266 (citing *Thatcher v. DeTar*, 173 S.W.2d 760, 762 (Mo. 1943)).

78. *Kamerick*, 907 S.W.2d at 266.

79. *McCrary v. Truman Med. Ctr.*, 916 S.W.2d 831 (Mo. Ct. App. 1996).

80. *Id.* at 832.

81. *Id.*

82. *Id.*

83. *Id.*

84. *McCrary*, 916 S.W.2d at 832.

85. *Id.*

86. *Id.*

physician, who recommended removal of the painful implant in 1988.<sup>87</sup> The court noted that the plaintiff complained of no negligence with respect to the physician's treatment after the recommendation of implant removal, making the plaintiff's suit time-barred.<sup>88</sup>

C. *Missouri Continuing Care Exception Cases Involving Health Care Entities*

While most of the continuing care cases involved a relationship between a patient and physician, several early cases, including *Shah v. Lehman*, *Dunagan v. Shalom Geriatric Center* and *Uelk v. Barnes-Jewish Hospital*, presented opportunities for Missouri courts to apply the continuing care rule in a relationship between a patient and a health care entity.<sup>89</sup> However, the circumstances in both *Shah* and *Dunagan* did not support application of the continuing care rule. As a result, the court did not actually reach or discuss whether the continuing care rule would apply in the context of a relationship between a patient and a health care entity in depth in either case. In contrast, the Missouri Court of Appeals in *Uelk*, relying on both *Shah* and *Dunagan*, explicitly held that the continuing care rule did not apply to hospitals because it had never been applied to a relationship other than that between an individual physician and patient.<sup>90</sup>

In *Shah v. Lehman*, the Eastern District held that a nine-year gap between a patient's treatment and contact with a hospital did not constitute continuing care.<sup>91</sup> In *Shah*, the plaintiff's hips had caused her to suffer for more than twenty years.<sup>92</sup> Each hip already had been replaced once before the alleged act of negligence occurred.<sup>93</sup> The surgery in question consisted of removal of her left hip prosthesis and replacement with a new one.<sup>94</sup> During the surgery, the physicians, who were medical residents employed by the defendant hospital, placed a cement restrictor in her hip, which was to be left as a medical implant.<sup>95</sup> Nine years later, another surgeon employed by the defendant hospital performed a second left hip revision on the plaintiff and advised her

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87. *Id.* The court added, "[P]laintiff did not keep an appointment for April 1988, and she did not return for three years. We can hardly deem this continuous treatment." *Id.*

88. *Id.* at 833.

89. *Shah v. Lehman*, 953 S.W.2d 955 (Mo. Ct. App. 1997); *Dunagan v. Shalom Geriatric Ctr.*, 967 S.W.2d 285 (Mo. Ct. App. 1998); *Uelk v. Barnes-Jewish Hosp.*, No. ED 77114, 2000 WL 1873293 (Mo. Ct. App. Dec. 26, 2000).

90. *Uelk*, 2000 WL 1873293, at \*2-3 (stating that the Missouri Court of Appeals in *Montgomery* held only one week earlier that the continuing care rule may apply to entities and therefore transferred the case to the Missouri Supreme Court).

91. *Shah*, 953 S.W.2d 955.

92. *Id.* at 956.

93. *Id.*

94. *Id.*

95. *Id.*

that a cement restrictor was embedded in her thigh muscle.<sup>96</sup> The plaintiff brought suit, alleging, among other counts, that “a series of hip revision procedures performed at the same hospital by both its staff members and non-resident physicians over a several year period constitute[d] ‘continuing care’ by the hospital.”<sup>97</sup> The court did not explicitly reject the plaintiff’s continuing care argument that the claim should be viewed as a whole rather than fragmented into only two visits.<sup>98</sup> The court pointed out, however, that there was no evidence of any contact between the plaintiff and the hospital for nine years between the first and second hip revision surgeries.<sup>99</sup> *Shah* held that such a large lapse between treatments clearly could not fall under the rubric of continuing care.<sup>100</sup>

The following year, *Dunagan v. Shalom Geriatric Center* presented yet another unclaimed opportunity for a Missouri court to address the application of the continuing care rule in the context of a relationship between a patient and a health care entity.<sup>101</sup> *Dunagan* sought to recover damages for five separate bone fracture injuries he sustained due to alleged negligent and careless acts that occurred while he resided at a nursing home facility.<sup>102</sup> The plaintiff claimed that the continuing care exception to section 516.105 tolled the statute of limitations on his claim until the nursing home discontinued his treatment for Alzheimer’s disease.<sup>103</sup> The court noted that *Shah* had declined to extend the exception to cases where a hospital allegedly provided continuing care over a period of time.<sup>104</sup> It did not hold, however, this issue dispositive of the plaintiff’s claim.<sup>105</sup> Rather, the court focused on the fact that the nursing home’s continuing treatment of the plaintiff for Alzheimer’s disease did not constitute continuing care for the injuries caused by the alleged acts of neglect.<sup>106</sup> Because the plaintiff did not allege that he received from the nursing home any continuing treatment of his fractures essential to his recovery, the continuing care exception was held not to apply.<sup>107</sup>

In 2000, the Eastern District in *Uelk v. Barnes-Jewish Hospital*, stated that because it had to follow existing precedent, it had no choice but to hold that the

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96. *Shah*, 953 S.W.2d at 956.

97. *Id.* at 958.

98. *Id.*

99. *Id.*

100. *Id.*

101. *Dunagan v. Shalom Geriatric Ctr.*, 967 S.W.2d 285 (Mo. Ct. App. 1998).

102. *Id.* at 287.

103. *Id.* at 289; see MO. REV. STAT. § 516.105 (2000).

104. *Dunagan*, 967 S.W.2d at 289.

105. *Id.*

106. *Id.*

107. *Id.*

continuing care rule did not apply to hospitals.<sup>108</sup> The plaintiff in *Uelk* brought suit against Barnes Hospital, Washington University and two physicians for alleged medical malpractice.<sup>109</sup> Uelk claimed that Barnes was negligent in performing a transjugular intrahepatic portosystemic shunt procedure on October 7, 1994.<sup>110</sup> Although not pled, both parties agreed that Uelk had returned to the hospital numerous times for treatment, including a brief hospital stay, and saw many of the hospital doctors.<sup>111</sup> The plaintiff filed suit on March 30, 1999, more than four years after the performance of the procedure.<sup>112</sup> On appeal, the plaintiff argued that his subsequent visits to the hospital qualified as “continuing care” so as to toll the statute of limitations against Barnes Hospital.<sup>113</sup>

The Eastern District court in *Uelk* cited both *Dunagan* and *Shah* for the principle that the continuing care exception applies only to individual physicians, and not to hospitals or other health care facilities.<sup>114</sup> The court added that

unlike an individual physician, who once having undertaken a course of treatment, may not abandon the treatment until the treatment is completed or reasonable provisions for its completion are provided, a medical institution does not have any control over a particular patient and does not know whether a patient will return to the institution at a later date.<sup>115</sup>

The Eastern District recognized that no Missouri court had ever held the continuing care exception applicable to hospitals in the past, and it would not apply it in *Uelk*.<sup>116</sup> Uelk argued that in this era of specialized health care, there are no policy reasons for *not* applying the continuing care doctrine to hospitals providing health care.<sup>117</sup> The court did not explicitly reject this argument, but noted that this was a matter for the supreme court or legislature to address.<sup>118</sup> *Uelk* thereafter transferred the case to the Missouri Supreme Court, adding that the Eastern District had also just transferred *Montgomery*, dealing with the same issue.<sup>119</sup>

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108. *Uelk v. Barnes-Jewish Hosp.*, No. ED 77114, 2000 WL 1873293, at \*2-3 (Mo. Ct. App. Dec. 26, 2000).

