UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

DONNA FAYE HUGHES,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**No. 2:18-cv-00057**
	)	
RIVERVIEW MEDICAL CENTER, LLC.,	)	
	)	
	)	
Defendant.	)	

MEMORANDUM OPINION AND ORDER

Was the discharge of Donna Hughes from Riverview Medical Center with a fractured humerus a case of "patient dumping" in violation of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd; or was it simply a case of medical malpractice, at most? Because this compound question can only be answered by a jury, Riverview's Motion for Summary Judgment (Doc. No. 40) will be denied.

I.[1]

On the morning of December 24, 2017, Hughes tripped and fell in her home, injuring her right arm. She went to the emergency department at Riverview in Carthage, Tennessee sometime around 9:30 or 10:00 a.m.

During intake, Hughes was asked whether she had insurance, and she responded in the negative. Hughes was also asked to urinate in a cup as a part of the screening process, but could not because of the pain she was experiencing. Hughes's blood pressure was checked, and she was given

[1] As required by Rule 56 of the Federal Rules of Procedure, the following facts are construed in Hughes's favor. Further, because the parties' filings indicate that they are well-aware of the standards governing motions for summary judgment and those standards are otherwise widely understood by federal civil practitioners, the Court dispenses with reiterating them here.

a pain pill and an ibuprofen.

Dr. Charles D. Ford was the emergency room attending physician that morning. At 11:17 a.m., he ordered a "two-view plain filter x-ray" of Hughes's upper right arm so that he could see the arm from more than one angle. (Doc. No. 43-3, Ford Depo. at 22). Upon reviewing the x-rays, Dr. Ford diagnosed a mid-shaft humeral fracture. His treatment plan consisted of (1) immobilization with a sling and swathe so that the arm would be secured to the body, and (2) follow-up in five to six days with Dr. Roy Terry, an orthopaedic surgeon. (Id., at 24). Although Dr. Ford does not recall speaking with Dr. Terry that day, he admits consulting with him on orthopaedic injury cases.

Dr. Terry has offices in Gallatin and Lebanon, Tennessee, and has admitting privileges at Riverview and other hospitals in the area. He performs scheduled surgeries at Riverview once-a-month, and emergency orthopaedic surgeries there when necessary. Additionally, even though Riverview does not have an official on-call schedule, Dr. Terry is called if there is an emergency orthopaedic problem that needs to be evaluated.

Dr. Terry received a text message at 11:48 a.m. from Dr. Ford stating, "[n]eurovascularly intact 49-year-old-female," that was accompanied by a picture of an x-ray of Hughes's right arm. Dr. Terry believes he then either called or texted Dr. Ford to find out what was going on. Dr. Terry informed Dr. Ford that he would come in that day and perform surgery on Hughes that evening to correct the fracture. Dr. Terry also called Riverview to see how Hughes was doing, and was told by a nurse that Hughes was "on her way out the door." (Doc. No. 43-4, Terry Depo. at 60).

After reviewing the x-rays, Dr. Ford told Hughes that her arm was broken, and she was instructed to see her regular physician in seven days. Hughes was provided a sling, and told to sit up when sleeping. Hughes was also given a prescription, but did not get it filled.

According to the discharge assessment, Hughes had "no functional deficits," meaning that she could dress herself, get in and out of bed, and use the bathroom facilities with little or no assistance. However, Hughes maintains she could do none of those things without a lot of help.

Hughes claims that the nurse did not discuss the upcoming plans for her care, nor did the nurse go over the discharge instructions with her. Instead, Hughes was told to sign the "Emergency Department Instructions" before she left, and was followed into the parking lot by the nurse so that Hughes' husband could sign the form as well. Hughes left the emergency room at 12:04 p.m.

Because of a lack of money, Hughes waited until January 19, 2018, to have corrective surgery. By then, according to Dr. Terry, there was further displacement and internal bleeding as a result of the delay. (Terry Depo., at 87).

> Dr. Terry has submitted a report on Hughes' behalf in which he states that Hughes's injury constitutes an emergency medical situation which may require surgical intervention in order to stabilize the displaced bone. A displaced fracture can cause, among other things, vascular injuries, neurological injuries, pain, and bone marrow embolus if not stabilized.
>
> Riverview Medical Center has facilities sufficient to perform a surgical fixation of Mrs. Hughes' arm. I told Dr. Ford that I would come in to perform the surgery immediately. Instead, the patient was discharged.
>
> A sling will not immobilize or stabilize a displaced fracture of this nature. When Mrs. Hughes was released with only a sling, her medical condition was not stable. Mrs. Hughes' condition worsened following her discharge and [she] suffered additional injuries which required additional medical treatment. Specifically, the unstable, sharp edges of the humerus bone punctured Mrs. Hughes' brachial artery, requiring additional surgery and multiple units of blood.
>
> It is my opinion within a reasonable degree of medical certainty that Mrs. Hughes suffered from a serious medical condition that required surgical intervention, but instead Riverview Regional Medical Center discharged her without stabilizing her injury. She was not stabilized when she was discharged with a sling.

