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WHITFIELD COUNTY, GEORGIA
21CI00561
AUG 26, 2021 11:44 AM
Babs Bailey
Babs Bailey, Clerk
Whitfield County, Georgia

IN THE SUPERIOR COURT OF WHITFIELD COUNTY
STATE OF GEORGIA

ANNETTE SMITH and MICHAEL SMITH, individually and as representatives of the Estate of MICHAELA SMITH, deceased,

Plaintiffs

— *versus* —

MICHAEL J. COONEY, MD,

VIRTUAL RADIOLOGIC CORPORATION,

KEVIN F. JOHNSON, MD,

NORTH GEORGIA RADIOLOGY, PA,

DAVID F. HAWKINS, MD,

EMERGENCY COVERAGE CORPORATION,

SOUTHEASTERN EMERGENCY PHYSICIANS, LLC,

TEAM HEALTH, LLC,

TEAM HEALTH HOLDINGS, INC.,

JEFFREY T. GLASS, MD,

HAMILTON MEDICAL CENTER, INC.,

HAMILTON HEALTH CARE SYSTEM, INC., and

JOHN/JANE DOES 1-7,

Defendants.

CIVIL ACTION

FILE NO. 21CI00561

Hon. David K. Smith

PLAINTIFFS' FIRST AMENDED COMPLAINT FOR DAMAGES

Purpose and Scope of Amendment

473. Plaintiffs hereby amend their Complaint for Damages (the "Complaint"), to substitute the following entities as additional Defendants vicariously liable for Defendant David F. Hawkins's negligence: Southeastern Emergency Physicians, LLC; Team Health, LLC; and Team Health Holdings, Inc. for John/Jane Does Defendants.[1]

474. Herein, these three additional Defendants and Defendant Emergency Coverage Corporation are collectively referred to as the "Team Health Defendants."

475. Plaintiffs also hereby amend the Complaint, to add a claim of ordinary negligence against all corporate Defendants.

476. This first amendment to the Complaint incorporates the Complaint in its entirety, including the affidavits and attachments submitted therewith.

477. This Amended Complaint thus consists of (a) the entire Complaint, (b) the affidavits and attachments filed with the Complaint, and (c) the additional allegations set forth herein.

478. All unqualified references to "Defendants" in the Complaint include and apply to all Defendants, including the Team Health Defendants.

Additional Defendants

479. The Complaint alleges that Defendant Emergency Coverage Corporation ("ECC") was Dr. Hawkins's employer or other principal, and that Dr. Hawkins was ECC's employee or other agent, at the time of his negligence. *See* Compl. ¶¶ 28-38.

480. As a result, the Complaint also alleges that ECC is vicariously liable for Dr. Hawkins's negligence. *See* Compl. ¶¶ 364, 395, 415.

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[1] To make it as easy as possible for Defendants to answer the First Amended Complaint, Plaintiffs here continue the paragraph numbering started in the Complaint.

481. The Complaint makes those allegations against ECC expressly based on the representations by the Team Health Defendants in response to a prelawsuit demand-letter from Plaintiffs. *See* Compl. ¶ 37.

482. Nevertheless, in their respective Answers to the Complaint, ECC and Dr. Hawkins partly or wholly deny the allegations that ECC was his employer or other principal, and he its employee or other agent, at the time of his negligence.

483. Based on those denials, Plaintiffs hereby plead the following allegations joining the three additional defendants.

484. **Defendant Southeastern Emergency Physicians, LLC ("SEP")** is a Tennessee limited liability company. SEP's principal office is: Legal Department, 265 Brookview Centre Way, Suite 400, Knoxville, TN 37919-4052. SEP's registered agent in Tennessee is: The Prentice-Hall Corporation System, Inc., 2908 Poston Avenue, Nashville, TN 37203-1312. SEP is also registered in Georgia. SEP's registered agent in Georgia is: Corporation Service Company, 2 Sun Court, Suite 400, Peachtree Corners, GA 30092.

485. SEP is subject to the personal jurisdiction of this Court.

486. SEP is subject to the subject-matter jurisdiction of this Court in this case.

487. SEP has been properly served with this Amended Complaint.

488. SEP has no defense to this lawsuit based on undue delay, whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

489. Pursuant to OCGA § 9-10-93, SEP is subject to venue in this Court because the cause of action arose in Whitfield County and because of one SEP's co-defendants is a Georgia resident subject to venue here.

490. At all times relevant to this action, SEP was the employer or other principal of Defendant David F. Hawkins.

491. If another entity was the employer or principal of Dr. Hawkins during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

492. SEP is vicariously liable for the professional negligence alleged against Dr. Hawkins in the Complaint and in the affidavits filed therewith, including the negligence outlined in Counts 6, 7, and 9 of the Complaint.

493. **Defendant Team Health, LLC ("Team Health")** is a Tennessee limited liability company. Team Health's principal office is: Legal Department, 265 Brookview Centre Way, Suite 400, Knoxville, TN 37919-4052. Team Health's registered agent. is: The Prentice-Hall Corporation System, Inc., 2908 Poston Avenue, Nashville, TN 37203-1312.