109. *Id.* at \*1.

110. *Id.*

111. *Id.*

112. *Id.*

113. *Uelk*, 2000 WL 1873293, at \*1.

114. *Id.* at \*2.

115. *Id.*

116. *Id.*

117. *Id.*

118. *Uelk*, 2000 WL 1873293, at \*2.

119. *Id.* at \*3.

While the courts in both *Dunagan* and *Shah* did not hold health care entities liable, the continuing care doctrine could not have applied in those circumstances.<sup>120</sup> Similarly, the *Uelk* court stated that it was unwilling to apply the continuing care rule to a health care entity absent supreme court precedent.<sup>121</sup> Many other jurisdictions, however, have applied a “continuing treatment” rule in the context of a relationship between a patient and a health care entity that is not the patient’s primary care physician, thus paving the way for the *Montgomery* holding.<sup>122</sup>

#### IV. OTHER JURISDICTIONS’ APPROACHES: CAN DIAGNOSTIC SERVICES CONSTITUTE CONTINUING TREATMENT?

Several jurisdictions, including New York, Wyoming, Delaware and South Dakota, applied the “continuing treatment” rule to health providers in circumstances similar to the facts in *Montgomery*. These jurisdictions have primarily focused on the fact that the services rendered by health care providers are of substantial underlying importance to the treating doctor.

As far back as 1975, New York recognized treatment by a diagnostic health care entity as constituting “continuing care.”<sup>123</sup> In *Fonda v. Paulsen*, an independent pathologist read the plaintiff’s biopsies on two occasions, thirty-two months apart.<sup>124</sup> *Fonda* held, “we are of the opinion that to hold [the defendant pathologist] as having ‘treated’ plaintiff only at the times of his biopsy diagnoses is to take a view of the case which is analogous to the outworn theories under which privity of contract was required before liability could ensue.”<sup>125</sup> The court noted that the nature of a pathologist’s work is such that he rarely has any direct physician-patient contact.<sup>126</sup> The physician, therefore, never treats patients in the conventional sense.<sup>127</sup> However, the court afforded greater weight to the plaintiff’s argument that a pathologist’s work is often the basis upon which the attending physician makes decisions as to subsequent treatments.<sup>128</sup> *Fonda* turned on the issues of foreseeability and reliance. The court held that where the pathologist should have reasonably expected that other practitioners would rely on his work in determining the mode of the patient’s treatment, constructive participation in the treatment

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120. *Montgomery v. S. County Radiologists*, No. ED 77285, 2000 WL 1846432, at \*13-14 (Mo. Ct. App. Dec. 19, 2000).

121. *Uelk*, 2000 WL 1873293, at \*2-3.

122. *Montgomery*, 2000 WL 1846432, at \*13-14; see discussion *infra* Part IV.

123. *Fonda v. Paulsen*, 46 A.D.2d 540 (N.Y. App. Div. 1975).

124. *Id.* at 541.

125. *Id.* at 542.

126. *Id.* at 545.

127. *Id.*

128. *Fonda*, 46 A.D.2d at 543.

would be imputed to the pathologist or diagnostician for as long as treatment continued.<sup>129</sup>

On similar facts, the Wyoming Supreme Court decided *Sharsmith v. Hill* in accordance with *Fonda*.<sup>130</sup> In *Sharsmith*, the plaintiff had contacted her physician regarding a lump behind her knee.<sup>131</sup> After testing, her physician concluded that the lump was benign, and took no action until the mass enlarged and required surgery for removal.<sup>132</sup> After the removal surgery, the mass was examined by two of the hospital's pathologists.<sup>133</sup> Both pathologists determined that the mass was benign.<sup>134</sup> The plaintiff experienced swelling at the operative site nine months after the surgery, at which point her physician requested that one of the original pathologists again review the slides of the mass.<sup>135</sup> That pathologist thereafter personally assured the plaintiff that the mass was benign.<sup>136</sup> The plaintiff later returned to her physician, who found two distinct masses around the operative site, and sent the plaintiff for a biopsy, which showed that the tumors were malignant.<sup>137</sup> Upon review of the original slides, it was determined that the original mass removed was malignant, and not benign as the pathologist had reported.<sup>138</sup> The plaintiff subsequently elected to have her leg amputated above the knee.<sup>139</sup>

The plaintiff filed suit against both pathologists who reviewed the original slides and misdiagnosed the mass as benign, claiming that the statute of limitations was tolled by way of the "continuous treatment" exception.<sup>140</sup> The plaintiff argued that her physician's course of treatment should be imputed to the pathologists and the hospital because her physician continued to rely upon the misdiagnosis of the pathologists throughout the course of the plaintiff's treatment.<sup>141</sup> The court agreed with plaintiff, finding that it was the physician's adherence to the pathologist's diagnosis that dictated the nature

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129. *Id.* at 543. Interpreted this way, the practitioner guilty of the initial malpractice is subject to the same period of limitations as those who continued the malpractice as a reasonably foreseeable result of the initial wrong. Of course, a point may come where continuation of a course of treatment was negligent in and of itself irrespective of the original erroneous diagnosis; at that point, the diagnostician's constructive continuance in the treatment would have ceased. *Id.*

130. *Sharsmith v. Hill*, 764 P.2d 667 (Wyo. 1988).

131. *Id.* at 668.

132. *Id.*

133. *Id.*

134. *Id.*

135. *Sharsmith*, 764 P.2d at 668.

136. *Id.*

137. *Id.* at 669.

138. *Id.* at 669-70.

139. *Id.* at 669.

140. *Sharsmith*, 764 P.2d at 669-70.

