

IN THE STATE COURT OF DOUGLAS COUNTY
STATE OF GEORGIA

MARLIN DAVID FIQUETTE, AND)	
MARLIN DAVID FIQUETTE, AS)	
EXECUTOR OF THE ESTATE OF LISA)	
RENEE FIQUETTE)	CIVIL ACTION
)	
Plaintiffs,)	FILE NO 16-SV-00275
)	
v.)	
)	
LINDA D. FORD, M.D., LINDA D. FORD,)	
M.D., P.C., WELLSTAR HEALTH)	
SYSTEM, INC., ROBERT N. CROSS,)	
M.D., RADIOLOGY ATLANTA GROUP,)	
P.C., and DOUGLAS HOSPITAL, INC.,)	
)	
Defendants.)	

PLAINTIFFS' THIRD AMENDED COMPLAINT

COMES NOW, Plaintiffs by and through their undersigned counsel, and hereby file their Third Amended Complaint as follows:

PARTIES

1.

Plaintiff Lisa Renee Fiquette was a resident of Douglas County, Georgia. She was the wife of Marlin David Fiquette and the mother of two children. She died on February 2, 2017.

2.

Marlin David Fiquette has been appointed as Executor of the Estate of Lisa Renee Fiquette. The Court has entered an Order substituting Marlin David Fiquette, as Executor of the Estate of Lisa Renee Fiquette, as a party Plaintiff in place of Lisa Renee Fiquette.

3.

At all times relevant hereto, Douglas Hospital, Inc. did business as Wellstar Douglas Hospital, which is located at 8954 Hospital Drive, Douglasville, Douglas County, Georgia 30134.

4.

The acts and omissions described herein on the part of Douglas Hospital, Inc. occurred at Wellstar Douglas Hospital, operated by Douglas Hospital, Inc., in Douglas County, Georgia.

5.

At all times relevant hereto, Wellstar Health System, Inc. did business as Wellstar Douglas Hospital, which is located at 8954 Hospital Drive, Douglasville, Douglas County, Georgia 30134.

6.

The acts and omissions described herein on the part of Wellstar Douglas Hospital occurred at Wellstar Douglas Hospital, operated by Douglas Hospital, Inc., in Douglas County, Georgia.

7.

At all times relevant hereto, a hospital/patient relationship existed between Wellstar Douglas Hospital and Lisa Fiquette, as she was a patient of said hospital in 2012 and 2013.

8.

Wellstar Health System, Inc. is a corporation organized and existing under Georgia law. Wellstar Health System, Inc. has been properly served in this action.

9.

Douglas Hospital, Inc. is a corporation organized and existing under Georgia law. Douglas Hospital, Inc. as been properly served in this action.

10.

Linda D. Ford, M.D. resides in Douglas County, Georgia.

11.

Linda D. Ford, M.D. is a Georgia licensed medical doctor, who at all times relative to the issues herein, maintained an office and practice of gynecology at 939 Bob Arnold Blvd, Suite A, Lithia Springs, Douglas County, Georgia 30122. The acts and omissions of Defendant Linda D. Ford, M.D., as described below, occurred at the office maintained by her in Douglas County, Georgia. Defendant Linda D. Ford, M.D. has been properly served in this action.

12.

Linda D. Ford, M.D., P.C. is a professional corporation organized and existing under Georgia law. At all times relevant hereto, Linda D. Ford, M.D., P.C. maintained a practice at 939 Bob Arnold Boulevard, Suite A, Lithia Springs, Douglas County, Georgia 30122.

13.

The acts and omissions of the agents and employees of Linda D. Ford, M.D., P.C., as further described herein, occurred at the office of Linda D. Ford, M.D., P.C., which at all times relevant hereto, was maintained in Douglas County, Georgia.

14.

Linda D. Ford, M.D., P.C. has been properly served in this action.

15.

Linda D. Ford, M.D., P.C. is a resident of Douglas County, Georgia.

16.

Robert N Cross, M.D. is a physician licensed to practice medicine in the state of Georgia. Defendant Robert N. Cross, M.D. has been properly served in this action.

17.

At all times relevant hereto, including in 2012 at the time of the negligent acts and omissions described below, Defendants Robert N. Cross, M.D., and Radiology Atlanta Group, P.C. maintained an office in Douglas County, Georgia, at which the acts and omissions described below on the part of these Defendants occurred.

18.

Radiology Atlanta Group, P.C. is a corporation organized and existing under Georgia Law. Defendant Radiology Atlanta Group, P.C. has been properly served in this action.

19.