494. Team Health is subject to the personal jurisdiction of this Court.

495. Team Health is subject to the subject-matter jurisdiction of this Court in this case.

496. Team Health has been properly served with this Amended Complaint.

497. Team Health has no defense to this lawsuit based on undue delay, whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

498. Pursuant to OCGA § 9-10-93, Team Health is subject to venue in this Court because the cause of action arose in Whitfield County and because of one Team Health's co-defendants is a Georgia resident subject to venue here.

499. At all times relevant to this action, Team Health was the employer or other principal of Defendant David F. Hawkins.

500. If another entity was the employer or principal of Dr. Hawkins during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

501. Team Health is vicariously liable for the professional negligence alleged against Dr. Hawkins in the Complaint and in the affidavits filed therewith, including the negligence outlined in Counts 6, 7, and 9 of the Complaint.

502. **Defendant Team Health Holdings, Inc. ("Team Health Holdings")** is a Delaware corporation with a principal place of business in Tennessee. Team Health Holdings's physical address is: Legal Department, 265 Brookview

Centre Way, Suite 400, Knoxville, TN 37919-4052. Team Health Holdings is registered in Tennessee. Its registered agent in Tennessee is: Corporation Service Company, 2908 Poston Avenue, Nashville, TN 37203-1312. Team Health Holdings's registered agent in Delaware is: Corporation Service Company, 251 Little Falls Drive, Wilmington, DE 19808, telephone (302) 636-5401.

503. Team Health Holdings is subject to the personal jurisdiction of this Court.

504. Team Health Holdings is subject to the subject-matter jurisdiction of this Court in this case.

505. Team Health Holdings has been properly served with this Amended Complaint.

506. Team Health Holdings has no defense to this lawsuit based on undue delay, whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

507. Pursuant to OCGA § 9-10-93, Team Health Holdings is subject to venue in this Court, because the cause of action arose in Whitfield County and because of one Team Health Holdings's co-defendants is a Georgia resident subject to venue here.

508. At all times relevant to this action, Team Health Holdings was the employer or other principal of Defendant David F. Hawkins.

509. If another entity was the employer or principal of Dr. Hawkins during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

510. Team Health Holdings is vicariously liable for the professional negligence alleged against Dr. Hawkins in the Complaint and in the affidavits filed therewith, including the negligence outlined in Counts 6, 7, and 9 of the Complaint.

511. At all times relevant to this action, Defendant David F. Hawkins was the employee or other agent of one or more of the Team Health Defendants.

512. Each of the Team Health Defendants is the parent, subsidiary, or other affiliate of each of the other Team Health Defendants.

Additional Count

Safety Principles

513. In 1999, the Institute of Medicine estimated that 44,000 to 98,000 Americans died each year from medical errors.

514. Since then, the healthcare industry, academia, and federal and state policymakers have started to focus on patient safety.

515. Nevertheless, in 2016, researchers at John Hopkins Medicine concluded that over 250,000 Americans die each year from medical errors.

516. The John Hopkins study revealed that medical error ranks as the third-leading cause of death in the United States, behind only heart disease and cancer, and ahead of respiratory disease.

517. It is now generally accepted that medical errors result largely from system failures.

518. That is, medical errors are not caused solely by “bad apple” individual clinicians directly involved in patient care.

519. Instead, medical errors often result from a combination of failures by multiple persons within an organization, rather than from individual failure alone.

520. Leaders, managers, and administrators of hospitals and other healthcare organizations are responsible for acting affirmatively to (a) protect patient safety and (b) prevent systemic failures enabling individual error.

521. Leaders, managers, and administrators owe patients an ordinary duty to safeguard their safety.

522. Leaders, managers, and administrators do not require professional licensing.

523. While leaders, managers, and administrators work with and through licensed healthcare professionals, the ultimate responsibility for patient safety rests with leaders, managers, and administrators. The buck stops with them.

524. Certain systemic sources of medical error are well recognized. They include, in no particular order:

   a. The failure to implement or enforce protocols for emergency care.

   b. Defects in the policies and procedures for the handoff of a patient's care.

   c. Lack of teamwork and communication.

   d. Flaws in procedures meant to prevent breakdowns in communication.

   e. The failure to train, supervise, and support healthcare providers, especially lower-ranking and less-experienced providers.

   f. Gaps in the systems for preventing medication mix-ups.

   g. Understaffing, particularly overnight, weekends, and holidays.

   h. Absence of mechanisms to escalate patient-safety issues in real time, without fear of retaliation.

   i. A culture that punishes providers who speak out on patient-safety issues.

   j. A culture that discourages the recognition and remediation of errors.

   k. The failure to build a culture that values and rewards patient advocacy.

   l. Problems with morale—from overwork, understaffing, unfair employment practices, and poor management decisions.

   m. Flaws in procedures for credentialing competent providers.

