LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

May 2006 Volume 14 Number 5

EMTALA: Intoxicated Patient Leaves AMA, Court Says Hospital Did Not Violate The Law.

An ambulance brought the patient to the hospital's emergency room after a prescription-drug overdose.

On admission to the E.R. he was disoriented, hallucinating and out of control, according to the US District Court for the Middle District of Florida.

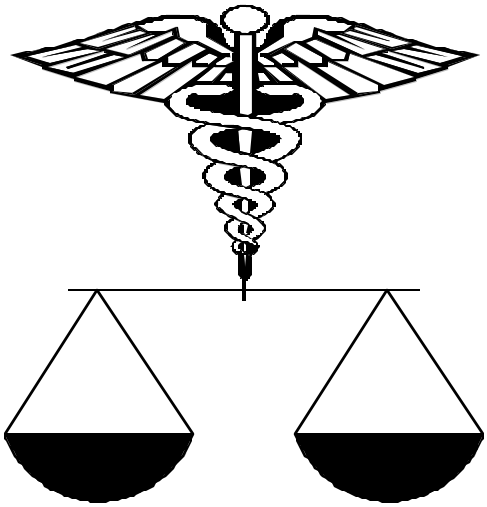
Appropriate Medical Screening Necessary Stabilizing Treatment

The US Emergency Medical Treatment and Active Labor Act (EMTALA) requires a hospital, if it has an emergency department, to provide an appropriate medical screening examination, within its existing capabilities, to determine if the patient has an emergency medical condition.

If the medical screening examination indicates the patient in fact has an emergency medical condition, the hospital must furnish necessary stabilizing treatment for the emergency condition, within the hospital's existing capabilities.

The court ruled this patient got an appropriate medical screening examination and received substantial efforts to stabilize his medical condition.

His hospital care also fulfilled the common-law standard of care. That is, he had no grounds to sue the hospital or his caregivers for malpractice.



A hospital cannot force a patient who comes in as a emergency case to leave before the patient has been examined and stabilized.

However, a patient who wants to leave voluntarily against medical advice can and must be allowed to go.

What this patient did after he left is not the hospital's fault.

UNITED STATES DISTRICT COURT
FLORIDA
March 20, 2006

The emergency physician promptly evaluated his condition on arrival.

He was admitted to the hospital's intensive care unit (ICU).

In the ICU he was assigned one-to-one monitoring by a nurse.

His cardiac tracings, respiratory rate, O_2 saturation and blood pressure were watched closely by his nurse.

IV fluids were started.

Stat lab work included tox screening and blood work including metabolic and chemistry panels and a chest x-ray.

There was also a nursing assessment of his risk for pressure sores.

Appropriate Transfer

The EMTALA also says that an unstabilized patient cannot be sent home or to another facility unless the circumstances of the patient's leaving the hospital meet the Act's rigorous legal test for an appropriate transfer.

In this case the patient asked to make a phone call. His nurse disconnected his monitors and IV so he could do so. He called someone to come right away and pick him up. The court ruled he left of his own free will against medical advice. What he did thereafter to get himself arrested, while apparently still under the influence, was not the hospital's fault. **Johnson v. Health Central Hosp., 2006 WL 709320 (M.D. Fla., March 20, 2006).**

Inside this month's issue ...

May 2006

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Unsanitary Nursing Practices: Court Imposes The Strictest Penalties Allowed By Law.

The US Court of Appeals for the Sixth Circuit reviewed the evidence and decided to uphold a $24,300 civil monetary penalty imposed on a skilled nursing facility by surveyors from the state's office of inspector general working through an agency agreement with the US Centers for Medicare and Medicaid Services, based on deficiencies found to constitute immediate jeopardy to patients' health and safety.