141. *Id.* at 670.



and duration of the plaintiff's treatment.<sup>142</sup> The Wyoming court, like New York, emphasized the fact that the plaintiff's physician relied on the misdiagnosis.<sup>143</sup> The court held that based on "grounds of fairness as well as basic logic," until the alleged misdiagnosis was corrected, or until her physician ceased to rely upon it, the pathologist's constructive involvement in that treatment was sufficient to prevent the running of the statute of limitations.<sup>144</sup>

The Delaware Superior Court relied on the *Fonda* decision and reached a similar conclusion in *Bissell v. Papavastros Associates Medical Imaging*.<sup>145</sup> In *Bissell*, the personal representative of the deceased patient's estate brought a medical malpractice action against a radiologist who negligently read and reported the results of a series of three mammograms performed by the same laboratory over a three-year period.<sup>146</sup> Each mammogram was compared to the others, and each time cancer was ruled out.<sup>147</sup> However, the plaintiff was diagnosed with cancer a year later and died the following year as a result.<sup>148</sup>

The plaintiff claimed that the tests were part of a collective pattern of negligent treatment, while the defendant argued that the tests were separate and discrete.<sup>149</sup> The court noted that each new test required not only the defendant's own analysis, but also a comparison to the prior test.<sup>150</sup> Citing *Fonda*, the *Bissell* court denied the defendant's motion for summary judgment, stating that it raised a genuine issue of material fact on the question of whether the mammograms were discrete negligent acts or a continuous negligent act.<sup>151</sup> The court stated that, in circumstances where the pathologist should have expected that his work would be relied on by practitioners in determining the mode of treatment, it was appropriate to impute to the diagnostician constructive participation for as long as treatment continued.<sup>152</sup>

In *Sander v. The Geib, Elston, Frost Professional Association*, a similar case in South Dakota, the court came to the same basic conclusion as *Bissell*.<sup>153</sup> The plaintiff in *Sander* received routine gynecological examinations from her general physician, including pap smears.<sup>154</sup> All of the pap smears taken by the

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142. *Id.*

143. *Id.*

144. *Id.* (quoting *Echols v. Keeler*, 735 P.2d 730, 731 (Wyo. 1987)).

145. 626 A.2d 856, 865 (Del. Super. Ct. 1993).

146. *Id.* at 857.

147. *Id.* at 858.

148. *Id.* at 859.

149. *Id.* at 864.

150. *Bissell*, 626 A.2d at 864.

151. *Id.* at 865.

152. *Id.*

153. 506 N.W.2d 107, 114 (S.D. 1993).

154. *Sander*, 506 N.W.2d at 110.

physician were sent to the same clinical laboratory for evaluation.<sup>155</sup> The laboratory had a process by which it analyzed each of the plaintiff's slides, comparing new slides to previous slides to make a diagnosis.<sup>156</sup> The pathologists reported no abnormal or atypical cells in any of the patient's slides.<sup>157</sup> However, when the plaintiff later consulted her physician complaining of pelvic pain, erratic periods, and tiredness, her physician took another smear which revealed cervical cancer.<sup>158</sup> After the previous slides were re-examined, it was discovered that the laboratory had misread the slides, and that cancerous cells had been present three years earlier.<sup>159</sup> The plaintiff brought a medical malpractice action against the clinical laboratory for alleged negligence in reading her pap smear slides. The trial court found that there was a continuing treatment relationship between the plaintiff and the laboratory.<sup>160</sup>

The South Dakota Supreme Court agreed with the trial court, recognizing that the continuing treatment doctrine is "based upon an on-going, continuous, developing and dependent relationship."<sup>161</sup> The court refused to take seriously the defendant's argument that information regarding deficiencies in its testing program had nothing to do with the plaintiff's level of trust.<sup>162</sup> The service provided by the laboratory was critically important to the patient who was completely dependent upon the professional to screen for an insidious disease.<sup>163</sup> *Sander*, like the previous courts cited above, focused on reliance, noting that the plaintiff's physician relied upon the laboratory's classification system for detecting potential cancer and relied upon its reports to facilitate his choice of therapy.<sup>164</sup> The court also found particularly relevant the fact that the relationship between the plaintiff and the lab was not sporadic, but routine.<sup>165</sup> Furthermore, during the time relevant to the suit, the plaintiff had no contact with any other party for her gynecology exams, pap smears, or screenings until after she was diagnosed with cancer.<sup>166</sup>

While this is only a small sampling of other jurisdictions' approaches in this area, the analysis required in deciding whether or not to apply the continuing care exception is highly fact-specific. The facts of these previously

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155. *Id.*

156. *Id.* at 115.

157. *Id.* at 111.

158. *Id.*

159. *Sander*, 506 N.W.2d at 112.

160. *Id.*

161. *Id.* at 114.

162. *Id.*

163. *Id.* (citing *Morgan v. Taylor*, 451 N.W.2d 852, 858 (Mich. 1990)).

164. *Sander*, 506 N.W.2d at 115.

165. *Id.*

166. *Id.*

discussed cases are remarkably similar to the facts in *Montgomery*. In addition, the underlying themes present in the courts' analyses shed light on the rationale underpinning the *Montgomery* decision.

V. *MONTGOMERY V. SOUTH COUNTY RADIOLOGISTS*: EXPANSION OF THE CONTINUING CARE RULE

A. *The Majority: A Diagnostic Health Care Entity's Duty of Continuing Care*

Evan Montgomery sought treatment from a neurosurgeon at St. Anthony's Medical Center in St. Louis, Missouri, for chronic lower back pain.<sup>167</sup> In order to make a diagnosis, Montgomery's neurosurgeon referred him for diagnostic radiological services to South County Radiologists ("SCR"), St. Anthony's exclusive radiological services provider.<sup>168</sup> SCR's medical doctors specialized in radiology.<sup>169</sup> These radiologists interpreted films, which were taken by technicians at St. Anthony's.<sup>170</sup> When a patient was first referred to SCR, a patient file was created, on which an SCR radiologist recorded patient diagnostics and information.<sup>171</sup> Each time an SCR radiologist reviewed a patient's films, the radiologist placed the film and the diagnostic report in the patient's file.<sup>172</sup> It was common for patients to receive additional radiological services after the initial consultation.<sup>173</sup> When this occurred, the radiologists reviewed and compared previous reports and films.<sup>174</sup>

Montgomery underwent a series of three services by SCR, each by different radiologists at the facility who, when reviewing his film, failed to recognize a cancerous tumor on his spine.<sup>175</sup> None of the radiologists personally saw or examined Montgomery, but only viewed his films.<sup>176</sup> Eight months after his first service at SCR, Montgomery contacted another radiologist not associated with SCR, who immediately detected the tumor in his lower back.<sup>177</sup> Montgomery thereafter terminated treatment by SCR, and two years and eight months from the inception of treatment by SCR, Montgomery and his wife filed suit against SCR and its three radiologists for medical negligence.<sup>178</sup>

167. *Montgomery v. S. County Radiologists*, 49 S.W.3d 191, 192 (Mo. 2001).

168. *Id.*

169. *Id.*

170. *Id.*

171. *Id.* at 193.

172. *Montgomery*, 49 S.W.3d at 193.

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

177. *Montgomery*, 49 S.W.3d at 193.