Robert N. Cross, M.D. was, at all times relative to the issues contained herein, an employee and agent of Radiology Atlanta Group, P.C., and Dr. Cross was acting in the course and scope of said agency and employment relationship.

20.

Radiology Atlanta Group, P.C. is responsible for the acts and omissions of Robert N. Cross, M.D., as he was acting within the course and scope of his employment/agency at all times relevant hereto.

21.

Linda D. Ford, M.D. was, at all times relative to the issues contained herein, an employee and agent of Linda D. Ford, M.D., P.C., and Dr. Ford was acting in the course and scope of said agency and employment relationship.

22.

Linda D. Ford, M.D., P.C. is responsible for the actions and inactions of Linda D. Ford, M.D. as she was acting within the scope and authority of her employment/agency relationship at all times relevant hereto.

23.

Venue is proper in Douglas County, Georgia as to Defendant Linda D. Ford, M.D.

24.

Venue is proper in Douglas County, Georgia as to Defendant Linda D. Ford, M.D., P.C.

25.

Venue is proper in Douglas County, Georgia as to Defendant Wellstar Health System, Inc.

26.

Venue is proper in Douglas County, Georgia as to Defendant Robert N. Cross, M.D.

27.

Venue is proper in Douglas County, Georgia as to Defendant Atlanta Radiology Group, P.C.

28.

Venue is proper in Douglas County, Georgia as to Defendant Douglas Hospital, Inc.

29.

The Court has personal jurisdiction over Defendant Linda D. Ford, M.D.

30.

The Court has personal jurisdiction over Defendant Linda D. Ford, M.D., P.C.

31.

The Court has personal jurisdiction over Defendant Robert N. Cross, M.D.

32.

The Court has personal jurisdiction over Defendant Atlanta Radiology Group, P.C.

33.

The Court has personal jurisdiction over Defendant Wellstar Health System, Inc.

34.

The Court has personal jurisdiction over Defendant Douglas Hospital, Inc.

35.

A physician/patient relationship existed between Lisa Renee Fiquette and Linda D. Ford, M.D. from 2009 to 2013 and at all times relevant hereto.

36.

A physician/patient relationship existed between Lisa Renee Fiquette and Linda D. Ford, M.D., P.C. from 2009 to 2013 and at all times relevant hereto.

37.

A physician/patient relationship existed between Lisa Renee Fiquette and Robert N. Cross, M.D. at all times relating to the issues included herein.

38.

A physician/patient relationship existed between Lisa Renee Fiquette and Radiology Atlanta Group, P.C. at all times relating to the issues included herein.

39.

A hospital/patient relationship existed between Lisa Renee Fiquette and Wellstar Health Systems, Inc. at all times relating to the issues included herein.

40.

A hospital/patient relationship existed between Lisa Renee Fiquette and Douglas Hospital, Inc. at all times relating to the issues included herein.

41.

At all times relevant hereto, Douglas Hospital, Inc. owned and operated Wellstar Douglas Hospital.

42.

At all times relevant hereto, Wellstar Health System, Inc. owned and operated Wellstar Douglas Hospital.

43.

Wellstar Health System, Inc. and Douglas Hospital, Inc. are hereinafter collectively referred to as Wellstar Douglas Hospital.

44.

At all times relevant hereto the persons, including radiology technicians, medical support staff, clerical staff, administrative staff, and others who were responsible for selecting and sending out letters to Lisa Renee Fiquette regarding her mammography and ultrasound results of June 13, 2012 (including letters providing a summary of her mammogram reports in compliance with 21 C.F.R. § 900.12©(2)), were employees and agents of Douglas Hospital, Inc. Furthermore, they were acting within the scope and course of said employment and agency relationship at all times relevant hereto.

45.

At all times relevant hereto the persons, including radiology technicians, medical support staff, clerical staff, administrative staff, and others who were responsible for selecting and

sending out letters to Lisa Renee Fiquette regarding her mammography and ultrasound results of June 13, 2012 (including letters providing a summary of her mammogram reports in compliance with 21 C.F.R. § 900.12(c)(2)), were employees and agents of Wellstar Health System, Inc. Furthermore, they were acting within the scope and course of said employment and agency relationship at all times relevant hereto.

46.

At all times relevant hereto, the persons, including radiology technicians, medical support staff, clerical staff, administrative staff, and others who were responsible for creating and implementing policies and procedures, providing communication, and training staff regarding their respective roles of radiologists and other staff in connection with a selection and sending out of lay letters regarding the results of breast imaging studies (including ultrasound and mammography studies) were employees and agents of Douglas Hospital, Inc. Furthermore, they were acting in the course and scope of said employment and agency relationship at all times relevant hereto.