(Doc. No. 50-3, Terry Depo. Ex. 9).

II.

EMTALA is not a federal medical malpractice act. Roberts v. Galen of Virginia, Inc., 111 F.3d 405, 409 (6th Cir. 1997). Instead, "the impetus for [its enactment] came from highly publicized incidents where hospital emergency rooms allegedly, based only on a patient's financial inadequacy, failed to provide a medical screening that would have been provided a paying patient, or transferred or discharged a patient without taking steps that would have been taken for a paying patient." Cleland v. Bronson Health Care Grp., Inc., 917 F.2d 266, 268 (6th Cir. 1990). Now, "[w]hen a patient arrives at a 'hospital that has a[n] emergency department,' EMTALA imposes three requirements upon the hospital: (1) the hospital must provide for an appropriate medical screening examination; (2) the hospital must provide necessary stabilizing treatment for emergency medical conditions; and (3) the hospital may not transfer a patient who is not stabilized (except in certain defined circumstances).'" Romine v. St. Joseph Health Sys., 541 F. App'x 614, 618 (6th Cir. 2013) (citing 42 U.S.C. § 1395dd). A patient's discharge is a "transfer" for purposes of the statute. 42 U.S.C. § 1395dd(e)(4).

Screening is not at issue here. As for stabilization, the EMTALA defines an "emergency medical condition" as one manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . [inter alia] placing the health of the individual ... in serious jeopardy[.]" Id. § 1395dd(e)(1)(A)(i). "To stabilize" means "to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility[.]" § 1395dd(e)(3)(A); see Moses v. Providence Hosp. & Med. Centers, Inc., 561 F.3d 573, 579 (6th Cir. 2009) (discussing the meaning of "emergency medical condition").

The Sixth Circuit has "long held that liability . . . requires actual knowledge of the condition," because "the duty to stabilize patients only arises when 'the hospital determines that the individual has an emergency medical condition.'" Roberts ex rel. Johnson v. Galen of Virginia, Inc., 325 F.3d 776, 786 (6th Cir. 2003) (citing 42 U.S.C. § 1395dd(b)(1)). Because individual physicians are not subject to liability under the statute, Moses, 561 F.3d 587, "knowledge" relates to the hospital's knowledge. Further, and contrary to the "classic dicta" in Cleland, knowledge is not limited to the treating physician, Roberts ex rel. Johnson, 325 F.3d at 788. Instead, "any hospital employee or agent that has knowledge of a patient's emergency medical condition might potentially subject the hospital to liability under EMTALA." Id.

Here, a jury could conclude Riverview knew Hughes had an emergency medical condition that was not stabilized at the time of her discharge. For this, the jury would have to go no further than believing Dr. Terry when he opined as much. Because he performed surgeries at Riverview monthly, emergency surgeries when necessary, and was the "go to guy" for orthopedic problems presented to the emergency room, a jury could find him to be Riverview's agent. "[T]he existence of an agency relationship 'is a question of fact under the circumstances of a particular case' based upon an examination of the agreements among the parties or of the parties' conduct." Bostic v. Dalton, 158 S.W.3d 347, 351 (Tenn. 2005). The same is true in EMTALA cases. See, Ramonas v. W. Virginia Univ. Hosp., No. 3:08-CV-136, 2009 WL 2450463, at *7 (N.D.W. Va. Aug. 7, 2009); Kenning v. St. Paul Fire & Marine Ins. Co., 990 F. Supp. 1104, 1111 (W.D. Ark. 1997).

In so ruling, the Court fully recognizes that Dr. Terry testified somewhat inconsistently in his deposition, and that his expert report seemingly contravenes some of what he testified to in his deposition. But this is not a case where a party is inappropriately trying to avoid summary judgment

by offering a sham affidavit or report, see, Aerel, S.R.L. v. PCC Airfoils, L.L.C., 448 F.3d 899, 906 (6th Cir. 2006), because Dr. Terry's expert report preceded his two-part deposition by months. Moreover, explanations have been provided for these apparent discrepancies, and it will be for the jury to determine credibility. Reeves v. Sanderson Plumbing, Inc., 120 S.Ct. 133, 150 (2000).

For example, Dr. Terry testified that Hughes was "not medically unstable" at the time of her discharge (Terry Depo. at 71, 83), but in his expert report he specifically opined that Hughes was "not stabilized when she was discharged with a sling" (id. , Ex. 9). However, Dr. Terry also testified that he understood the term "stable" to be used in two different ways, one having to do with vital signs and whether Hughes faced imminent death, and the other having to do with the stability of her right arm and whether it was subject to material deterioration. (Terry Depo. at 97-98).

