No. SC100089

IN THE SUPREME COURT OF MISSOURI

DANE TEMPLETON,

Plaintiff/Appellant

v.

CHARLES ORTH, DO AND ORTHOPEDIC SURGEONS, INC.

Defendants/Respondents.

Appeal from the Circuit Court of Clay County
Circuit Court Case No. 18CY-CV10374
Honorable David Paul Chamberlain, Circuit Judge
Case No. WD85405

AMICI CURIAE BRIEF OF THE MISSOURI STATE MEDICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AND CHAMBER OF COMMERCE OF THE UNITED STATES, IN SUPPORT OF DEFENDANTS/RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici are the Missouri State Medical Association (MSMA), American Medical Association (AMA), and Chamber of Commerce of the United States of America (U.S. Chamber). They have an interest in the proper enforcement of the statute of limitations governing medical-malpractice actions against health-care and mental-health providers set forth in section 516.105.[1] *Amici* submit this brief to explain why the continuous-course-of-treatment doctrine does not toll the statute of limitations for medical-malpractice claims against a physician if a patient is no longer receiving continuing care from that physician. This brief explains why tolling the statute of limitations here undermines the will of the Missouri General Assembly and the effective provision of health care in the State.

The MSMA is an organization of physicians and medical students. MSMA has approximately 4,000 members and is located in Jefferson City. Founded in 1850, MSMA serves its members through the promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

AMA is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policymaking process. The AMA was founded in 1847 to promote the science and art of

[1] All statutory references are to RSMo. 2016, unless otherwise noted.

medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty area and in every state, including Missouri.

The AMA and MSMA appear on their own behalves and as representatives of the AMA Litigation Center. The Litigation Center is a coalition among the AMA and the medical societies of every state, plus the District of Columbia. The Litigation Center is the voice of America's medical profession in legal proceedings across the country. Its mission is to represent the interests of the medical profession in the courts. It brings lawsuits, files amicus briefs, and otherwise provides support or becomes actively involved in litigation of general importance to physicians. *Amici*'s participation on behalf of their physician memberships will help educate the Court on the potential impact of this case on the practice of medicine in Missouri.

The U.S. Chamber is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than three million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the U.S. Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the U.S. Chamber regularly files *amicus curiae* briefs in cases, like this one, that raise issues of concern related to the proper application of liability law, including statutes of limitations.

CONSENT OF PARTIES

Pursuant to Missouri Supreme Court Rule 84.05(f), *amici* notified the parties on September 26, 2023, of their intent to file this *amici curiae* brief. Counsel for Defendants

consented to this filing, but counsel for Plaintiff withheld consent. Therefore, *amici* file this brief pursuant to Rule 84.05(f)(3) of the Missouri Rules of Civil Procedure in conjunction with a motion for leave to file the brief.

JURISDICTIONAL STATEMENT

Amici adopt Respondent's Jurisdictional Statement.

STATEMENT OF FACTS

The facts are not in dispute on the issues presented, which involve the statute of limitations for allegations of medical malpractice against Dr. Orth and Orthopedic Surgeons. As explained in the Court of Appeals ruling, Mr. Templeton was involved in a golf cart crash on September 16, 2012. He was ejected into a barbed wire fence and tree, injuring his right leg. Dr. Orth started treating him on September 18, 2012 and operated on his leg. *See Templeton v. Orth*, WD85405, 2023 WL 2776876, at *2 (Mo. App. Apr. 4, 2023). Templeton last visited Dr. Orth for this treatment on December 6, 2012, at which time Dr. Orth's clinic note states, "I am releasing [Templeton] from my care." *Id.*

More than three years later, on December 10, 2015, Templeton sought care from Dr. Orth a second time, this time for swelling in his right knee. Dr. Orth performed several procedures on Templeton, including an arthroscopy and arthrotomy on Templeton's right knee in March and May 2016, respectively. *See id*. at *2-3. Dr. Orth treated Templeton several times over the summer of 2016, with the last appointment being on August 29, 2016, at which point Dr. Orth wrote Templeton a prescription for Bactrim and advised Templeton to return for follow up care. *See id*. Templeton did not return or schedule any appointments with Dr. Orth after August 29, 2016. *Id*. at *3-4.