47.

At all times relevant hereto, the persons, including radiology technicians, medical support staff, clerical staff, administrative staff, and others who were responsible for creating and implementing policies and procedures, providing communication, and training staff regarding their respective roles of radiologists and other staff in connection with a selection and sending out of lay letters regarding the results of breast imaging studies (including ultrasound and mammography studies) were employees and agents of Wellstar Health System, Inc. Furthermore, they were acting in the course and scope of said employment and agency relationship at all times relevant hereto.

48.

At all times relevant hereto, and specifically in 2012, Lynn Hanks was employed by Wellstar Health System, Inc.

49.

At all times relevant hereto, and specifically in 2012, Lynn Hanks was employed by Douglas Hospital, Inc.

50.

In 2012 Wellstar Health System, Inc. was the entity responsible for sending out letters to patients regarding the results of their mammography and ultrasound studies performed at Wellstar Douglas Hospital.

51.

In 2012 Douglas Hospital, Inc. was the entity responsible for sending out letters to patients regarding the results of their mammography and ultrasound studies performed at Wellstar Douglas Hospital.

FACTS

52.

Plaintiffs incorporate herein paragraphs 1 through 51 above as though set forth fully verbatim.

53.

On May 24, 2012, Lisa Renee Fiquette underwent an annual gynecological exam including a breast exam at the offices of Linda D. Ford, M.D.

54.

During the annual exam on May 24, 2012, at the office of Linda D. Ford, M.D., Dr. Ford discovered a 2 cm mass in the left breast of Lisa Renee Fiquette.

55.

Linda D. Ford, M.D. ordered a mammogram of both breasts of Lisa Renee Fiquette following the May 24, 2012 annual exam.

56.

On June 13, 2012, Lisa Renee Fiquette underwent a diagnostic mammogram and ultrasound at Wellstar Douglas Hospital.

57.

Wellstar Douglas Hospital, as well as its employees and agents, were informed that Lisa Renee Fiquette had a palpable mass in her left breast when she was present for the diagnostic mammogram and ultrasound on June 13, 2012.

58.

The June 13, 2012 mammogram on Lisa Renee Fiquette was read and interpreted by Defendant Robert N. Cross, M.D.

59.

Dr. Cross was unable to see the 2 cm palpable mass, which was in Lisa Renee Fiquette's left breast, on the mammogram performed on June 13, 2012.

60.

A report was issued relating to said mammogram of June 13, 2012 and same was sent to the office of Linda D. Ford, M.D. by Wellstar Douglas Hospital within a week. Said report provided in part, "The breast tissue is extremely dense. This may lower the sensitivity of

mammography No significant masses, suspicious microcalcifications or findings are seen in either breast.” The report further stated: “There is no mammographic evidence of malignancy. Recommend screening mammogram in one year. The patient will be provided a lay person version of this report.” Said report was Read and Released by Robert N. Cross, M.D.

61.

Defendants failed to properly communicate the results of Lisa Fiquette’s mammogram to her. They provided her misleading information regarding those results, and provided her false, misleading, and inappropriate medical advice to her. A letter regarding the results of her mammogram of June 13, 2012 was sent to Lisa Fiquette via mail dated June 14, 2012 by Wellstar Douglas Hospital Women’s Imaging, and signed by “Your Mammography Team.” The letter did not inform the patient that the radiologist had failed to encounter, detect or see the area of concern or the mass on the left breast. Said letter provided that, “the results of your recent mammogram are normal/benign (not cancer).”

62.

The letter regarding the results of Lisa Fiquette’s mammogram of June 13, 2012 was sent to Lisa Fiquette by Defendant Douglas Hospital, Inc. in June of 2012.

63.

The letter regarding the results of Lisa Fiquette’s mammogram of June 13, 2012 was sent to Lisa Fiquette by Defendant Wellstar Health System, Inc. in June of 2012.

64.

The letter regarding the results of her mammogram of June 13, 2012, did not inform Lisa Renee Fiquette that Dr. Cross could not see the mass or determine if it was cancer. Additionally,

the letter did not advise Lisa Fiquette that she needed to return to her physician to have the mass further evaluated.

65.

On June 13, 2012, Lisa Renee Fiquette also underwent an ultrasound examination of her left breast at Wellstar Douglas Hospital, 8954 Hospital Drive, Douglasville (Douglas County), Georgia.

66.

The ultrasound examination of June 13, 2012 was read and interpreted by Defendant Robert N. Cross, M.D.

67.

Dr. Cross was unable to see the 2 cm palpable mass, which was in Lisa Renee Fiquette's left breast, on the ultrasound performed on June 13, 2012.