525. Safeguarding patient safety thus requires, among other things:

a. Ensuring that systems are in place to avoid known sources of medical error. Such systems include technologies (like electronic medical-record systems) as well as effective policies, protocols, and practices.

b. Ensuring that individual providers understand and are trained on policies, protocols, and practices, and are prepared to implement them.

c. Ensuring proper training, supervision, and support of individual providers, particularly nurses and residents.

d. Ensuring compliance through assessments, evaluations, and audits.

e. Ensuring competence of providers at the time of credentialing.

f. Maintaining provider morale through institutional transparency, accountability, and responsiveness.

g. Cultivating a culture of safety that (a) vigilantly mitigates systemic sources of medical errors and (b) actively acknowledges and remediates medical errors to prevent their recurrence.

Count 10: Ordinary Negligence – Against vRAD, NGR, the Hamilton Defendants, and the Team Health Defendants[2]

526. Plaintiff incorporates by reference all paragraphs of the First Amended Complaint (including the Complaint) as though fully set forth herein.

527. Defendants vRAD, NGR, Hamilton, Hamilton Health, ECC, SEP, Team Health, and Team Health Holdings (together, the "Corporate Defendants") each owed their patients an ordinary duty to safeguard their safety.

528. Each of the Corporate Defendants, through its respective leaders, managers, and administrators, breached that duty, by failing to implement policies, procedures, and practices sufficient to safeguard patient safety.

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[2] Because this Count is for ordinary negligence by the Corporate Defendants through their leaders, managers, and administrators (as opposed to a claim for professional negligence, based on the conduct of licensed healthcare professionals), this Count is not subject to the requirements of OCGA § 9-11-9.1.

529. The repeated confounding failures by the individual Defendants reveal and exemplify those systemic failures.

530. Dr. Cooney's failure to identify the obvious signs of a stroke on CT imaging, for example, suggests that vRAD and the Hamilton Defendants failed to have, disseminate, and enforce policies for the accurate reading and reporting of even basic diagnostic imaging.

531. Defendant vRAD is a commercial "nighthawk" radiology business. As such, it provides radiology-interpretation services around the clock, through a network of radiologists working remotely from the hospitals they serve.

532. Dr. Cooney's failure suggests that vRAD radiologists review large numbers of radiology images at all hours of the night, isolated from patients and attending providers, in an environment fraught with the risk of error.

533. Likewise, Dr. Johnson's repeated failures to identify signs of a stroke on the same CT and on the MRI suggest that NGR and the Hamilton Defendants also failed to have, disseminate, and enforce policies for the accurate reading and reporting of even basic diagnostic imaging.

534. Nurse Martin's failures to notify the attending ER physician immediately, provide emergent care, and initiate a stroke protocol all suggest that the Hamilton Defendants failed to have, disseminate, and enforce stroke protocols.

535. Nurse Martin's failures also suggest that the Hamilton Defendants failed to provide sufficient training on recognizing and treating stroke patients.

536. Nurse Martin's failures even to triage and assess Michaela confirm these systemic failures.

537. Dr. Hawkins's failures to recognize, diagnose, and treat Michaela's stroke, to order vascular imaging, and to perform even basic stroke-screening tests suggest that the Team Health Defendants systematically failed to hire, contract, and outsource competent emergency-medicine physicians.

538. Dr. Glass's failures to recognize, diagnose, and treat Michaela's stroke, and to order vascular imaging, likewise suggest the same systemic failures by the Hamilton Defendants.

539. Dr. Hawkins's wanton delay in examining Michaela suggests that the Team Health Defendants and the Hamilton Defendants failed to have, disseminate, and enforce protocols for the rapid evaluation and treatment of stroke patients. Dr. Glass's similar delay confirm those systemic failures by the Hamilton Defendants.

540. Nurse Brock's and Nurse Herman's gross failures to perform even one complete neurological assessment, even while Michaela was obviously deteriorating, show that the Hamilton Defendants failed to have, disseminate, and enforce policies and procedures for assessing patients with serious neurological deficits.

541. Such failures by the individual Defendants also suggest that the Corporate Defendants were understaffed nights, weekends, and holidays. Michaela Smith checked into Hamilton late Friday night, and returned Saturday morning, the weekend leading up to the Fourth of July.

542. Such institutional failures, moreover, are widespread across healthcare organizations—a fact that reinforces the systemic breaches inferred from individual failures here.

543. Published studies, for example, have found that patients admitted to hospitals on weekends are more likely to die within 30 days, compared to those admitted at other times. This phenomenon has been dubbed "the Weekend Effect."

544. The failures by the individual Defendants thus exemplify the Corporate Defendants' breaches of their ordinary duty to safeguard patient safety.

545. The Corporate Defendants' systemic breaches were thus a cause of Michaela's pain, suffering, injury, and death.

August 26, 2021

/s/ Lloyd N. Bell
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Hon. David K. Smith

Certificate of Service

I hereby certify that I have served a copy of the within and foregoing **Plaintiffs' First Amended Complaint for Damages** upon all parties and counsels of record to this proceeding by electronically filing the same with the Clerk of Court using PeachCourt which will send electronic notification to counsel of record as follows**:**

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