Resident #4

Surveyors saw a nurse use unsanitized scissors she took out of her pocket to care for a resident's coccyx pressure sore. While changing the dressing the resident had a bowel movement. The nurse put a new dressing on the pressure sore without adequately cleaning the skin, then continued to wipe the fecal matter in a manner that pushed it up under the dressing. The fecal matter was wiped from back to front despite the fact the female resident had a Foley catheter. Then the nurse repositioned the patient wearing the same soiled gloves she had worn while doing the dressing change and cleansing the feces.

Resident #2

Another nurse also used unsanitized scissors just taken from her pocket to remove a soiled dressing and then to cut a fresh dressing.

The soiled dressing was put into a bag the nurse used to carry around a box of personal cleansing cloths she and an aide used to wipe their hands.

This resident had come in with a history of vulnerability to pressure sores but got no skin assessment or care plan on admission, then went on to develop a purple and black necrotic lesion on her heel.

Her chart said her heel protectors were being put on on a daily basis by staff, which if actually being done would have given staff the opportunity to observe the start and early progression of what became an avoidable late-stage lesion. **Barbourville Nursing Home v. US Dept. of Health & Human Services, 2006 WL 908631 (6th Cir., April 6, 2006).**

A skilled nursing facility can be shouldered with a civil monetary penalty of $3,050 to $10,000 per day of noncompliance for deficiencies constituting immediate jeopardy.

Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of Medicare or Medicaid participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident.

Considered less serious are widespread deficiencies which cause harm but not immediate jeopardy.

Considered even less serious are deficiencies which are widespread and have a potential for more than minimal harm but not for immediate jeopardy.

Surveyors and their supervisors ought to have some degree of flexibility in applying these concepts which are less than precise.

Administrative law judges and the courts must uphold the surveyors' judgments as to level of seriousness they find unless they are clearly erroneous.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
April 6, 2006

Illegal Use Of Restraints: Nursing Home Liable For Patient's Death.

Because of her schizophrenia the patient had to move out of her son's home into a nursing home for twenty-four-hour professional care.

As soon as she was admitted the nursing home staff began use of restraints by strapping the patient to her bed without a physician's order. According to the Court of Appeal of Louisiana, the patient was restrained solely for the convenience of the nursing home's staff.

The treating physician later did write an order for the restraint, with the patient to be checked q 30 minutes and released for at least 10 minutes q 2 hours.

According to the court, the nursing home staff simply ignored the physician's orders and continued to strap the patient to her bed for their own convenience rather than using the restraints for the patient's care and benefit as prescribed by the physician.

Eighteen months into her stay at the nursing home the patient died of asphyxiation, hanged upside down from her restraints on the side of her bed. The court approved a substantial monetary judgment for the family. **Wilcox v. Gamble Guest Care Corp., __ So. 2d __, 2006 WL 932027 (La. App., April 12, 2006).**

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Patient Falls: Court Sees Lack Of Nursing Leadership, Seat Alarm Should Have Been Used.

The Court of Appeals of Kansas threw out the judge's ruling which had dismissed a family's lawsuit against a nursing home. The Court of Appeals found there was evidence of staff negligence leading to the deceased patient's fall, at least enough evidence that a jury should have decided whether there was liability.

Lack of Nursing Leadership

The Court of Appeals agreed with the family's nursing expert that there was a lack of nursing leadership at the facility which contributed to a disorganized patient-care atmosphere which led to this patient's fall. That is, no specific aide was assigned to keep tabs on the resident to assure that she would not be placing herself in harm's way by standing up and trying to walk away from her wheelchair.

Chair Alarm

The facility also did not have care protocols for high-fall-risk patients. A proper fall-risk protocol for this patient, the court believed, should have included use of a chair alarm to alert staff when she attempted to rise. **Anderson v. K & E Health Management Inc., 2006 WL 851471 (Kan. App., March 31, 2006).**

The deceased patient's family has raised valid concerns over the quality of their late mother's care.

An advanced registered nurse practitioner who was hired as an expert by the family's attorney related her fall from her wheelchair to a lack of nursing leadership and professionalism at the nursing home.