Rather, on September 7, 2016, Templeton sought care from a different orthopedic surgeon, Dr. Tilley. *Id.* at *3. Dr. Tilley advised Templeton to stop taking the medication prescribed by Dr. Orth to see if the condition worsened, which would be indicative of an infection. *Id.* Templeton heeded Dr. Tilley's instructions, stopped taking the medication, and returned for follow up care on October 10, 2016. *Id.* On October 11, 2016, Dr. Tilley performed surgery on Templeton's right leg finding two foreign bodies in Templeton's leg that may have entered his leg during the 2012 golf cart crash. *Id*.

On October 9, 2018, Templeton filed this action against Dr. Orth and Orthopedic Surgeons. *Id.* at *4. Whether defendants violated the standard of care and committed malpractice is not before the Court; this appeal relates solely to the statute of limitations, which is two years from the date of the malpractice alleged. *See* § 516.105, RSMo. Because the last date Dr. Orth saw Templeton was more than two years before the filing of the claim, Templeton is seeking to have the statute of limitations tolled under the continuous-course-of-treatment doctrine. The sole question here is whether Templeton was under Dr. Orth's care on October 9, 2016—two years before the suit was filed.

ARGUMENT

I. INTRODUCTION & SUMMARY OF ARGUMENT

The Missouri General Assembly enacted a strict two-year statute of limitations for medical-malpractice actions in § 516.105 to promote the prompt and fair adjudication of health care-related claims. Although not provided for in the statute, this Court has adopted the continuous-course-of-treatment doctrine, which tolls the statute of limitations in the highly limited circumstance where a patient has experienced an act of medical

malpractice and continues to receive care from the same physician for the injury. *See Weiss v. Rojanasathit*, 975 S.W.2d 113 (Mo. banc 1998). This doctrine is designed to foster an ongoing physician-patient relationship by enabling the physician to work to correct any medical errors without the patient having to resort to adversarial litigation against the physician to maintain a timely claim. The doctrine is not applicable, as here, when a patient was no longer receiving care from the allegedly negligent physician. In fact, Templeton was receiving treatment from another doctor.

Here, the circuit court correctly granted Defendants' Motion for Summary Judgment. It found "that the facts demonstrate that Defendants are entitled to judgment in their favor as a matter of law because Plaintiff's claims are barred by the two-year statute of limitations set forth in [] 516.105." D123 at 2. The circuit court likewise correctly found that "the facts demonstrate that Plaintiff's claims do not fit within any statutory exception," including the continuous-course-of-treatment doctrine. *Id.*

The Court of Appeals, in the first part of its ruling, correctly determined that any claims filed in 2018 related to the care Dr. Orth provided to Templeton in 2012 were clearly time-barred by the statute of limitations, and Templeton's decision to see Dr. Orth in 2015 and 2016 did not trigger the continuous-course-of-treatment exception. As the Court of Appeals explained, "'continuing care' only exists if a patient is actually receiving continuing treatment from the health-care provider for the condition on which the claim of negligence is based." *Templeton*, 2023 WL 2776876 at *8 (quoting *Tiemann v. SSM Reg'l Health Servs*., 632 S.W.3d 833, 846 (Mo. App. 2021)). Such continuing care "is not established merely because the patient later" returns for treatment. *Id.*

(quoting *Tiemann*, 632 S.W.3d at 846)). As the Court of Appeals observed, in all cases where the continuous-course-of-treatment doctrine tolled the statute of limitations, the patient "return[ed] to [the] medical defendants within two years of the alleged malpractice." *Id.* at *7. Therefore, once the two-year statute of limitations for the care Dr. Orth provided Templeton in 2012 expired in 2014, any claims related to the 2012 care expired and could not be revived by future medical care.

However, the Court of Appeals faltered in its second ruling when it departed from the circuit court and failed to apply this same law to the care Dr. Orth provided to Templeton in 2015 and 2016. Any claims Templeton may have had against Dr. Orth for medical malpractice related to care on or before August 29, 2016, were clearly time-barred under the two-year statute of limitations when the claims were filed on October 9, 2018. Further, Templeton was no longer being treated by Dr. Orth two years before the claims were filed—on October 9, 2016—so the continuous-course-of-treatment doctrine did not toll the statute of limitations to make the claims timely. The last time Templeton saw Dr. Orth was on August 29, 2016. Templeton stopped taking the medication Dr. Orth prescribed for him in mid-September 2016, and Templeton never returned to see Dr. Orth. In addition, Templeton demonstrably ended his relationship with Dr. Orth for these purposes in September 2016 once he submitted himself to Dr. Tilley's care, which included ending medication Dr. Orth prescribed so that Dr. Tilley could independently diagnose Templeton and recommend a course of treatment, which Dr. Tilley did.

