WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Wisconsin Department of Safety and Professional Services
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Department of Safety and Professional Services website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Safety and Professional Services from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Safety and Professional Services data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Safety and Professional Services, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Safety and Professional Services is shown on the Department's Web Site under "License Lookup."
  The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DSPS website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

FILE COPY

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
THOMAS PAUL ENGEL, R.N., RESPONDENT.	:	ORDER 0001810

The parties to this proceeding for the purposes of Wis. Stats. sec. 227.16 are:

Thomas Paul Engel, R.N.
2428-A West Michigan Avenue
Milwaukee, Wisconsin 53233

Board of Nursing
1400 East Washington Avenue
P.O. Box 8936
Madison, Wisconsin 53708

Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
Madison, Wisconsin 53708

A party aggrieved by this decision may petition the board for rehearing within twenty (20) days after service of this decision pursuant to Wis. Stats. sec. 227.12. The party to be named as respondent in the petition in Thomas Paul Engel.

A party aggrieved by this decision who is a resident of this state may also petition for judicial review by filing the petition in the office of the clerk of the circuit court for the county where the party aggrieved resides within thirty (30) days after service of this decision. A party aggrieved by this decision who is not a resident of this state must file the petition for judicial review in the office of the clerk of circuit court for Dane County. A party aggrieved must also serve the board and other parties with a copy of the petition for judicial review within thirty (30) days after service of this decision pursuant to Wis. Stats. sec. 227.16. The party to be named as respondent in the petition is the State of Wisconsin Board of Nursing.

Two days of hearing were held in the above-captioned matter. The respondent, Thomas P. Engel, appeared personally and by his attorneys, William M. Coffey and David P. Geraghty, COFFEY, COFFEY & GERAGHTY, Suite 700, 1100 West Wells Street, Milwaukee, Wisconsin 53233. The complainant appeared by Attorney Steven M. Gloe, Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Avenue, P.O. Box 8936, Madison, Wisconsin 53708. Subsequent to the hearing, the attorneys for the parties filed written closing arguments, the last of which was received and filed on January 4, 1985.

The hearing examiner filed his Proposed Decision in the matter on February 5, 1985, and the board considered the Proposed Decision at its meeting of March 18 and 19, 1985. Based upon the Proposed Decision and the record in this case, the Board of Nursing makes the following Findings of Fact, Conclusion of Law and Order.

FINDINGS OF FACT

1. Thomas Paul Engel, hereinafter referred to as Engel, was at all times material to these proceedings duly licensed as a registered nurse in the State of Wisconsin. His license bears number 81927 and was issued on June 25, 1982.

2. Engel entered Marquette University in Milwaukee, Wisconsin in August, 1977. In May of 1981, Engel received a bachelor's degree in nursing from Marquette University.

3. Between March of 1980 and May of 1981, and while attending Marquette University, Engel was employed at St. Michael Hospital in Milwaukee, Wisconsin as a nursing assistant. His duties included assisting professional nurses in performing various patient care activities. During the latter part of this period of employment at St. Michael Hospital, Engel was assigned to assist the nurses and physicians in rendering care to patients in the emergency room.

4. Subsequent to his graduation from Marquette University, Engel accepted a six month internship position at the Northridge Hospital Medical Center in Northridge, California. This position involved training regarding the care of patients regarding intensive care, as well as coronary care. After the completion of this internship program, Engel accepted employment with the Stanford University Hospital Medical Center in Palo Alto, California, and was assigned to the coronary care of patients.

5. Engel returned to this state and accepted employment with St. Michael Hospital in approximately May of 1982. Engel was assigned to the hospital's coronary care unit, also known as the "CCU". Engel was assigned to the CCU during all times material to this proceeding. Engel's duties within the CCU included the provision of professional nursing care for patients with various coronary or respiratory conditions, as well as stroke victims.

6. On August 27, 1983, Joseph Dohr suffered a stroke at his home. He was convenyed to St. Michael Hospital where he was connected to life support systems and placed in the CCU. The life support system consisted in part of placing an endotracheal tube (or "ventilator" tube) into Mr. Dohr's airway, which was connected to a ventilator (or "respirator"). The ventilator performed the breathing function for Mr. Dohr. Engel was responsible for providing nursing care to Mr. Dohr during his work shift.

7. At some time prior to Mr. Dohr's death on September 14, 1983, Engel became aware that the desire of Mr. Dohr's wife and family was that Mr. Dohr be disconnected from the life support system.