That is, personal care was disorganized at the facility. Aides were not assigned to specific residents and there were no formal reports by aides to aides at shift changes.

The deceased should have been flagged as a fall risk. There were no formal protocols in place so that aides would know how to prevent high-fall-risk patients from falling. That fact reflects poorly on the facility's concern for patients' safety.

COURT OF APPEALS OF KANSAS
March 31, 2006

Patient Falls: Court Finds No Liability.

The hospital patient was classified as a moderately high fall risk because she was being treated on the geriatric psych unit for schizophrenia and because the big toe on one of her feet had been amputated.

The hospital's nursing fall-risk plan for this patient required a nurse to make contact and observe the patient at least every fifteen minutes.

The patient fell and fractured her hip trying to get out of bed to use her bedside commode. She died three days later.

The Court of Appeal of Louisiana could find no evidence of negligence and agreed with the lower court judge's decision to dismiss the family's lawsuit.

The court ruled there was nothing substandard with the nursing assessment of this patient or with the decision to place her on q 15 minute observations as a fall precaution or with the decision to continue the bedside commode.

Before the incident it was documented in the nursing progress notes that the patient was ringing and receiving assistance before trying to get out of bed.

The court discounted as hearsay a statement from her physician that the patient told him she had rung her call bell for assistance but could not wait and had to get up by herself to use the bedside commode and the physician's statement that a nurse had told him that a staff nurse had been reassigned from the unit that evening leaving the unit one nurse short-staffed. **Weeks v. Byrd Medical Clinic, Inc., __ So. 2d __, 2006 WL 862966 (La. App., April 5, 2006).**

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E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
12026 15th Avenue N.E., Suite 206
Seattle, WA 98125-5049
Phone (206) 440-5860
info@nursinglaw.com
www.nursinglaw.com

Patient's Unexplained Wrist Fracture: Court Looks At The Nursing Documentation To Blame Nursing Home, Exonerate Hospital.

The patient fell at home and broke his hip. He had hip surgery at a US Veterans Administration hospital and was discharged to a privately owned nursing home.

At some point he also fractured his wrist, most likely in a fall.

He sued the US government in Federal court claiming negligence by his VA hospital caregivers allowed the wrist fracture to occur, and he also filed a similar lawsuit in state court against the nursing home. The two lawsuits were consolidated in Federal District Court in the Northern District of Illinois.

The nursing home offered the patient a settlement, amount undisclosed, and the Federal judge dismissed the nursing home from the case in exchange for payment of the settlement.

The US attorney then argued for dismissal of the case against the US based on no negligence by the VA hospital's nursing caregivers. The court agreed and dismissed the US government from the case on the basis of no negligence.

Outcome of Court Case Turned On Nursing Documentation

The completeness of the nursing progress documentation and flow charting at the hospital, in contrast to the lack of proper documentation at the nursing home, was the deciding factor in the favorable legal outcome for the hospital.

Hospital Nursing Documentation

The patient's thorough initial nursing assessment on arrival included complaints of hip pain but no left-wrist symptoms. The nurse made note of his age, fall history, mobility problems, generalized weakness, medications and substance abuse, all of which pointed to a high-fall-risk classification for this patient.

The hospital nursing staff meticulously saw to it that a basic 24-hour nursing flow sheet was completed each day.

The early nursing flow sheets did, in fact, document reports of pain and signs of edema in his left wrist, for which he received medication. The early nursing progress notes documented that the edema subsided after two days.

A few days into his stay the patient began to experience dementia, most likely related to alcohol withdrawal and Wernicke-Korsakoff syndrome, and he had to be restrained to keep him in bed and to keep him from pulling out his IV lines.

While in restraints he was checked frequently by the nursing staff. Restraint monitoring included having a nurse at least once q shift place a finger under the wrist restraints to insure proper positioning, circulation and skin integrity. The daily protective-device flow sheets made no mention of any pain, swelling, deformity or instability in either wrist.