The Court also recognizes Riverview's argument that not even Dr. Terry believed Hughes' condition to be an emergency because he did not (1) call or text Dr. Ford and say that Hughes needed to be admitted; (2) tell the nurse who told him Hughes was on her way "out the door" that she needed to stay; or (3) say he would perform the surgery immediately. This has all the making of a good jury argument but, for purposes of summary judgment, it raises more questions than answers.

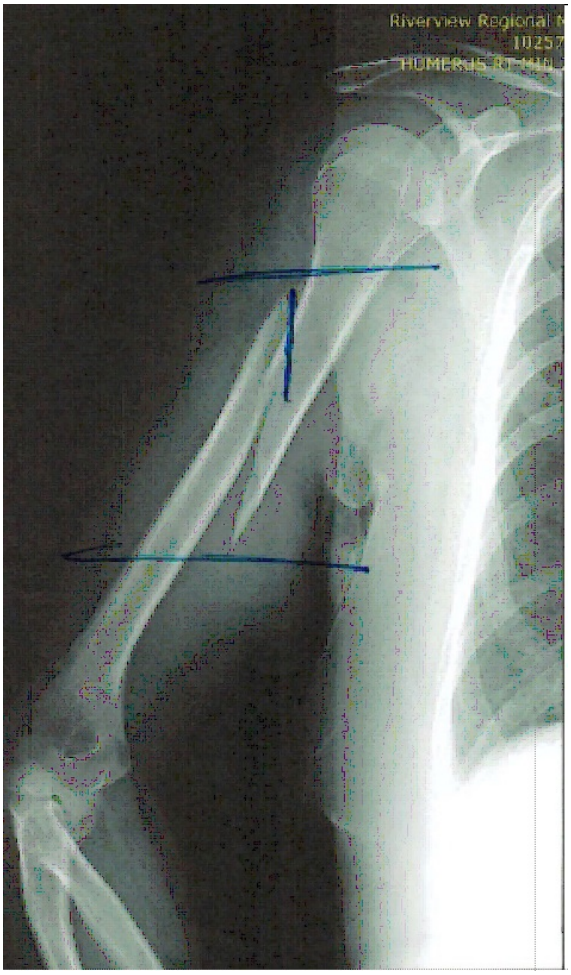
Maybe Dr. Terry believed surgery that evening was soon enough; maybe he thought Dr. Ford himself recognized the gravity of the situation because Dr. Ford texted him in the first place; maybe Dr. Terry was otherwise occupied; maybe he thought the swelling that was present would go down before an evening surgery; or maybe Dr. Terry thought that Hughes's right arm was actually immobilized when she left the hospital, as Dr. Ford claims to have envisioned. The Court could conjure up many more "maybes," but these are more than enough to show there are questions that need to be considered and answered by the jury.

Finally, Riverview argues that "[c]ourt*s* have held that no EMTALA violation existed when a plaintiff who presented to an ER with a broken humerus and was discharged with his arm in a splint was still in pain with a swollen arm when his paperwork indicated he was 'stable' upon discharge." (Doc. No. 52) (emphasis added). However, as sole support it cites only Garaffa v. JFK Med. Ctr., 2006 WL 2033752 (N.J. Super. Ct. App. Div. July 21, 2006). There, dismissal was affirmed because, "[a]lthough EMTALA does not expressly require the submission of expert reports, plaintiff's mere assertions of inadequate care and failure to stabilize are themselves insufficient to raise an issue of fact sufficient to defeat summary judgment." Id. Here, Hughes was discharged with a sling, not a splint. More importantly, Dr. Terry has expressed his medical opinion that Hughes was not stable within the meaning of EMTALA when she was discharged. See, Lozoya v. Anderson, No. 07CV2148-IEG-WMC, 2008 WL 2476187, at *3 (S.D. Cal. June 17, 2008) (denying dismissal of an EMTALA case involving a broken humerus because court could not say as a matter of law that a "sling and painkillers constituted the treatment 'necessary to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer [or discharge] of the individual from a facility'").

III.

The Court ends pretty much where it began. Was a patient who was discharged with just a sling and pain pills dumped in violation of the EMTALA when her x-ray[2] looked like this?:

[2] In his deposition, Dr. Ford identified the vertical line as the approximate location of the brachial artery between the breaks in Hughes' arm.



Only a jury can answer that question and, therefore, Riverview's Motion for Summary Judgment (Doc. No.40) is **DENIED**.

IT IS SO ORDERED.

WAVERLY D. CRENSHAW, JR.
CHIEF UNITED STATES DISTRICT JUDGE