68.

A report was issued relating to said ultrasound and same was sent to the office of Linda D. Ford, M.D. by Wellstar Douglas Hospital within a week. Said report provided in part: "No solid or cystic mass lesion was encountered It should be noted that a negative mammogram and negative ultrasound do not exclude the possibility of malignancy and should never delay biopsy of a clinically suspicious mass . . . recommend screening mammogram in one year The patient will be provided a lay person version of this report." Said report was Read and Released by Robert N. Cross, M.D.

69.

Defendants failed to properly communicate the results of Lisa Fiquette's ultrasound to her. They provided her misleading information regarding those results, and provided her false,

misleading, and inappropriate medical advice to her. A letter regarding the results of the ultrasound of June 13, 2013 was sent to Lisa Fiquette via mail dated June 14, 2012, by Wellstar Douglas Hospital Women's Imaging, and signed by "Your Mammography Team." The letter did not inform the patient that the radiologist had failed to encounter, detect or see the mass or the area of concern in Lisa Fiquette's left breast. The letter regarding the results of the ultrasound of June 13, 2012, did not inform Lisa Renee Fiquette that Dr. Cross was unable to determine if the mass in her left breast was cancer. Said letter provided that, "the results of your recent ultrasound are normal/benign (not cancer)." Additionally, the letter did not advise Lisa Fiquette that she needed to return to her physician to have the mass further evaluated.

70.

Douglas Hospital, Inc. sent a letter regarding the results of the ultrasound of June 13, 2012 to Lisa Fiquette (via mail dated June 14, 2012).

71.

Wellstar Health System, Inc. sent a letter regarding the results of the ultrasound of June 13, 2012 to Lisa Fiquette (via mail dated June 14, 2012).

72.

While interpreting and reading the ultrasound and diagnostic mammography studies of June 13, 2012, Dr. Cross failed to visualize or see the lump in Ms. Fiquette's breast, which was the reason she had gone for the diagnostic mammogram and ultrasound.

73.

Despite the fact that Dr. Cross was unable to visualize the mass in Lisa Fiquette's breast and was unable to provide any information regarding whether the mass was cancerous, Dr. Ford failed to take any action to further determine if the mass was cancer. In particular, Dr. Ford

failed to contact Lisa Fiquette and explain to her the results of the ultrasound and diagnostic mammogram; failed to counsel Lisa Fiquette and advise Lisa Fiquette of her options, including the option for a biopsy; failed to order additional diagnostic studies of the mass; and failed to refer Lisa Fiquette to a breast surgeon or breast center for a biopsy.

74.

On June 4, 2013, Lisa Renee Fiquette underwent an annual gynecological exam to include a breast exam at the offices of Linda D. Ford, M.D. at 939 Bob Arnold Blvd, Suite A, Lithia Springs (Douglas County), Georgia.

75.

During the annual exam on June 4, 2013, Dr. Ford confirmed the continued existence of a lump/mass/lesion in the left breast of Lisa Renee Fiquette.

76.

In late July of 2013, Lisa Fiquette was diagnosed with advanced Stage IV breast cancer.

77.

On July 26, 2013, Dr. Al Soltan counseled Lisa Renee Fiquette regarding the findings of the various tests, informing her that she suffers from Invasive Ductal Carcinoma and Metastatic Carcinoma, that said disease is incurable, and that treatment is given with the purpose(s) of palliation and prolongation of life.

78.

Lisa Fiquette's breast cancer was not diagnosed in a timely fashion as a result of the negligence and malpractice of Defendants.

79.

Lisa Fiquette underwent extensive treatment for breast cancer. She ultimately died on February 2, 2017.

COUNT I
MEDICAL MALPRACTICE

80.

Plaintiffs incorporate herein paragraphs 1 through 79 above as though set forth fully verbatim.

81.

The medical staff, administrative staff, radiology technicians, and other employees working at Wellstar Douglas Hospital had a duty to exercise that degree of skill and care exercised by such persons generally under similar conditions and like surrounding circumstances in selecting and sending lay letters regarding the results of mammography and ultrasound studies to patients, including the lay letters required by 21 C.F.R. § 900.12(c)(2).

82.