He had an IV in his left hand for his hip surgery. The surgical nurse's and anesthesiologist's notes mention no problem with the left wrist.

Nursing Home Nursing Documentation

The initial physical therapy assessment included an assessment of upper body strength capability for the purpose of going ahead with hip rehab. Nothing was found wrong with either wrist.

Then after admission there was an eleven-day period for which the nursing notes and new orders sheets were completely blank, the court said.

The silence was broken by a nursing note from a visiting nurse from the hospital stating he complained of left wrist pain, his left forearm was swollen and there was a deformity at the wrist. The nurse also noted his mental condition made him a poor historian and she was not able to determine from talking to him when or how it happened.

He was taken back to the hospital for x-rays and then had surgery to repair the wrist. Delay in detecting the fracture did compound the healing process and left him with a partial residual disability. **Anderson v. US, 2006 WL 862860 (N.D. Ill., March 30, 2006).**

The patient was discharged from the hospital to a nursing home to recuperate from hip surgery.

The patient sued both the hospital and the nursing home for a wrist fracture, claiming that all of his care givers, doctors, nurses, physical therapists, etc., missed the fact he somehow broke his wrist while under their care.

The hospital's nursing documentation and flow charting are very complete. There is no evidence of a wrist fracture.

The nursing home's nursing documentation, on the other hand, is completely blank for an eleven day period. All we have is a notation he suddenly could not move his wrist – a fact which was discovered by a visiting nurse from the hospital when she came to see him in the nursing home.

We also know that he was no longer in restraints at the nursing home, notwithstanding his mental status related to Wernicke-Korsakoff syndrome, and that he was repeatedly attempting to get out of bed.

UNITED STATES DISTRICT COURT
ILLINOIS
March 30, 2006

Patient Abuse: Psych Patient's Hair Cut, Face Shaved While Physically Restrained.

The Veterans Hospital had a barber shop where patients who could afford the nominal cost could get a haircut or a shave. The patient in question, a paranoid schizophrenic undergoing inpatient psychiatric treatment, had the money but just did not like getting haircuts or shaving.

A psychiatric registered nurse with seventeen years experience in the VA psych unit decided to give him a haircut and shave his face. When he tried to roll himself away in his wheelchair the nurse had one aide hold the wheels and another aide hold his wrists as she gave him a haircut and tried to shave him.

The patient testified later he resisted verbally but not physically because he did not want to injure one of the two aides who was pregnant.

Patient abuse includes mental, physical, sexual and verbal abuse, such as any action or behavior that conflicts with patients' rights, willful violation of a patient's privacy or willful physical injury.

UNITED STATES COURT OF APPEALS
FEDERAL CIRCUIT
March 17, 2006

The US Court of Appeals for the Federal Circuit ruled the RN's conduct was patient abuse and serious enough to justify the maximum penalty of termination from her position at the hospital notwithstanding her lengthy seniority. **Taylor v. Dept. of Veterans Affairs, 2006 WL 678926 (Fed. Cir., March 17, 2006).**

Stillborn Fetus: Hospital Unable To Account For Remains, Court Says Parents Can Sue.

Both sides agree the fetus was, by law, a person.

The hospital's procedure for this situation was to place the fetus in a quart-sized plastic container and put the container in the refrigerator in the pathology department for pick-up by the funeral home.

It is not perfectly clear what happened to the remains.

However, it is clear that the hospital never followed through to have the remains picked up or taken to the funeral home according to the parents' wishes.

This amounts to reckless disregard by someone on the hospital staff for the parents' right to a proper and dignified burial for the fetus.

The legal case precedents start with an 1891 case which gave the widow the right to sue the hospital which dissected her deceased husband's body without her permission.

The right of possession of a dead body for preservation and burial belongs to the deceased's surviving spouse or next of kin, and the law protects that right.

COURT OF APPEALS OF MINNESOTA
March 28, 2006

Delivery was induced at the hospital after the fetus had died *in utero.* The fetus was 6 1/2 inches long, weighed two ounces and had ten fingers and toes.