A straightforward application of § 516.105 and the continuous-course-of-treatment doctrine is necessary. Otherwise, a patient may subjectively decide when he is no longer

under a physician's care, thereby giving him the ability to make his otherwise time-barred claims timely. *See id.* at *9 (stating Templeton "concedes that he manifested an intent to terminate his physician-patient relationship with Dr. Orth on October 10, 2016"). Without this clear application there would be no bright line rule or predictability. Templeton could have extended his time for filing a claim under the continuous-course-of-treatment doctrine indefinitely, simply by asserting that he planned to return to Dr. Orth at some point, including after surgery with Dr. Tilley. He could state he never harbored a subjective intent to terminate his relationship with Dr. Orth, despite his objective actions demonstrating that he did.

Extending Missouri's continuous-course-of-treatment doctrine whenever a patient subjectively decides he or she is in a physician-patient relationship would create a large, unintended loophole in the statute of limitations. Such a result would transform this narrow public-policy exception into a broad tolling provision in which medical-malpractice claims could be extended indefinitely. Rather than promptly dismiss untimely claims, a relaxed application of the doctrine would result in unnecessary, expensive trials that would raise the cost of health care for Missouri residents. Such a result would eliminate the clarity and predictability the General Assembly sought to establish for a fair and well-ordered medical-malpractice system.

For these reasons, *amici* respectfully urge the Court to affirm the circuit court's ruling that the statute of limitations bars the claims related to the care Dr. Orth provided Templeton in 2012 **and** that the continuing course-of-treatment doctrine did not toll the statute of limitations for the care Dr. Orth provided Templeton in 2015 and 2016.

II. THE CONTINUOUS-COURSE-OF-TREATMENT DOCTRINE IS A LIMITED RULE DESIGNED TO PROMOTE AN EFFECTIVE ONGOING RELATIONSHIP BETWEEN A PATIENT AND HIS OR HER PHYSICIAN.

The rationale for tolling the statute of limitations under the continuous-course-of-treatment doctrine in this case is not supported by the law in Missouri or comparable states. As in other states, this Court adopted the continuous-course-of-treatment doctrine to toll the statute of limitations for medical-malpractice claims in limited circumstances: when needed "to ensure that a patient—facing the short statute of limitations imposed by the statute—is not faced with the impossible choice of either disturbing a course of treatment by initiating suit against a caregiver or losing a viable cause of action." *Newton v. Mercy Clinic East Communities*, 596 S.W.3d 625, 627 (Mo. banc 2020).

The concern, as courts have explained, is "the trust and confidence that marks the physician-patient relationship puts the patient at a disadvantage to question the doctor's techniques" while care from *that* physician continues, and may impair the "patient's ability to make an informed judgment as to negligent treatment." *Harrison v. Valentini*, 184 S.W.3d 521, 524-525 (Ky. 2005) (internal quotation omitted). It was believed the continuous-course-of-treatment doctrine would "avoid creating a dilemma for the patient, who must choose between silently accepting continued corrective treatment from the offending physician, with the risk that the patient's claim will be time-barred or promptly instituting an action, with the risk that the physician-patient relationship will be destroyed." *Ceffaratti v. Aranow*, 138 A.3d 837, 845 (Conn. 2016); *see also Borgia v. City of New York*, 187 N.E.2d 777, 779 (N.Y. 1962) ("It would be absurd to require a

wronged patient to interrupt corrective efforts by serving a summons on the physician or hospital superintendent or by filing a notice of claim in the case of a city hospital.”).

Thus, the doctrine is rooted in prioritizing patient care, not legal leniency. The courts have recognized that “the patient and physician harbor a genuine desire to improve the patient’s condition.” *Harrison*, 184 S.W.3d at 525. And, “the most efficacious medical care will be obtained when the attending physician remains on the case from onset to cure.” *Ceffaratti*, 138 A.3d at 845 (quotations and alternations omitted). There are many circumstances when that physician is in the best position “to identify and correct his or her malpractice.” *McDermott v. Torre*, 437 N.E.2d 1108, 1112 (N.Y. 1982). If he or she can do so, it not only advances the patient’s care, but also can avoid the need for litigation. *See Frysinger v. Leech*, 512 N.E.2d 337, 341 (Ohio 1987) (observing that the doctrine “encourages the parties to resolve their dispute without litigation, and stimulates the physician to mitigate the patient’s damages”).