The medical staff, administrative staff, radiology technologists, and other employees working at and employed by Wellstar Douglas Hospital deviated from the standard of care exercised by such persons generally under similar conditions and like surrounding circumstances as those presented by Lisa Renee Fiquette in June of 2012. In particular, these deviations include, but are not limited to, the following:

- a. Failing to select and send the patient a complete and accurate summary of the mammography report written in lay terms. The letter sent to Lisa Fiquette was misleading and not the correct letter. The letter, which Ms. Fiquette was sent regarding her mammogram, specifically stated that the results of her mammogram

- were “normal/benign (not cancer).” This was misleading and false because the radiologist was not able to see the known palpable mass. If the radiologist cannot see it, the radiologist cannot determine that it is not cancerous, and the patient should not have been sent a letter reassuring her that she did not have cancer. Since the area of concern could not be seen on imaging, the question as to whether the patient’s mass was cancerous had not been answered. Lisa Renee Fiquette should have been sent a letter making a clear recommendation that she should go back to her physician so that the mass could be further evaluated.
- b. The facility also sent the patient a letter, which was inaccurate and misleading regarding her ultrasound because it stated that her ultrasound was “normal/benign (not cancer).” This was false and misleading because the radiologist was not able to see the known palpable mass on ultrasound. Since the radiologist could not see it, the radiologist cannot determine if it was not cancerous and the patient should not have been sent a letter reassuring her that she did not have cancer. The question as to whether the patient’s mass was cancerous had not been answered. The letter regarding the ultrasound should have made a clear recommendation that the patient go back to her physician so that the mass could be further evaluated.
- c. The facility had the responsibility of sending an accurate letter to the patient. The facility should have seen there was a discrepancy between Dr. Cross’ reports and the letters that were being sent to the patient, which were not consistent.
- d. Failing to make sure that the healthcare providers and staff understood their respective roles in connection with selecting and sending out of lay letters (including the letters required by the “Mammography Quality Standards Act”), and in particular

- making sure that the radiologist understood that they were expected to select the appropriate lay letter to be sent to the patient regarding the results of breast imaging studies (including ultrasound and mammographic studies). The hospital was required to have adequate communication, training, policies, procedures, and protocols in place to make sure that the radiologists understood that the selection of appropriate lay letters was the responsibility of the radiologists and to be done by the radiologists. The hospital staff failed to promulgate necessary policies and procedures making it clear that this was the responsibility of the radiologist. The hospital staff also failed properly train their staff (including the radiologists) to ensure that the radiologists understood that the selection of the letter was their responsibility.
- e. Failing to have an appropriate and properly functioning patient notification system for sending lay letters to patients, and failing to maintain said system in an organized manner;
 - f. Failing to communicate to the radiologists that they were responsible for selecting the letters; and
 - g. Failing to properly train the radiologists and make sure that they understood how to select the letters on the Penrad software system.

83.

Dr. Robert N. Cross had a duty to comply with the standard of care and skill exercised by physicians generally under similar conditions and like surrounding circumstances as those presented by Lisa Renee Fiquette in 2012.

84.

Dr. Robert N. Cross, M.D. deviated from the standard of care and skill exercised by physicians generally under similar conditions and like surrounding circumstances as those presented by Lisa Fiquette in June of 2012. These deviations include, but are not limited to:

- a. Failing to prepare a sufficient and adequate report in connection with the studies done on June 13, 2012;
- b. Failing to know and understand that he was responsible for selecting the appropriate lay letters to be sent to patients (and in particular Lisa Fiquette) regarding her breast imagining studies (including the ultrasound and mammography studies), including the letter required by the Mammography Quality Standards Act (MQSA);
- c. Failing to select the appropriate letters, including the letter required the Mammography Quality Standards Act (MQSA) to be sent to Lisa Fiquette regarding the results of her breast imaging studies (including the ultrasound and mammography studies);
- d. The letters that were sent to Lisa Fiquette (regarding both the mammography and ultrasound studies) failed to comply with the standard of care. In particular, the letters stated that Lisa Fiquette did not have cancer. These letters were inappropriate because they were inaccurate and misleading to her. They were false and misleading because the radiologist was not able to see the known palpable mass. Since the radiologist could not see it, the radiologist could not determine that it was not cancerous, and the patient should not have been sent a letter reassuring her that she did not have cancer. Since the area of concern could

not be seen on imaging, the question as to whether the patient's mass was cancerous had not been answered. The patient should have been sent letters, regarding her mammogram and ultrasound studies, which explained to her that the area of concern had not been imaged. The letter that she was sent should have made a recommendation that she should go back to her physician for further evaluation. The letters in use by Defendant Wellstar, and available on its Penrad computer system, contained such a letter.

85.

The reports of Dr. Robert N. Cross and Wellstar Douglas Hospital relating to the ultrasound and mammogram of Lisa Renee Fiquette on June 13, 2012 provided that, "The patient will be provided a lay person version of this report." However, the patient was not provided accurate lay person versions of the reports. Instead she was provided materially different, inaccurate and misleading letters.