Hospital staff wrapped the fetus in a blanket and placed him in a small basket. The parents were encouraged to hold the fetus, name him and keep him in their hospital room overnight so that they could bond with him.

Then the parents were given three options: a private funeral, cremation, or the fetus could be kept in the hospital morgue until spring when it would be possible for a local funeral home to bury the fetus in a shared casket with other fetal remains. The parents chose the shared-casket option.

The fetal remains were taken to the morgue, placed in a plastic container and labeled for identification and then taken to the pathology department.

In the spring when the parents asked the funeral home about the shared-casket burial observance, the funeral home said it never got the remains. Eventually the hospital chaplain determined, and so informed the parents, that the remains were most likely transported from the pathology department for incineration along with medical waste and surgical byproducts.

Lawsuit Upheld
Interference With A Dead Body

The Court of Appeals of Minnesota made note of an 1891 case precedent, as well as more current legal commentaries, that support the right of the next of kin to sue over mishandling of a relative's dead body, if the way the body was mishandled was willful or wanton, that is, more serious that ordinary negligence.

The court ruled the parents had the right to sue. However, the jury's verdict of $150,000 was excessive, the jury having been unduly influenced by prejudicial remarks from the parents' lawyer, necessitating a new trial of the case. **Gooch v. North Country Regional Hosp., 2006 WL 771384 (Minn. App., March 28, 2006).**

Whistleblower: Aide Can Sue For Wrongful Termination, Had Raised The Issue Of Abuse Regarding Patient's Fall.

A certified nursing assistant worked in a nursing home as the staffing coordinator.

She was approached by an aide who reported to her that two weeks earlier a patient had fallen and been bruised. The aide had offered to assist the other aide in transferring the wheelchair-bound patient from her wheelchair, but the other aide refused to let her. The next thing the aide saw was the patient on the floor with no gait belt anywhere in sight. The aide said she had already informed the administrator and acting director of nursing, but nothing was being done.

The same day an LPN also approached the staffing coordinator about the same incident. The LPN did not actually see it happen but wanted to voice her concern that nothing was being done.

The staffing coordinator corroborated the incident with the aide who helped get the resident off the floor after it happened, then reported the incident to the state department of health and human services.

The staffing coordinator came in and found that the lock had been changed so she could not get into her office. She was told she had to resign.

Whistleblower's Wrongful-Termination Lawsuit Upheld

The Supreme Court of Nebraska upheld her right to sue and endorsed the jury's $79,000 verdict in her favor, that is, $4,000 lost income while she found another job and $75,000 for mental anguish and emotional distress.

Improper handling of a vulnerable adult by a paid caregiver is abuse. Nurses, aides, physicians, etc., are mandatory reporters of such abuse, that is, they must report it to the authorities and they are protected by law from employer retaliation for doing their legal duty in this respect. **Wendeln v. Beatrice Manor, Inc., 271 Neb. 373, __ N.W. 2d __, 2006 WL 903598 (Neb., April 7, 2006).**

The staffing coordinator believed in good faith that a two-person assist with a gait belt is the only proper method to transfer a wheelchair-bound patient from a wheelchair.

She corroborated that one person alone tried to transfer the patient, with no gait belt, and that the patient fell, was injured and needed pain medication for her injuries.

The legal definition of abuse includes any knowing, intentional or negligent act by a caregiver which results in physical injury to a vulnerable adult.

Nursing caregivers fall within the class of persons who by law must report abuse of a vulnerable adult in their care to proper legal authorities.

It is not the usual case, but one form a whistleblower lawsuit can take is an employee suing a former employer for damages for being terminated for carrying out her legal duty to report what she believed in good faith to have been an episode of abuse.

SUPREME COURT OF NEBRASKA
April 7, 2006

Post-Surgical Ambulation: Court Sees No Deviation From Legal Standard Of Care.