8. On September 14, 1983, Engel became aware that a conference had been held that day involving the family of Joseph Dohr, the attending physician, the neurologist, and the chaplin, who was a registered nurse. Engel was aware that although the family of Joseph Dohr desired the termination of the life support system, the neurologist decided that Joseph Dohr should be maintained upon the life support system since his death was imminent within a few hours to a few days.

9. In the late afternoon of September 14, 1983, Engel entered Joseph Dohr's room and, without physician authorization, deactivated the alarm mechanisms and disconnected the ventilator tube from Mr. Dohr's respirator. After a few minutes, the heart monitor attached to Mr. Dohr indicated a straight line. Joseph Dohr was pronounced dead shortly after 6:00 p.m. that day.

10. Engel had attempted to disconnect Joseph Dohr from the life support system without physician authorization on September 12, 1983, but failed to carry through with this intention when he heard a physician enter the CCU.

11. On May 9, 1984, Engel was found guilty upon a plea of no contest by the State of Wisconsin Circuit Court, Branch 35, for Milwaukee County of the misdemeanor crime of having practiced medicine without a license contrary to sections 448.03(1) and 448.09(1) of the Wisconsin Statutes. The basis for the conviction was Engel's conduct as set forth in paragraph 9 above. Pursuant to the conviction, Engel was placed upon probation for a period of 20 months and ordered to commit "no further crimes".

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this proceeding pursuant to Wis. Stats. sec. 441.07.

2. The conduct of Engel, as set forth in paragraphs 9 and 10 of the Findings of Fact, constitutes a violation of Wis. Stats. sec. 441.07(1)(d), and is grounds for the imposition of disciplinary sanctions against his license.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Thomas Paul Engel to practice as a registered nurse in the State of Wisconsin be, and hereby is, revoked, effective ten days from the date hereof.

IT IS FURTHER ORDERED that, Thomas Paul Engel may apply for reinstatement of his license one year from the effective date hereof. Upon such application, upon presentation to the board of evidence of having successfully completed a course satisfactory to the board on the subject of nursing ethics or bioethics, and if Engel's application is otherwise satisfactory, Thomas Paul Engel shall be granted a limited license. Such limited license, if granted, shall be subject to the following terms and conditions:

(1) The term of the limitation shall be for a period of two years or until Engel has been employed in a nursing capacity for a period of two years, whichever is later.

(2) During the period of limitation, Thomas Paul Engel shall be responsible for providing to the board quarterly reports from his nursing employer(s) setting forth Engel's job duties, responsibilities and progress, and establishing that Engel is, and continues to be, capable of safely and competently practicing as a registered nurse.

(3) Thomas Paul Engel may, at any time during the period of limitation, petition the board for termination of the limitation for good cause shown.

EXPLANATION OF VARIANCE

The board has accepted the hearing examiner's Findings of Fact and Conclusions of law in their entirety. The recommended Order has been modified, however, to provide that if Engel completes a course in nursing ethics or bioethics during the period of revocation, he may apply for reinstatement after one year and that the application, if otherwise in order, will be granted. The board's order also provides that Engel's license, if reinstated, will be limited for a period of two years by requiring quarterly reports of Engel's job performance from Engel's nursing employer.

The board considers these modifications to the recommended disciplinary order to accomplish two things. First, it provides to Mr. Engel guidance as to what the board will require in affirmatively acting upon any application for reinstatement following the statutorily mandated one year period of revocation. It also provides some assurance of ultimate reinstatement.

Additionally, the board's order permits the board to monitor Mr. Engel's practice of nursing following reinstatement to ensure that his manner of practice does not manifest a proclivity to exceed the scope of his license to practice as a professional nurse.

Finally, in providing to Mr. Engel assurance of ultimate eligibility for reinstatement, the board has recognized that while Mr. Engel's actions in this case were in his words "grievously inappropriate", the evidence indicates that those actions were motivated by altruism. Given those circumstances, the board feels constrained to provide to Mr. Engel the procedural means to ultimately resume the practice of his profession.

Dated at Madison, Wisconsin this 19th day of March, 1985.

STATE OF WISCONSIN BOARD OF NURSING

By _____
John Bartkowski
Chairman

139-654

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	NOTICE OF FILING
THOMAS PAUL ENGEL, R.N., RESPONDENT	:	PROPOSED DECISION

To: William M. Coffey
David P. Geraghty
COFFEY, COFFEY & GERAGHTY
Attorneys at Law
Suite 700
1100 West Wells Street
Milwaukee, Wisconsin 53233

Steven M. Gloe
Attorney at Law
Department of Regulation & Licensing
Division of Enforcement
P. O. Box 8936
Madison, Wisconsin 53708

PLEASE TAKE NOTICE that a Proposed Decision in the above-captioned matter has been filed with the Board of Nursing by the Hearing Examiner, Donald R. Rittel. A copy of the Proposed Decision is attached hereto.