178. *Id.*

Both SCR and Dr. Szoko, the first radiologist who reviewed Montgomery's films, moved for summary judgment alleging that Montgomery filed suit after the two-year statute of limitations.<sup>179</sup> The circuit court ruled for Szoko and SCR, specifically noting that the "continuing care" exception did not apply.<sup>180</sup> On appeal, the Eastern District reversed the grant of summary judgment to both Szoko and SCR and remanded the case.<sup>181</sup> *Montgomery* arrived at the Missouri Supreme Court after a dissenting judge transferred the case.<sup>182</sup>

Judge Duane Benton delivered the supreme court's opinion in *Montgomery*, concluding that: (1) the court properly entered summary judgment in favor of Szoko because the Montgomerys' suit exceeded the two-year statute of limitations of section 516.105 and did not fall under the "continuing care" exception; and (2) the court erred in granting partial summary judgment to SCR because it was a health care entity that owed a duty of continuing care to the plaintiff.<sup>183</sup>

Regarding the plaintiff's claim against Dr. Szoko, the supreme court noted that Szoko committed only one act on one specific date: the initial diagnostic service on February 14, 1995.<sup>184</sup> The plaintiffs claimed that Szoko had a duty of continuing care to Montgomery based on the fact that Szoko performed the initial radiological service, participated as a shareholder with other physicians in a rotating assignment system, never withdrew or was dismissed as Montgomery's physician and provided essential services to Montgomery.<sup>185</sup> This argument was dismissed by the court without any explicit consideration, other than to say that where a physician only has contact with a patient once, the statute of limitations begins to run on that date.<sup>186</sup> Citing *Thatcher*, the *Montgomery* court noted that a prerequisite for the continuing care exception is that a patient was under the doctor's ongoing care.<sup>187</sup> The court found that the Montgomerys' allegations were insufficient to show that Szoko's care was "continuing."<sup>188</sup> Therefore, summary judgment was granted to Dr. Szoko.

With regard to the claim against SCR, the court held that the Montgomerys alleged a genuine issue of material fact concerning whether SCR had a duty of continuing care.<sup>189</sup> The plaintiffs successfully argued that, since SCR was the

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179. *Id.*

180. *Id.*

181. *Id.* at 192.

182. *Montgomery*, 49 S.W.3d at 193.

183. *Id.* at 194-95.

184. *Id.* at 194.

185. *Id.*

186. *Id.*

187. *Montgomery*, 49 S.W.3d at 194.

188. *Id.*

189. *Id.*

sole provider of radiological services for St. Anthony's, adopted the system of rotating physicians, never withdrew or was dismissed as Montgomery's provider of diagnostic services, and provided three services over nine months that were essential to Montgomery, there was a sufficient relationship to constitute "continuing care" between SCR and the plaintiff.<sup>190</sup>

Just as the defendant in *Shah* argued that services should be fragmented rather than viewed as a whole, SCR argued that each interpretation of an x-ray or MRI was a discrete, intermittent service, so that the prerequisite of "continuing care" was not met.<sup>191</sup> SCR reasoned that the treatment relationship ended with each film interpretation, which they asserted was the "necessity that gave rise to the relationship."<sup>192</sup>

The court found that SCR's view of the relationship between a diagnostic service provider and patient was too narrow.<sup>193</sup> It held that "the necessity that gives rise to the relationship is the patient's ailment or condition."<sup>194</sup> Citing *Cazzell v. Schofield*,<sup>195</sup> the court reaffirmed the long enunciated proposition that the physician-patient relationship can only be terminated in a few select ways, namely "by the consent of the parties, or . . . by the dismissal of the physician, or until his services are no longer needed."<sup>196</sup> The court implied that none of these factors were present in this case.

SCR's argued that only the treating physician can have a duty of continuing care and treatment to the patient, and that SCR's diagnostic services were not of such a nature as to charge it with a duty of continuing care.<sup>197</sup> *Montgomery* stated that SCR's argument was without validity, as neither *Shah* nor *Dunagan* held that health-care entities could *never* have a duty of continuing care.<sup>198</sup> The court noted that by invoking section 516.105, SCR had already conceded that it was an "entity providing health care services."<sup>199</sup> Looking only at the text of section 516.105, the court found that the statute covers any "entity providing health care services," without distinguishing between different types of providers.<sup>200</sup>

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190. *Id.*

191. *Shah v. Lehman*, 953 S.W.2d 955, 956 (Mo. Ct. App. 1997); *Montgomery*, 49 S.W.3d at 194.

192. *Montgomery*, 49 S.W.3d at 194.

193. *Id.*

194. *Id.*

195. *Cazzell v. Schofield*, 8 S.W.2d 580, 587 (Mo. 1928).

196. *Montgomery*, 49 S.W.3d at 194 (citing *Cazzell*, 8 S.W.2d at 587).

197. *Montgomery*, 49 S.W.3d at 195. SCR cited dicta from both *Shah* and *Dunagan* for the proposition that health care entities cannot have a duty of continuing care.

198. *Id.* As discussed *supra*, both *Shah* and *Dunagan* did not reach the issue of whether health care entities could have a duty of continuing care, but rather held that the rule did not apply under the factual circumstances in each case. See *supra* notes 89-107 and accompanying text.

199. *Montgomery*, 49 S.W.3d at 195; MO REV. STAT. § 516.105 (2000).

200. *Montgomery*, 49 S.W.3d at 195; MO REV. STAT. § 516.105 (2000).

The court recognized that the treating physician must rely on specialists, such as those providing radiological and other diagnostic services.<sup>201</sup> As stated in *Weiss*, “the doctor must render [continuing care and treatment] or must see to it that some other competent person does so until termination of the physician-patient relationship.”<sup>202</sup> Fleshing out this line of reasoning, the majority found that just as a treating physician owes a comprehensive duty of continuing care and treatment to a patient, “an entity that provides continuing radiological services has a proportionate duty of continuing care until its relation[ship] with the patient ends.”<sup>203</sup>

Lastly, the court dismissed SCR’s argument that radiologists do not have a physician-patient relationship that charges them with any duty of continuing care.<sup>204</sup> Citing *Shaw*, SCR argued that its relationship with Montgomery was not a “highly personal and close one.”<sup>205</sup> The court found this argument to be without validity holding that SCR was composed of ten medical doctors specializing in radiology.<sup>206</sup> While the radiology group’s obligations are not as comprehensive as the treating physician’s, “its services are of such a type as to charge it with accurately interpreting and comparing x-rays and MRIs for the same complaint by the same patient about the same part of the body, three times within a nine-month period.”<sup>207</sup>

*B. Limbaugh’s Dissent: Was There a Sufficient Relationship to Warrant Extending Continuing Care?*

Judge Benton’s holding, tolling the statute of limitations against SCR, drew a single dissenter, Chief Justice Limbaugh. Limbaugh argued that extending the continuing care exception to SCR was inconsistent with the rationale behind the exception. Limbaugh primarily disagreed with the court’s argument that the necessity giving rise to the continuing care relationship was the patient’s ailment or condition.<sup>208</sup> Limbaugh posited that when SCR and its physicians undertook each examination of the patient, neither they, nor the patient intended that care or treatment would continue beyond the conduct of the examination ordered.<sup>209</sup>

Limbaugh further argued that, since the treating physician was “calling the shots” as to whether SCR and its physician should conduct additional

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201. *Montgomery*, 49 S.W.3d at 195.

202. *Id.* (quoting *Weiss v. Rojanasathit*, 975 S.W.2d 113, 120 (Mo. 1988) (en banc)) (alteration in original).