86.

Linda D. Ford, M.D. owed a duty to exercise that degree of care and skill exercised by physicians generally under similar conditions and like surrounding circumstances in 2012 in their care and treatment of Lisa Renee Fiquette.

87.

Linda D. Ford, M.D. deviated from the standard of care and skill exercised by physicians generally under similar conditions and like surrounding circumstances as those presented by Lisa Renee Fiquette in 2012 and 2013 in one or more of the following ways:

- a. Linda D. Ford, M.D. failed to personally review the radiology reports for the diagnostic mammogram and ultrasound of June 13, 2012, and failed to recognize

- that the radiologist failed to observe, detect, or visualize the mass in Lisa Fiquette's left breast; instead, Dr. Ford allowed an unlicensed assistant to read the reports and make the determination whether any additional action was necessary;
- b. Linda D. Ford, M.D. failed to take action based upon the reports of the diagnostic mammogram and ultrasound of June 13, 2012;
 - c. Linda D. Ford, M.D. failed to explain to Lisa Fiquette that the diagnostic mammogram and ultrasound of the lump in her left breast did not provide information as to whether the lump was cancer, and failed to explain to Lisa Fiquette what her options were, including a biopsy, to find out if the mass in her breast was cancer;
 - d. Linda D. Ford, M.D. failed to refer the patient for a biopsy of the lump discovered in Lisa Renee Fiquette's left breast in May of 2012;
 - e. Linda D. Ford, M.D. failed to schedule a follow up examination of Lisa Renee Fiquette within a short period of time following May 24, 2012;
 - f. Linda D. Ford, M.D. failed to order further diagnostic testing of the lump in Lisa Fiquette's left breast following the mammogram and ultrasound of June 13, 2012;
and
 - g. Linda D. Ford, M.D. had a policy and practice in place of allowing an unlicensed assistant to take sole responsibility for viewing reports of diagnostic mammograms and ultrasounds, which were done to determine the nature of a lump in a patient's breast, and make decisions as to what action, if any, should and would be taken in response to said reports.

88.

The deviations from the standard of care on the part of the Defendants, as described herein, caused a substantial delay in the diagnosis of Lisa Renee Fiquette's breast cancer. If the Defendants had not deviated from the standard of care, within a reasonable degree of medical probability, Lisa Renee Fiquette's breast cancer would have been discovered promptly, treated successfully, and she would have been cured.

89.

As a result of the deviations from the standard of care on the part of the Defendants, Lisa Fiquette's cancer was not discovered until it had progressed to Stage IV and could not be treated successfully. Lisa Fiquette's breast cancer spread to her brain, eyes, bones, and other areas of her body.

90.

The medical malpractice of Defendants, as well as the agents and employees of Defendants, proximately caused Lisa Renee Fiquette to suffer personal injury, permanent impairment to her body, medical expenses, pain and suffering, and other damages, which will be more particularly proven at trial.

91.

Marlin David Fiquette, as the Executor of the Estate of Lisa Renee Fiquette, is entitled to recover damages for the permanent impairment of Lisa Renee Fiquette's body, medical expenses, pain and suffering, and other damages as may be shown at trial.

92.

The Defendants are liable for all general and special damages resulting from injury to Lisa Renee Fiquette proximately caused by the Defendants. Marlin David Fiquette, as Executor of the Estate of Lisa Renee Fiquette, is entitled to recover these damages from Defendants.

93.

The acts and omissions of Defendants, described above, caused and contributed to damages sustained by Plaintiff Marlin David Fiquette for loss of consortium, including loss of services of his wife.

94.

The acts, omissions, and medical malpractice, of the Defendants, as described above, caused and contributed to the death of Lisa Renee Fiquette. Defendants' acts and omissions, and medical malpractice, as described above, were the proximate cause of the death of Lisa Renee Fiquette.

95.

Marlin David Fiquette is entitled to recover for the full value of the life of Lisa Renee Fiquette.

96.

Defendants are liable for the wrongful death of Lisa Renee Fiquette.

97.

Plaintiffs have complied with the Official Code of Georgia § 9-11-9.1 by attaching Affidavits to their original Complaint.

COUNT II
ORDINARY/SIMPLE NEGLIGENCE

98.

Plaintiffs incorporate herein paragraphs 1 through 97 above as though set forth fully verbatim.

99.