Accordingly, courts in those states, as in Missouri, have diligently required actual, continuing treatment to justify tolling the statute of limitations. In New York, the doctrine applies only when “there has been continuous treatment, and not merely a continuing relationship between the physician and patient.” *McDermott*, 437 N.E.2d at 1110. The Louisiana Supreme Court held the doctrine tolls a claim only when there is “a showing that the physician provided continued treatment to the patient that is related to the alleged act of malpractice and that is more than perfunctory.” *See Mitchell v. Baton Rouge Orthopedic Clinic*, L.L.C., 333 So.3d 368, 378-80 (La. 2021) (finding routine follow up appointments to gauge a patient’s recovery did not toll limitations period). The North

Carolina Supreme Court requires a plaintiff to show "both a continuous relationship with a physician and subsequent treatment from that physician" consisting of "an affirmative act or an omission related to the original act, omission, or failure which gave rise to the claim." *Horton v. Carolina Medicorp*., Inc., 472 S.E.2d 778, 781 (N.C. 1996).

None of these rationales are implicated when a patient discontinues treatment with a defendant physician, including by switching care to another provider—as here. *See Watkins v. Fromm*, 488 N.Y.S.2d 768, 773 (N.Y. App. Div. 1985) ("[O]nce a patient has severed his relationship with a doctor, there is no real impediment to his bringing suit against the doctor and no sound reason to give him the benefit of a toll of the Statute of Limitations."). When there is "no reason to expect ongoing treatment for [the condition] from the defendant, there is no reason to apply the doctrine," and the statute of limitations begins to run. *Grey v. Stamford Health Sys., Inc*., 924 A.2d 831, 839 (Conn. 2007).

Indeed, courts in other states have repeatedly refused to extend the statute of limitations under the continuous-course-of-treatment doctrine, even where, unlike here, the plaintiff maintained a concrete relationship with the physician. For example, the Arkansas Supreme Court did not allow the doctrine when the physician scheduled office visits after the alleged malpractice, *see Raynor v. Kyser*, 993 S.W.2d 913, 916 (Ark. 1999), or when a patient continued to take a medication prescribed by her physician, *see Tullock v. Eck*, 845 S.W.2d 517, 519 (Ark. 1993).[2] The North Dakota Supreme Court also

[2] The Arkansas Supreme Court permits tolling only when there is a series of negligent acts or a continuing course of improper treatment, rather than single, isolated acts of negligence. *See Pledger v. Carrick*, 208 S.W.3d 100, 104 (Ark. 2005). Other courts have narrowly confined the doctrine in a similar manner. *See, e.g., Langner v. Simpson*, 533

requires more than "continuing on prescribed medications, return visits to merely check the patient's condition, or monitoring without additional treatment." *Hoffner v. Johnson*, 660 N.W.2d 909, 919 (N.D. 2003) (citing *Harlfinger v. Martin*, 754 N.E.2d 63, 75 (Mass. 2001)). The Massachusetts Supreme Judicial Court held the continuing treatment doctrine does not apply even when "the physician had at one time been part of the same 'treatment team' as the physicians who continue to provide care." *Parr v. Rosenthal*, 57 N.E.3d 947, 950 (Mass. 2016).[3] The continuing course-of-treatment doctrine ceases "once the allegedly negligent physician no longer has any role in treating the plaintiff." *Id.*

As these courts have appreciated, the continuous-course-of-treatment doctrine "is not a broad remedial doctrine" for ameliorating consequences of statutes of limitations. *Grey*, 924 A.2d at 843. In fact, many states have rejected establishing the doctrine though common law, finding it intrudes too far upon the state legislature's policy-setting role in setting statutes of limitations for medical-malpractice claims.[4] In Kansas, the Supreme Court has refused to recognize the doctrine on four occasions, stating it "must strictly

N.W.2d 511, 521 (Iowa 1995) (finding that "efforts to merely remedy or cure an act of malpractice" do not toll the statute of limitations and finding the doctrine applies when it is unclear when in the course of treatment the negligent act occurred).

[3] *See also Sneed v. Univ. of Louisville Hosp.*, 600 S.W.3d 221, 228 (Ky. 2020) (rejecting invitation to expand the continuous-course-of-treatment doctrine to include situations in which the plaintiff continues to receive care at the same hospital, but not by the same physician, even when most, if not all, of the physicians who treated her were part of the same large medical group).