203. *Montgomery*, 49 S.W.3d at 195.

204. *Id.*

205. *Id.* (quoting *Shaw v. Clough*, 597 S.W.2d 212, 215 (Mo. Ct. App. 1980)).

206. *Montgomery*, 49 S.W.3d at 195.

207. *Id.*

208. *Id.* at 196 (Limbaugh, J., dissenting).

209. *Id.*

examinations, and SCR did not have the option or the duty to continue or discontinue the series of examinations that was ordered, there was no “relationship” to speak of.<sup>210</sup> Additionally, Limbaugh focused on the fact that while entities, as well as individuals, may have a duty of continuing care, radiological service providers do not have the same duty as individuals serving in the role of a treating physician.<sup>211</sup>

## VI. AUTHOR’S ANALYSIS

### A. *Policy Considerations*

While the holding in *Montgomery* was rendered decades after other jurisdictions already extended the continuing care exception to diagnostic health care providers, this decision clearly reflects the vast and continuing changes that have taken place in current health care practice.<sup>212</sup> The Eastern District in *Montgomery* noted that in our rapidly changing technological society, there are daily medical advancements and achievements, which have influenced both the practice of health care and the quality of patients’ lives.<sup>213</sup> People expect expanding care for the wide range of medical complaints they have, and the astute patient realizes that the manner in which health care in this country is provided is changing.<sup>214</sup> Today, patients no longer go to a single physician expecting total treatment, but instead understand that one doctor is neither capable nor competent to provide for every medical exigency.<sup>215</sup> While a patient’s regular physician may prove effective and affordable in many circumstances, specialists are integral members of the modern health care team and may be more successful and efficient in providing care to patients than a regular physician in particular clinical circumstances.<sup>216</sup> The Eastern District noted, however, that, in spite of the fact that one physician often cannot provide treatment in many specialized situations, “patients do expect that their primary doctor will refer, consult, and rely on a team of duly qualified health care professionals to maintain and treat medical conditions for their total health care needs.”<sup>217</sup>

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210. *Id.*

211. *Montgomery*, 49 S.W.3d at 196.

212. *Montgomery v. S. County Radiologists*, No. ED 77285, 2000 WL 1846432, at \*12 (Mo. Ct. App. Dec. 19, 2000).

213. *Id.*

214. *Id.*

215. *Id.*

216. Bryan A. Liang, *Access to Health Care in the United States*, 22 J. LEGAL MED. 211, 217 (2001).

217. *Montgomery*, 2000 WL 1846432, at \*12.

Today, doctors' expanding caseloads require assistance from other health care professionals for specialized care and treatment.<sup>218</sup> "Changes in our health care system are continuing, even accelerating."<sup>219</sup> Because of such changes, patients inevitably receive health care from a diverse number of providers, a phenomenon that is only certain to increase with the additional emphasis on primary care and managed care.<sup>220</sup> In light of these facts, patients understand that doctors are no longer capable of providing every essential service or treatment. Patients understand that they will be assisted and monitored by professional health care providers as part of a treatment team focused on providing them with medical care in all areas necessary for treatment and diagnosis.<sup>221</sup> Unfortunately, however, even though modern medicine involves other decision-making entities such as hospitals and HMOs, "[c]ourts have been slow to recognize that these institutions are an integral part of the care that a patient receives, and that such care often encompasses the 'continuing care' that follows an incident of malpractice resulting in injury."<sup>222</sup> Up until the *Montgomery* decision, Missouri had not taken a step in that direction.

As noted by Dr. F. Ronald Feinstein, an administrator of the largest managed care organization in the world, "[t]he fundamental shift required to provide both quality and cost-effective care must be to a health care system with members acting as a team using a patient-centered model for care delivery."<sup>223</sup> However, because doctors so often must rely on specialists to provide full medical care to patients, these specialists must ultimately be accountable for their actions.<sup>224</sup>

The Eastern District emphasized that the court does not wish to encourage primary care providers to attempt medical care outside their capabilities, and specialists should not be immunized from liability due to the fact that they are providing specialized treatment as part of a medical care team.<sup>225</sup> For this reason, the Eastern District court found that treatment by a diagnostic care facility should be viewed as part of a total health care management plan, rather than fragmented into particular visits or examinations.

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218. *Id.* at \*13.

219. Ezekiel J. Emanuel, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, JAMA, Jan. 25, 1994, at 4.

220. *Id.*

221. *Montgomery*, 2000 WL 1846432, at \*13.

222. *Uelk*, 2000 WL 1873293, at \*3 (Teitelman, J., concurring).

223. Liang, *supra* note 220, at 217.

224. *Montgomery*, 2000 WL 1846432, at \*13.

225. *Id.* "Under this paradigm, . . . the members of the team will represent all the expertise required to comprehensively treat the patient so that the right thing is done at the right time." Liang, *supra* note 200, at 217.



*B. Montgomery Revisited*

Applying this reasoning to *Montgomery*, the continuing care rule should apply to Szoko as well as SCR, yet the court refused to toll the statute against Szoko.<sup>226</sup> The majority rejected SCR's argument that the service the group provides is discrete and intermittent, ending with each interpretation.<sup>227</sup> The court reasoned that SCR's view of the relationship was too narrow, and on that reasoning it only logically follows that the statute of limitations should be tolled against Szoko as well. Viewing the radiology group as only a small part of a total health management team, and Dr. Szoko as a part of that group, the duty of continuing care should equally extend to both. Both SCR and Szoko were part of that health care team providing continuing services to patients at St. Anthony's. After all, it was Szoko's initial diagnosis that Montgomery's physician relied on in commencing a treatment plan for Montgomery. Additionally, each of the other two radiologists who viewed Montgomery's subsequent films utilized Szoko's report to some extent in making their diagnoses. As recognized in *Sharsmith*, Szoko's treatment of Montgomery continued for as long as his physician relied on that negligent interpretation of the film in his continuing treatment of Montgomery, or until the misdiagnosis was corrected.<sup>228</sup> For this reason, it seems logical that the court should view Dr. Szoko's liability as it views the radiology group's.

Moreover, as the Eastern District recognized, SCR argued in *Montgomery* that each service it provided was merely a discrete, intermittent service.<sup>229</sup> This argument is unrealistic, as well as contrary to what the radiology group's own policy contemplated. SCR's formal method of reviewing patient information on each visit and synthesizing findings with those reported previously indicate that SCR anticipated providing continuing care to patients on a regular basis.<sup>230</sup> Furthermore, most diagnostic service providers in SCR's position, the sole contracted service provider for a hospital, could certainly not be surprised to find that the diagnosis they provide to a treating physician is an integral part in the physician's treatment and diagnosis.<sup>231</sup> Clearly, clinical laboratories provide essential health services in aiding physicians by furnishing information that is invaluable to the diagnosis and treatment of disease.<sup>232</sup> Moreover, the improper performance of a laboratory procedure may induce an erroneous diagnosis or contribute to the selection of an inappropriate method

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226. *Montgomery v. S. County Radiologists*, 49 S.W.3d 191, 194 (Mo. 2001).