Wellstar Douglas Hospital (as well as its staff, employees and agents) had a duty to exercise ordinary and reasonable care in preparing, selecting, and sending accurate letters to Lisa Renee Fiquette. In particular, they had a duty to exercise ordinary and reasonable care in preparing, selecting, and sending accurate letters to Lisa Renee Fiquette regarding the results of her mammogram and ultrasound studies. Further, they had a duty to exercise ordinary and reasonable care in making sure the letters sent to Lisa Renee Fiquette regarding the results of her mammogram and ultrasound studies were complete, accurate, and not misleading.

100.

Defendant Wellstar Douglas Hospital committed ordinary and simple negligence by failing to comply with the duties set forth above. The letters sent by Wellstar Douglas Hospital (as well as its staff, employees and agents) to Lisa Renee Fiquette were inaccurate, misleading, and incomplete. In particular, these letters falsely stated that the results of Lisa Fiquette's mammogram and ultrasound studies showed that the lump in her breast was not cancer, and suggested that the mass had been visualized and determined not to be cancer. However, during the mammograms and ultrasound of June of 2012, the radiologist and hospital staff failed to detect the lesion/mass in Lisa Renee Fiquette's left breast and failed to ascertain whether it was cancerous.

101.

Defendant Wellstar Douglas Hospital had a duty to exercise ordinary and reasonable care in making sure that the healthcare providers and staff understood their respective roles in connection with the sending out of the lay letters (including the letters required by the Mammography Quality Standards Act), and in particular making sure that the radiologists understood that they were expected to select the appropriate letter to be sent to the patient regarding the results of breast imaging studies. Wellstar Douglas Hospital was required to have adequate communication, training, policies, procedures, and protocols in place to make sure that the radiologists understood that the selection of the appropriate lay letter was the responsibility of the radiologists and was to be done by the radiologists. Furthermore, Defendant Wellstar Douglas Hospital had a duty to exercise ordinary and reasonable care in making sure that it had an adequate and properly functioning patient notification system, which was maintained in an organized manner such that the Defendants' employees and radiologists were properly using it.

102.

Wellstar failed to promulgate necessary policies and procedures, and failed to have adequate communication, making it clear that the selection of the letter was the responsibility of the radiologists. Wellstar also failed to adequately train their staff and radiologists to ensure that the radiologists understood that the selection of the letter was their responsibility. Furthermore, Defendant Wellstar failed to exercise ordinary and reasonable care in making sure that there was an appropriate patient notification system in place for the results of mammogram and ultrasound studies, and failed to maintain the system in an organized manner such that the Wellstar staff and radiologists were using it properly.

103.

Defendant Wellstar Douglas Hospital (and its employees and agents) had a duty to exercise reasonable and ordinary care in communicating to the radiologists that they were responsible for the selection of the lay letters, to be sent to patients, regarding the results of imaging studies (including mammogram and ultrasound studies). Wellstar Douglas Hospital failed to adequately communicate to the radiologists that they were responsible for selecting the appropriate lay letters to be sent to patients regarding the results of breast imaging studies (including ultrasound and mammography studies).

104.

Defendant Wellstar Douglas Hospital had a duty to properly train employees, medical staff, and radiologists, as to how to use the new Penrad system, which was put in place by Wellstar Douglas Hospital, and to make sure that the radiologists understood how to select the appropriate lay letter (to be sent to patients regarding the results of breast imaging studies) on the Penrad system.

105.

Defendant Wellstar Douglas Hospital failed to properly train the radiologists on how to navigate the Penrad system and to select the appropriate lay letters to be sent to patients regarding the results of their breast imaging studies.

106.

As a result of the ordinary and simple negligence of Defendant Wellstar Douglas Hospital, Lisa Fiquette was sent letters that, as stated above, were inappropriate, misleading, and deceptive because they stated that the results of her mammography and ultrasound studies showed that the mass in her breast was benign and not cancer. This, in fact, had not been

determined and was false. Furthermore, it appears that the letters that she was sent were neither selected by the hospital staff nor the radiologist, and that no one made a decision as to which letters she would be sent.

107.

The ordinary negligence of Defendant Wellstar Douglas Hospital caused and contributed to Plaintiff Lisa Renee Fiquette's injuries as described above. Therefore, Defendants are liable to Marlin David Fiquette, as Executor of the Estate of Lisa Renee Fiquette, for Lisa Fiquette's general and special damages, medical expenses, and pain and suffering.

108.

The ordinary/simply negligence of Defendant Wellstar Douglas Hospital was the proximate cause of the death of Lisa Renee Fiquette.

109.

Defendant Wellstar Douglas Hospital is liable for the wrongful death of Lisa Renee Fiquette.

110.

Marlin David Fiquette is entitled to recover for the full value of the life of Lisa Renee Fiquette.