The day after hip-replacement surgery the surgeon wrote orders for the patient to stand, bear weight and walk to the extent she was able to tolerate it.

The patient's nurse and a licensed physical therapist stood by as several physical therapy assistant students ambulated the patient from her bed to the restroom in her hospital room.

A gait belt was used. One student held the belt firmly from behind when the patient was on her feet. The patient held on to a walker. A second student was by her side the whole time and another student followed behind with a wheelchair.

A student helped her stand up from the toilet and gave her her walker. While they were negotiating the narrow bathroom door she fell. The Court of Appeals of Mississippi described it as a "controlled descent" slowed by the student who had been grasping the gait belt.

The proper technique for assisting a patient to stand and walk who has just had hip replacement surgery is not something that is within the common knowledge of lay persons.

To sue a healthcare provider for negligence, expert testimony is required.

COURT OF APPEALS OF MISSISSIPPI
March 28, 2006

Even though the patient did dislocate her hip, the court dismissed her personal-injury lawsuit. **Lyons v. Biloxi H.M.A., Inc., __ So. 2d __, 2006 WL 772869 (Miss. App., March 28, 2006).**

Epilepsy: Court Finds Post-Ictal Emergency Care Substandard.

The US District Court for the District of Puerto Rico awarded almost $5 million to the family of a patient who died in a US Veterans Administration hospital from respiratory arrest following an epileptic seizure and fall at home.

The court's ruling pointed squarely at the substandard assessment and monitoring the patient received from the hospital's emergency room nursing staff.

The patient had been in the same E.R. many times before after his epileptic seizures. When he came in this time he was left for more than an hour with only minimal attention from the E.R. nursing staff.

American College of Emergency Physicians Clinical Policy for the Initial Approach to Patients Presenting with Altered Mental Status requires an apneic, hypoxic and hypotensive post-ictal patient, among other things, to be assessed for a patent airway.

The patient may just need a little O_2 from a face mask, or he may need to be intubated immediately to save his life.

UNITED STATES DISTRICT COURT
PUERTO RICO
April 4, 2006

The court pointed to the fact no paper strips could be found to support the nurse's testimony she had promptly placed him on a cardiac monitor, was taking vitals and was watching his O_2 saturation closely. The court felt he was more likely left lying alone on a stretcher even though he was hardly breathing. **Santana Otero v. US, __ F. Supp. 2d __, 2006 WL 866526 (D. Puerto Rico, April 4, 2006).**

Substandard IV Technique: Court Declines To Hold Nurse Liable.

In a convoluted ruling, the Court of Appeal of Louisiana upheld a jury verdict finding a nurse not liable for a patient developing reflex sympathetic dystrophy in his hand after an IV insertion.

The IV was started by the nurse in connection with carpal-tunnel surgery on the other hand.

There was nothing wrong with the nurse's technique up to the point the patient reported an unpleasant electric shock sensation as the nurse started the needle. At that point the nurse should have gone to a completely different site away from that wrist.

COURT OF APPEAL OF LOUISIANA
April 11, 2006

The court ruled that a nurse, once a patient has reported pain or another unpleasant sensation, should abandon the wrist and choose another site altogether.

However, in this case when the nurse moved the needle only a few millimeters and tried again in the same wrist, although improper technique in the court's judgement, nothing unusual happened.

Therefore, the nerve injury had to have been caused by the first insertion, which was not negligently performed, rather than the second insertion, which was.

Under accepted legal concepts of cause-and-effect, a nurse cannot be held liable for actions which are not negligent even if harm does occur to the patient. **Frick v. Ochsner Foundation Hosp., __ So. 2d __, 2006 WL 910003 (La. App., April 11, 2006).**

Substandard Nursing Home Care: Court Upholds Fraud Conviction.

The US District Court for the Western District of Pennsylvania upheld a nursing home operator's conviction for violating the US health care fraud statute.

Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice —

(1) To defraud any health care benefit program, or

(2) To obtain by means of false or fraudulent pretenses, representations, or promises, any of the money or property ... of any health care benefit program, in connection with the delivery of or payment for health care benefits ... or services ... shall be fined ... or imprisoned ... or both.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
April 12, 2006

The court said the evidence went beyond a mere failure to provide the standard of care required by Federal nursing-home regulations, although in certain circumstances that can be considered a crime in and of itself.

In this case, the court said, the nursing home operator went to considerable lengths by falsifying residents' treatment records to conceal the fact that required care was not being furnished.

It was the intentional falsification of records that justified prosecution for health-care fraud, the court ruled. **US v. Bell, 2006 WL 952214 (W.D. Pa., April 12, 2006).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

US Fair Labor Standards Act: Hourly Nurse Practitioners And Hourly Physicians Assistants Do Qualify For Overtime Pay.

The US Circuit Court of Appeals for the Fifth Circuit has ruled that nurse practitioners and physicians assistants who are paid on an hourly basis are entitled to time and one-half for overtime worked in excess of forty hours per week.

The US Fair Labor Standards Act (FLSA) says that an employee who works in a *bona fide* professional or administrative capacity, and is paid on a salaried basis, is not entitled to overtime for hours worked in excess of forty per week.

Under the court's interpretation of the US Department of Labor regulations that go with the FLSA, nurses, nurse practitioners and physicians assistants are *bona fide* professionals. Thus if persons in these professions are paid on a salaried basis they are not entitled to overtime pay. Only if they are paid on an hourly basis do they qualify for time and one-half for overtime, even as professionals.

Not Practicing Medicine

The FLSA says that physicians, lawyers and teachers are *bona fide* professionals, but they are not entitled to time and one-half for overtime even if they are paid on an hourly basis.

The argument raised by the nurse practitioners' and physicians assistants' employer, a corporation which staffs hospital emergency rooms in more that twenty states nationwide, was that nurse practitioners and physicians assistants are engaged in the practice of medicine and should be treated the same as physicians under the FLSA's no-overtime rule for physicians.

The court ruled that nurse practitioners and physicians assistants do not practice medicine. Reading between the lines it appears the court basically worked backward to this conclusion to allow these caregivers to fall outside the FLSA's rule for physicians so they can receive the overtime compensation the court believed they equitably deserve. **Belt v. EmCare, Inc., __ F. 3d __, 2006 WL 758277 (5th Cir., March 24, 2006).**

Nurse Practitioners vs. Physicians Assistants: Nurses' Equal Pay Act Lawsuit Will Go Forward.

The US Circuit Court of Appeals for the Sixth Circuit found unpersuasive the justifications offered by the US Veterans Administration for paying mostly-male physicians assistants significantly more than mostly-female nurse practitioners.

The US Equal Pay Act says explicitly that every employer in the US must pay men and women the same wages for doing essentially the same work.

The Court of Appeals issued a complex opinion examining the question whether physicians assistants and nurse practitioners, that is, the ones working in US Veterans Administration hospitals, do or do not do essentially the same work so as to invoke the nurse practitioners' rights under the Equal Pay Act.

The Veterans Administration has not convinced the court there is anything but gender discrimination behind the disparity in pay between predominately male physicians assistants and predominately female nurse practitioners.

The District Court should not have dismissed the nurse practitioners' case without giving them their full-fledged day in court.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
March 17, 2006

The Court of Appeals seemed to insinuate there was nothing but old-fashioned gender discrimination behind the VA's practice of paying nurse practitioners less than physicians assistants.

However, the thrust of the Court of Appeal's complex ruling was only to show that the Federal District Court judge was wrong to grant a summary judgment against the nurse practitioners on a very complex legal question without giving them their day in court to develop fully their evidence of Equal Pay Act violations.

This is not a definitive ruling that nurse practitioners are entitled to equal pay with physicians assistants, but it could be a meaningful step in that direction. **Beck-Wilson v. Principi, 441 F. 3d 353 (6th Cir., March 17, 2006).**