227. *Id.*

228. *Sharsmith v. Hill*, 764 P.2d 667, 670 (Wyo. 1988).

229. *Montgomery*, 2000 WL 1846432, at \*3.

230. *Id.* at \*13.

231. *Montgomery*, 49 S.W.3d at 195.

232. Blum, *supra* note 1, at 46. This definition of clinical laboratories is set forth in N.Y. PUB. HEALTH LAW § 570 (Consol. 1990).

of treatment, resulting in prolonged or unnecessary hospitalization, injury, or even death.<sup>233</sup> Although the services of a physician and laboratory are divisible, they act as collaborators, not antagonists.<sup>234</sup> The work of a patient's physician and a radiologist interpreting the patient's films, for example, is interrelated, "for the analysis performed by a laboratory . . . bears directly upon the course of medical treatment to be provided; a proper diagnosis can facilitate recovery while an incorrect analysis can spell prolonged affliction."<sup>235</sup>

Additionally, while the supreme court chose not to set forth specific policy reasons underlying its denial of summary judgment to SCR, the holding is consistent with the rationale evidenced by the Eastern District in *Montgomery* at the appellate level.<sup>236</sup> The same theme of trust and reliance on the expertise of professionals, found in cases in other jurisdictions applying the continuing treatment exception, applies in *Montgomery*.

The facts of *Montgomery* are noticeably similar to the factual circumstances in cases from other jurisdictions where courts have extended the "continuing care" exception. Just as the South Dakota court recognized in *Sander*,<sup>237</sup> not only did Montgomery himself rely on the diagnostic services, but Montgomery's neurologist equally relied upon the laboratory's specific system for detecting disease in order to properly diagnose Montgomery. Additionally, the review system used by SCR in *Montgomery* was similar to that of the diagnostic group in *Sander* in that both groups reviewed the previous reports and films on the particular patient when the patient returned for subsequent treatment at the facility.<sup>238</sup> For that reason, SCR, like the *Sander* diagnostic group, knew that they were providing continuing care as a team to patients who routinely returned for radiological services.<sup>239</sup>

The facts of *Montgomery* are, likewise, similar to *Sharsmith*.<sup>240</sup> Like the general practitioner in *Sharsmith* who treated the patient based on the diagnosis obtained from the laboratory, Montgomery's physician continued to rely upon the misdiagnosis of the pathologists throughout his course of treatment of the plaintiff, and it was his neurologist's adherence to the pathologist's diagnosis

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233. *Id.* The court in *Calvin v. Schlossman* recognized this principle where it held that a private medical laboratory had the status necessary to bring it within the jurisdiction's medical malpractice statutory scheme. 427 N.Y.S.2d 632 (N.Y. App. Div. 1980).

234. Blum, *supra* note 1, at 47.

235. *Id.*

236. *Montgomery v. S. County Radiologists*, No. ED 77285, 2000 WL 1846432, at \*13 (Mo. Ct. App. Dec. 19, 2000); *see also Sharsmith v. Hill*, 764 P.2d 667, 670 (Wyo. 1988).

237. *Sander v. The Geib, Elston, Frost Prof'l Ass'n*, 506 N.W.2d 107, 114-15 (S.D. 1993).

238. *Id.*

239. *Montgomery*, 2000 WL 1846432, at \*13.

240. *Montgomery v. S. County Radiologists*, 49 S.W.3d 191 (Mo. 2001); *Sharsmith*, 764 P.2d 667.

that dictated the nature and duration of the plaintiff's treatment.<sup>241</sup> SCR's services were essential to Montgomery's neurologist's diagnosis, and essential to his treatment of Montgomery's lower back ailments.<sup>242</sup>

As the Eastern District recognized, the radiological services provided to Montgomery were an essential part of his care without which his neurosurgeon could not have properly treated him.<sup>243</sup> Montgomery placed his trust in his neurosurgeon and in those health care professionals who his neurosurgeon involved as part of the health care team in the continuous treatment of his lower back pain.<sup>244</sup> While *Montgomery* did not specifically explain the reasons for the holding, this rationale comports with that of the Eastern District and other jurisdictions deciding cases under similar fact patterns.

While Limbaugh focused a large portion of his dissent on the fact that SCR and its physicians did not anticipate a continuing relationship with Montgomery,<sup>245</sup> the flaw in this argument is in its suggestion that the care provider's *intention* in treatment is of the greatest importance to the duty of continuing care. Does a physician or health care provider have to intend for treatment to continue in order for care to be continuing?

Whether the health care provider is a physician or a diagnostic group, the patient's needs should be determinative of whether care will continue, and that patient's needs often stem from the existence of a particular ailment or condition. To argue that a diagnostic group intends to provide only a one-time service ignores the fact that diagnostic entities provide an essential service that affects a patient's entire mode of treatment.

Under the circumstances in *Montgomery*, where a physician does not have the specialized training to recognize the presence of disease in the patient's film, the radiologist is providing more than just a one-time service, he is providing a diagnosis that will affect the physician's course of treatment of that patient.<sup>246</sup> In that sense, the radiologist's care is continuing. His diagnosis, or in Montgomery's case, misdiagnosis, has a substantial effect on the treatment scheme that the physician provides for the patient. The fact that the physician treats the patient relying on the radiologist's finding after viewing only a few slides on a few occasions does not exempt the radiologist from continuing to be a part of the patient's health care management team. So long as that physician is still relying on the diagnosis of that particular diagnostic group in treating the patient, the radiologist's treatment does not end until either the patient or physician terminates the radiologist's role as part of the patient's

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241. *Sharsmith*, 764 P.2d at 670.

242. *Montgomery*, 2000 WL 1846432, at \*13.

243. *Id.* at \*12.

244. *Id.*

245. *Montgomery*, 49 S.W.3d at 196-98.

246. *Montgomery*, 2000 WL 1846432, at \*12.

health care team or until the cessation of the necessity that gave rise to the relationship.<sup>247</sup>

But, as Limbaugh would ask, was not the treating physician “calling the shots?” Under Limbaugh’s reasoning, a diagnostic service provider would never be held accountable for negligence. Where the radiology group is the sole provider of services for a particular physician, and that physician employs the group’s services in the treatment of a patient, that group is part of a health care team involved in the continuing treatment of the patient. The physician may “call the shots,” but the physician does so relying on the expertise of other team members. Negligence on the part of any one service provider who is part of that team can have an effect on the entire course of treatment that the physician takes. Society has chosen accountability as its main mechanism to ensure respect for those in the health care field.<sup>248</sup> Therefore, all medical decision-makers must be held equally accountable for their decisions affecting patients’ health.

C. *The Malpractice Statute Should Be Tolled—But is the Continuing Care Rule the Way to Go?*

The author agrees with the other jurisdictions that focus on reliance as the primary justification for applying the continuing care rule to diagnostic health care entities. It is important to note, however, as stated above, that the Missouri continuing care rule first articulated in *Thatcher* is based on the rationale that “[t]he doctor-patient relationship is . . . a highly personal and close one.”<sup>249</sup> When, if ever, does a patient have a highly close and personal relationship with a diagnostic services physician or group practice? While the author agrees with the *Montgomery* court’s decision to toll the statute of limitations, the *Montgomery* court’s use of the continuing care rule in doing so is inappropriate. The justification behind the continuing care rule articulated in *Thatcher* simply does not comport with the relationship between a diagnostic radiologist or diagnostic group and a patient.