111.

The ordinary/simple negligence of Defendant Wellstar Douglas Hospital caused and contributed to injuries and damages sustained by Plaintiff Marlin David Fiquette. Therefore, Defendants are liable to Marlin David Fiquette for damages sustained by Marlin David Fiquette, including loss of consortium.

COUNT III
NEGLIGENCE PER SE

112.

Plaintiffs incorporate herein paragraphs 1 through 111 above as though set forth fully verbatim.

113.

21 C.F.R. § 900.12(c)(2) provides in pertinent part:

Communication of mammography results to the patients. Each facility shall send each patient a summary of the mammography report written in lay terms within 30 days of the mammographic examination.

114.

Plaintiff Lisa Renee Fiquette falls within the class of persons that this regulation was intended to protect. Furthermore, the harm complained of (the unnecessary and negligently caused spreading and metastasis of Lisa Renee Fiquette's breast cancer) was the same harm that the statute was intended to guard against.

115.

Defendants Wellstar Douglas Hospital (its staff, agents, and employees), Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. had a duty to comply with 21 C.F.R. § 900.12(c)(2).

116.

Wellstar Douglas Hospital (its medical staff, agents and employees), Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. had a duty pursuant to 21 C.F.R. § 900.12(c)(2) to ensure that the letter they sent to Lisa Renee Fiquette, regarding the results of her diagnostic mammogram of June 13, 2012, was accurate, complete, not misleading.

117.

The letter sent by Wellstar Douglas Hospital (its medical staff, agents and employees), Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. to Lisa Renee Fiquette regrading her mammogram of June 13, 2012, was inaccurate, misleading, and incomplete. In particular, the letter stated that Lisa Renee Fiquette did not have cancer and suggested that the mass, for which she was having diagnostic mammogram, had been detected and evaluated, and was not cancer.

118.

Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. violated 21 C.F.R. § 900.12(c)(2).

119.

The violations of 21 C.F.R. § 900.12(c)(2) by said Defendants constitute negligence *per se*.

120.

The negligence *per se* of Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. caused and contributed to the injuries, general damages, and special damages sustained by Plaintiff Lisa Renee Fiquette as described above, including, but not limited to, medical expenses, and pain and suffering. Therefore, Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. are liable to Plaintiff Marlin David Fiquette, as Executor of the Estate of Lisa Renee Fiquette, for general and special damages sustained by Lisa Renee Fiquette.

121.

Marlin David Fiquette, as Executor of the Estate of Lisa Renee Fiquette, is entitled to recover the damages suffered by Lisa Renee Fiquette, including pain and suffering, injuries to her body, mental and emotional distress, and medical expenses.

122.

The negligence *per se* of Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. caused and contributed to the injuries and damages sustained by Plaintiff Marlin David Fiquette as described above, including, but not limited to, loss of consortium. Therefore, Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. are liable to Plaintiff Marlin David Fiquette for loss of consortium.

123.

The negligence *per se* of Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. was the proximate cause of the death of Lisa Fiquette. Therefore, Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. are liable to Plaintiff Marlin David Fiquette for the wrongful death of Lisa Renee Fiquette.

124.

Defendants Wellstar Douglas Hospital, Dr. Robert N. Cross, and Radiology Atlanta Group, P.C. are liable to Plaintiff Marlin David Fiquette, Individually, for the full value of the life of Lisa Renee Fiquette.

WHEREFORE, Plaintiffs pray and demand:

- a. Process issue and service of summons and this Complaint be made upon the Defendants;
- b. Trial by jury;
- c. That Plaintiff Marlin David Fiquette recover a judgment against Defendants for the wrongful death of Lisa Renee Fiquette in an amount in excess of \$10,000.00;
- d. That Plaintiff Marlin David Fiquette, Individually, recover a judgment against Defendants for loss of consortium in an amount in excess of \$10,000.00;
- e. That Plaintiff Marlin David Fiquette, as Executor of the Estate of Lisa Renee Fiquette, recover a judgment against Defendants for the pain and suffering, medical expenses, emotional distress, and other general and special damages sustained by Lisa Renee Fiquette in an amount in excess of \$10,000.00;
- f. That all costs be taxed to the Defendants; and
- g. Such other relief as is equitable and appropriate in the interest of justice.

This the 17th day of April, 2017.

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CERTIFICATE OF SERVICE

I hereby certify I have this 17th day of April, 2017, filed the within and foregoing pleading with the Court through the Odyssey eFile System, which will cause a copy to be served upon all counsel of record. I have also emailed and mailed a copy in the U.S. Mail with sufficient postage to ensure first class delivery to:

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