[4] *See, e.g.*, *Jones v. McDonald*, 631 So.2d 869, 873 (Ala. 1993); *Ewing v. Beck*, 520 A.2d 653, 660-61 (Del. 1987); *Young v. Williams*, 560 S.E.2d 690, 693 (Ga. 2002); *Cunningham v. Huffman*, 609 N.E.2d 321, 324 (Ill. 1993); *Jones v. Speed*, 577 A.2d 64, 67-68 (Md. 1990); *Edwards v. Andrews, Davis, Legg, Bixler, Milsten & Murrah, Inc.*,

follow the legislature's intent." *See Bonin v. Vannaman*, 929 P.2d 754, 772 (Kan. 1996). In Nebraska, the Supreme Court recently overruled prior inconsistent cases applying the doctrine, holding them inconsistent with the state's current statute of limitations for medical liability actions. *See Bogue v. Gillis*, 973 N.W.2d 338, 349 (Neb. 2022). It limited the doctrine to situations where there is continuing *negligent* treatment. *See id.*

The Missouri General Assembly determined that a two-year limitations period is appropriate for medical-malpractice cases. This law has been in place for many years, and patients and attorneys have adjusted accordingly. Extending the limitations period for when Templeton can sue Dr. Orth and Orthopedic Surgeons does not meet the criteria or purpose of the continuous-course-of-treatment doctrine, and the Court should not expand this exception to the General Assembly's enactment when the patient was no longer receiving continuous care from the physician in question. As Judge Chapman's dissent explains in stating why the circuit court's ruling should be upheld in its entirety, the undisputed facts here do not support application of the continuous-course-of-treatment doctrine. *Templeton*, 2023 WL 2776876 at *13 (Chapman, J., dissenting). Accordingly, the Court should affirm the circuit court's ruling and hold these claims are time-barred.

III. PLAINTIFF'S PROPOSED EXTENSION OF THE CONTINUOUS-COURSE-OF-TREATMENT DOCTRINE WOULD UNDERMINE THE GENERAL ASSEMBLY'S OBJECTIVES IN ENACTING SECTION 516.105, RSMO. (2016).

The Court should not shy away from enforcing the statute of limitations here. It has long recognized that "[s]tatutes of limitation are favored in the law and cannot be

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650 P.2d 857, 860 (Okla. 1982); *Harrison v. Bevilacqua*, 580 S.E.2d 109, 114 (S.C. 2003); *Stanbury v. Bacardi*, 953 S.W.2d 671, 676-77 (Tenn. 1997).

avoided unless the party seeking to do so brings himself strictly within a claimed exception." *Butler v. Mitchell–Hugeback, Inc.*, 895 S.W.2d 15, 19 (Mo. banc 1995).

Since 1921, the Missouri General Assembly has established a specific statute of limitation for all medical-malpractice causes of actions at two years. *See* § 516.140, RSMo. (2016). In 1976, the General Assembly replaced this statute with § 516.105, RSMo. (1976), which reaffirmed that all medical-malpractice claims against health-care and mental-health providers must "be brought within two years from the date of occurrence of the act of neglect complained of." There has been a history of health-care crises in Missouri,[5] and the General Assembly has purposefully limited narrow exceptions to this statute to ensure that affordable health care is available to Missouri residents. For a century, adherence to this statute has promoted the prompt and fair adjudication of claims by Missouri patients.

This history is consistent with the general acceptance of statutes of limitations, which are essential elements of a fair and well-ordered civil justice system. They bring "security and stability to human affairs." *Gabelli v. SEC*, 568 U.S. 442, 448-49 (2013); *see also Wood v. Carpenter*, 101 U.S. 135, 139 (1879) (calling them "vital to the welfare of society"). Courts have consistently recognized their value in allowing "more certainty and reliability" in civil litigation—policy goals that "are a necessity in a marketplace where stability and reliance are essential components of valuation and expectation." *California Pub. Employees' Ret. Sys. v. ANZ Sec., Inc.*, 582 U.S. 497, 515 (2017). "[I]n

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[5] *See* Mo. Dep't. of Ins., Medical Malpractice Insurance in Missouri: The Current Difficulties in Perspective (2003).

the judgment of most legislatures and courts, there comes a point at which the delay of a plaintiff in asserting a claim is sufficiently likely . . . to impair the accuracy of the fact-finding process." *Bd. of Regents v. Tomanio*, 446 U.S. 478, 487 (1980). These laws are "critically important in the due administration of justice. They should not lightly be discarded." *Shay v. Walters*, 702 F.3d 76, 81 (1st Cir. 2012).