Diagnostic radiologists diagnose diseases of the human body using x-rays, ultrasound, radio waves and radioactive materials.<sup>250</sup> They generally act as consultants to other physicians who are caring for a patient, reading films for medical diagnostic purposes.<sup>251</sup> Diagnostic radiologists advise doctors of the best radiographic examination to perform for a particular patient’s problem,

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247. *Weiss v. Rojanasathit*, 975 S.W.2d 113, 119-20 (Mo. 1998) (en banc).

248. See Carl Gieseler, *Managers of Medicine: The Interplay Between MCOs, Quality of Care, and Tort Reform*, 6 TEX. WESLEYAN L. REV. 31, 63 (1999).

249. *Shaw v. Clough*, 597 S.W.2d 212, 215 (Mo. Ct. App. 1980).

250. Kaitatari Hihirangi, *Diagnostic Radiologist*, at [http://www.careers.co.nz/jobs/3c\\_doc/j80011a.htm](http://www.careers.co.nz/jobs/3c_doc/j80011a.htm) (last modified Apr. 12, 2001).

251. University of Maryland Medicine, *Radiology Information Guide*, at <http://www.marylandradiology.com> (last visited Jan. 22, 2002).

supervise radiographic examinations of a patient performed by the medical radiation technologist, interpret images from radiographic examinations, and review examinations with the doctors treating the patient.<sup>252</sup> Just about every area of medicine uses diagnostic radiology to aid in treatment of the patient.<sup>253</sup>

Because of the types of tasks the diagnostic radiologist and the diagnostic group perform, the relationship between a diagnostic radiologist and a patient is frequently anything but “close and personal.” Often, the diagnostic radiologist is nothing more than a faceless specialist acting behind the scenes, making conclusions that affect a patient’s whole course of treatment without ever having met the patient. For this reason, courts have found that radiology traditionally has not involved the close personal relationship likely to develop between a patient and a treating physician in other specialties.<sup>254</sup>

Because diagnostic radiologists so often do not develop the personal relationship with the patient that the continuing care rule presupposes, it does not seem fit under Missouri’s rationale to apply the continuing care rule against such specialists. However, *Montgomery* likely responded to the modern changes in health care by expanding this rule. The fact remains that expanding this rule to include a diagnostic entity that does not have that personal physician-patient relationship goes directly against the rationale behind the continuing care rule. However, if the court cannot extend the continuing care exception in worthy circumstances, such as those present in *Montgomery*, what other possible recourse is out there?

#### D. *An Alternative Approach*

While the *Montgomery* decision will likely have a great impact on claims of medical negligence involving health care services provided by diagnostic specialty groups in Missouri, the few reasons *Montgomery* advances in support of its argument are less than enlightening. Because *Montgomery* did not fully seize this opportunity to explain its reasoning behind extending the continuing care rule to a diagnostic group, which clearly did not have a personal relationship with *Montgomery*, it may be that this exception has run its course. In other words, this decision may be evidence that the court supports adoption of a discovery rule.

Thus far, Missouri courts have repeatedly rejected the adoption of a discovery rule for medical malpractice actions, stating that the argument is best

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252. Irirangi, *supra* note 250.

253. University of Maryland Medicine, *supra* note 251.

254. See *Eslami v. Eslami*, 591 A.2d 411 (Conn. 1991); Patricia C. Kuszler, *Telemedicine and Integrated Health Care Delivery: Compounding Malpractice Liability*, 25 AM. J.L. & MED. 297, 326 n.11 (1999).

addressed by the General Assembly.<sup>255</sup> The discovery rule provides that a cause of action accrues not at the time of the negligent act, as section 516.105 now provides, but at the time a plaintiff discovers, or reasonably should have discovered, the injury.<sup>256</sup> This is a more reasonable approach since plaintiffs are frequently unable to detect the problem giving rise to liability for negligence on the date the act occurred, often because the problem may not emerge until much later, after the statutory period has run.<sup>257</sup> At least twenty-six states currently have a discovery rule in effect for medical malpractice claims.<sup>258</sup> These states have given various reasons for adoption of the

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255. While recognizing that a discovery rule for malpractice actions is appealing as far as justice is concerned, the court in *Weiss* noted that the legislative branch of the government has determined the policy of this state and has clearly fixed the time when the limitation period begins to run against actions for malpractice. *Weiss v. Rojanasathit*, 975 S.W.2d 113, 121 (Mo. 1998).

In *Laughlin v. Forgrave*, the Missouri Supreme Court was faced with a request to adopt a discovery rule in cases where foreign objects were left within a patient after surgery. At that time, the court responded:

It is obvious that plaintiff did not know and could not have known of the cause of her injury and damage or that she had a cause of action against the defendant before September, 1962; she certainly could not have discovered the cause of her pain and the damage she sustained when seven doctors did not. This argument is appealing and has some force, so far as justice is concerned; in that respect the conclusion we reach is distasteful to us. But, the legislative branch of the government has determined the policy of the state and clearly fixed the time when the limitation period begins to run against actions for malpractice. This argument addressed to the court properly should be addressed to the General Assembly. Our function is to interpret the law; it is not to disregard the law as written by the General Assembly.

*Laughlin v. Forgrave*, 432 S.W.2d 308, 314 (Mo. 1968).

More recently, the court reconsidered the issue in *Miller v. Duhart*. The court stated: [Section 516.105] is written with clarity and precision, and does not allow this court to assume that legislative intent was to the contrary. However, the legislature is strongly urged to correct the inequity which the present malpractice statute creates in discovery cases other than those concerned with foreign objects. Despite arguments to the contrary, that body is the best forum with which to deal with this problem. Courts should not legislate. Many of the problems in our legal system and indeed in our society as a whole have been caused by the judicial activism which creates uncertainty and instability in the law. This court declines to adopt a discovery rule.

*Miller v. Duhart*, 637 S.W.2d 183, 190 (Mo. Ct. App. 1982).

256. John F. Appelquist, *Will Missouri's 'Open Court' Guarantee Open the Door to Adoption of the 'Discovery Rule' in Medical Malpractice Cases?*, 52 MO. L. REV. 977, 984 (1987).

257. *Bartimus*, *supra* note 1, at 33. As section 516.105 is written, it can be argued that this statute bars meritorious cases through the use of a restrictive statute of limitation. While this statute seeks to cut down on the number of medical malpractice cases filed, it simultaneously has the potential to force some vague, questionable cases to be filed. Some non-meritorious cases are undoubtedly filed each year because attorneys, rushed by the shortened time period, do not have the time to have these matters adequately and properly evaluated. *Id.* at 34.

258. Appelquist, *supra* note 256, at 284. See *Leech v. Brailar*, 275 F. Supp. 897, 902 (D. Ariz. 1967); *Costa v. Regents of Univ. of Cal.*, 254 P.2d 85, 91 (Cal. Dist. Ct. App. 1953);

discovery rule.<sup>259</sup> Some courts have declared that the use of any different rule would allow an unjust result. Others have found that it is within the province of the judiciary to find a discovery rule when the legislature has been silent on the issue and the court determines that such a reform is necessary. Still others argued that the discovery rule must be adopted or else the statute of limitations without such a rule creates unreasonable and absurd results.<sup>260</sup> Nevertheless, Missouri remains in the minority in declining to implement this rule.

As of the *Montgomery* decision, Missouri has not adopted a discovery rule. Missouri, however, has slowly extended the continuing care exception and also has slowly chipped away at section 516.105 through the addition of other exceptions, which toll the statute of limitations in specific instances.

For instance, in response to the court's opinions in specific cases, the legislature has set forth two exceptions, which allow the discovery rule in limited circumstances: in cases involving foreign bodies and medical testing.<sup>261</sup> In cases in which a foreign object has negligently been left in the patient's body, section 516.105 allows the action to be brought "within two years from the date of discovery of the negligent act, or from the date on which the patient in the exercise of ordinary care should have discovered such alleged negligence."<sup>262</sup> A similar exception exists for a situation where there has been a negligent failure to inform a patient of the results of medical tests.<sup>263</sup>

The "*Thatcher* rule" came into existence long before these two exceptions were added to section 516.105, and this rule has likely survived for half a century due to its adaptability. Because the legislature has only adopted these few exceptions to section 516.105, and because the legislature has not codified

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Rosane v. Senger, 149 P.2d 372, 376 (Colo. 1944); City of Miami v. Brooks, 70 So.2d 306, 309 (Fla. 1954); Yoshizaki v. Hilo Hosp., 433 P.2d 220, 223 (Haw. 1967); Billings v. Sisters of Mercy, 389 P.2d 224, 232 (Idaho 1964); Lipsey v. Michael Reese Hosp., 262 N.E.2d 450, 455 (Ill. 1970); Waldman v. Rohrbaugh, 215 A.2d 825, 830 (Md. 1966); Johnson v. Caldwell, 123 N.W.2d 785, 791 (Mich. 1963); Johnson v. St. Patrick's Hosp., 417 P.2d 469, 473 (Mont. 1966); Spath v. Morrow, 115 N.W.2d 581, 585 (Neb. 1962); Flanagan v. Mount Eden Gen. Hosp., 248 N.E.2d 871, 873 (N.Y. 1969); Iverson v. Lancaster, 158 N.W.2d 507, 510 (N.C. 1968); Seitz v. Jones, 370 P.2d 300, 302 (Okla. 1961); Berry v. Branner, 421 P.2d 996, 1000 (Or. 1966); Ayers v. Morgan, 154 A.2d 788, 794 (Pa. 1959); Ruth v. Dight, 453 P.2d 631, 636 (Wash. 1969); Morgan v. Grace Hosp., 144 S.E.2d 156, 162 (W.Va. 1965).

259. *McBeth*, *supra* note 6, at 560-61.

260. *Id.*; Yoshizaki v. Hilo Hosp., 433 P.2d 220, 224 n.7 (Haw. 1967); Wilkinson v. Harrington, 243 A.2d 745, 749 (R.I. 1968); Layton v. Allen, 246 A.2d 794, 797 (Del. 1968); Frohs v. Greene, 452 P.2d 564, 565 (Or. 1969). Some states which have adopted the discovery rule also impose a double limitation by setting a time limit in which the claim must be brought after discovery of the injury, not to exceed an ultimate time limit which runs from the date of the negligent act itself. *McBeth*, *supra* note 6, at 561.

261. *Thatcher v. DeTar*, 173 S.W.2d 760 (Mo. 1943); *Weiss v. Rojanasathit*, 975 S.W.2d 113 (Mo. 1998); MO. REV. STAT. § 516.105 (2000).

262. MO. REV. STAT. § 516.105.

263. *Id.*

this exception, the continuing care rule continues to evolve as a tool for the court to toll the statute of limitations in deserving instances. The extension of this rule to diagnostic health care providers in *Montgomery* is no exception. At this rate, the continuing care rule may repeatedly be expanded to act like a discovery rule. While this trend could continue, there is at least one good reason why the discovery rule is a better alternative and should replace the continuing care exception.

Because the continuing care exception tolls the statute of limitations until the patient's relationship with the health care provider terminates, this exception has the potential to create an incentive for physicians and health care entities to terminate care at the earliest sign that a negligent act has been performed in order to start the running of the statute of limitations. While the *Thatcher* rationale focused on the duty of a health care provider to continue to provide treatment for a patient, it has also been recognized that one way to terminate the relationship is by the physician's withdrawal after reasonable notice.<sup>264</sup> In a situation where a negligent act has been committed, which does not fit into the "foreign body" or "medical test" exception, and the patient is still in a continuing care relationship with that physician, the only way the statute of limitations will begin to run is through termination of that relationship by one of the four means articulated in *Weiss*.<sup>265</sup> The potential for harm to the patient in a situation like this far outweighs any danger that could result from instituting a discovery rule. The Eastern District has made an "urgent plea" to the General Assembly to reconsider this issue in light of the injustice inherent in the current statute of limitations.<sup>266</sup> However, to this date, the Missouri Legislature has failed to do so.

Without adoption of the discovery rule, Missouri courts may find it impossible to expand the continuing care exception to accommodate every twist and turn so as to prevent unfairness to a patient who is being treated by a health care team. The discovery rule would eliminate the problems that the court currently faces in trying to stretch the continuing care exception to apply to diagnostic groups. This is likely the true reason why the court set forth so few reasons for its current expansion of the continuing treatment exception. Because of the potential injustice inherent in rejecting the discovery rule in favor of the "continuing care" exception, adopting a discovery rule is the only way of ensuring that justice prevails.

## VII. CONCLUSION

Since its beginning in Missouri nearly half a century ago, the continuing care exception has expanded and changed form to toll the often harsh statute of

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264. *Weiss*, 975 S.W.2d at 119.

265. *Id.* at 119-20.

266. Appelquist, *supra* note 256, at 986.



limitations in many deserving circumstances. *Montgomery* is certainly no exception. Because the court is powerless to institute a discovery rule, however, this exception has remained the only tool for the court to use to extend the statute of limitations. Dissenters may argue that the *Thatcher* rationale behind the continuing care exception simply will not allow the exception to withstand the continual changes in the medical world. That argument, however, is at odds with the reality that the state of health care in the United States is ever-evolving, with no end in sight. Although *Montgomery*'s sizeable stretch of the rationale behind this exception should alert the legislature that statutory change is a must, the long history of Missouri courts' futile efforts in breaking through to the legislature proves that this outlook would be naïve. Health care's continual transformation will only force the continuing care exception to perform more acrobatics in the years to come. At some point, before the "continuing care" bubble bursts, the Missouri legislature must take action and institute a discovery rule.

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