To this end, most civil claims are subject to a finite statute of limitations. Here, the General Assembly determined that two years sufficiently balances an individual's ability to bring a medical-malpractice lawsuit with the ability of health-care and mental-health providers to mount a fair defense and protects courts from stale or fraudulent claims. Indeed, one of the important functions of statutes of limitations is to allow judges and juries to evaluate the liability of an individual or a business when the best evidence is available. *See Wheeler v. Briggs*, 941 S.W.2d 512, 518 (Mo. banc 1997) (Holstein, C.J., dissenting in part and concurring in part) (noting the statute of limitations protects medical providers from "liability based on stale evidence"). Without them, defendants would "face a series of problems in presenting a proper defense: lost evidence, fading memories, missing witnesses." *McCollum v. Sisters of Charity of Nazareth Health Corp.*, 799 S.W.2d 15, 19 (Ky. 1990).

Overall, claims that significantly rely on people's memories or statements or whether a person acted or did not act in the way society expected at that time typically must be brought in a short time period. The more time that elapses between the event and the lawsuit, the more challenging it becomes to determine whether the defendant failed to meet the appropriate standards of care and whether any such failure caused the alleged

injury. They also help decrease the likelihood that such claims will be brought for non-medical reasons, such as frustration with a physician or personality differences.

In the context of medical-malpractice claims, one of the most difficult tasks is for the courts to "differentiate between adverse events and medical errors." David Sohn, *Negligence, Genuine Error, and Litigation*, 6 Int'l J. Gen. Med. 49, 50 (2013). According to a Harvard Public Health Study, only about 27 percent of adverse events are caused by negligence. *See* T. A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 13 Qual. Saf. Health Care 145, 146 (2004). Limiting the period for bringing a suit can focus patients and physicians on only colorable claims. It also promotes diligence by the plaintiffs in bringing a valid case and gives medical providers the ability to accurately gauge their potential liability as well as make informed decisions with respect to critical issues such as document retention and insurance coverage.

The continuous-course-of-treatment doctrine, which is judicially created, should not subvert the will of the General Assembly by exposing health care providers to indefinite medical liability claims based on the subjective views of patients as to when their relationship with a physician ended. Statutes of limitations are supposed to be predictable bright-line rules that can be easily applied. Relegating the applicability of the continuous-course-of-treatment doctrine to a factual issue for a jury is contrary to this purpose. There is a substantial difference in cost for a defendant that obtains a prompt dismissal of an untimely medical liability claim from the court and a defendant that must go to trial to obtain the same result: a defense verdict at trial costs five times more than obtaining dismissal from the court. *See* Am. Med. Ass'n, Medical Liability Reform

Now!, at 4 (2023) (reporting, based on 2016 to 2018 data, that the average defense cost for tried medical liability claims resulting in a defense verdict was $158,843, while the cost of defending cases that were dropped, dismissed, or withdrawn was $30,439).

Here, the facts demonstrate Templeton was no longer following Dr. Orth's treatment two years before the claims were filed. Therefore, his claims are time barred. As the Court stated in *Laughlin v. Forgrave*, the two-year limitations period for medical-malpractice claims "fixes a reasonable date from which the statute commences to run and accords and limits a reasonable time thereafter within which malpractice actions may be brought." 432 S.W.2d 308, 314 (Mo. banc 1968). It does not impose an excessive burden on plaintiffs. Indeed, there is no assertion here that Templeton did not have ample time to file his claims. He did. If he believed that Dr. Orth provided him with negligent care, he had two years from when he stopped being treated by Dr. Orth to file his claim. He failed to follow this longstanding rule, and the Court should not create an exception.

CONCLUSION

For these reasons, *amici* respectfully request that this Court find the claims filed on October 9, 2018, relating to Dr. Orth's care of Templeton in 2012 and 2016, are time-barred by the statute of limitations and that the continuous-course-of-treatment doctrine did not toll the statute of limitations for either set of care through the filing date.

Respectfully submitted,

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Dated: September 28, 2023

CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that this Brief: (1) includes the information required by Rule 55.03; (2) complies with the requirements contained in Mo. R. Civ. P. 81.18 and 84.06; and (3) contains 4,542 words.

Respectfully Submitted,

/s/ Jennifer J. Artman
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Dated: September 28, 2023

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing was served through the Missouri Supreme Court's electronic filing system on September 28, 2023 to the attorneys of record for all parties.

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Dated: September 28, 2023