If you are adversely affected by, and have objections to, the Proposed Decision, you may file your objections, briefly stating the reasons and authorities for each objection, and argue with respect to those objections in writing. Your objections and argument must be submitted and received at the office of the Board of Nursing, Room 174, Department of Regulation and Licensing, 1400 East Washington Avenue, P. O. Box 8936, Madison, Wisconsin 53708, on or before March 1, 1985.

Dated at Madison, Wisconsin, this 5th day of February, 1985.

Donald R. Rittel

Donald R. Rittel
Hearing Examiner

pc955-530

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST THOMAS PAUL ENGEL, R.N., RESPONDENT.	PROPOSED DECISION

The parties to this proceeding for the purposes of Wis. Stats. sec. 227.16 are:

Thomas Paul Engel, R.N.
2428-A West Michigan Avenue
Milwaukee, Wisconsin 53233

Board of Nursing
1400 East Washington Avenue
P.O. Box 8936
Madison, Wisconsin 53708

Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
Madison, Wisconsin 53708

Two days of hearing were held in the above-captioned matter. The respondent, Thomas P. Engel, appeared personally and by his attorneys, William M. Coffey and David P. Geraghty, COFFEY, COFFEY & GERAGHTY, Suite 700, 1100 West Wells Street, Milwaukee, Wisconsin 53233. The complainant appeared by Attorney Steven M. Gloe, Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Avenue, P.O. Box 8936, Madison, Wisconsin 53708. Subsequent to the hearing, the attorneys for the parties filed written closing arguments, the last of which was received and filed on January 4, 1985.

Based upon the record in this case, the examiner recommends that the Board of Nursing adopt as its final decision the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Thomas Paul Engel, hereinafter referred to as Engel, was at all times material to these proceedings duly licensed as a registered nurse in the State of Wisconsin. His license bears number 81927 and was issued on June 25, 1982.

2. Engel entered Marquette University in Milwaukee, Wisconsin in August, 1977. In May of 1981, Engel received a bachelor's degree in nursing from Marquette University.

3. Between March of 1980 and May of 1981, and while attending Marquette University, Engel was employed at St. Michael Hospital in Milwaukee, Wisconsin as a nursing assistant. His duties included assisting professional nurses in performing various patient care activities. During the latter part of this period of employment at St. Michael Hospital, Engel was assigned to assist the nurses and physicians in rendering care to patients in the emergency room.

4. Subsequent to his graduation from Marquette University, Engel accepted a six month internship position at the Northridge Hospital Medical Center in Northridge, California. This position involved training regarding the care of patients regarding intensive care, as well as coronary care. After the completion of this internship program, Engel accepted employment with the Stanford University Hospital Medical Center in Palo Alto, California, and was assigned to the coronary care of patients.

5. Engel returned to this state and accepted employment with St. Michael Hospital in approximately May of 1982. Engel was assigned to the hospital's coronary care unit, also known as the "CCU". Engel was assigned to the CCU during all times material to this proceeding. Engel's duties within the CCU included the provision of professional nursing care for patients with various coronary or respiratory conditions, as well as stroke victims.

6. On August 27, 1983, Joseph Dohr suffered a stroke at his home. He was conveyed to St. Michael Hospital where he was connected to life support systems and placed in the CCU. The life support system consisted in part of placing an endotracheal tube (or "ventilator" tube) into Mr. Dohr's airway, which was connected to a ventilator (or "respirator"). The ventilator performed the breathing function for Mr. Dohr. Engel was responsible for providing nursing care to Mr. Dohr during his work shift.

7. At some time prior to Mr. Dohr's death on September 14, 1983, Engel became aware that the desire of Mr. Dohr's wife and family was that Mr. Dohr be disconnected from the life support system.

8. On September 14, 1983, Engel became aware that a conference had been held that day involving the family of Joseph Dohr, the attending physician, the neurologist, and the chaplin, who was a registered nurse. Engel was aware that although the family of Joseph Dohr desired the termination of the life support system, the neurologist decided that Joseph Dohr should be maintained upon the life support system since his death was imminent within a few hours to a few days.

9. In the late afternoon of September 14, 1983, Engel entered Joseph Dohr's room and, without physician authorization, deactivated the alarm mechanisms and disconnected the ventilator tube from Mr. Dohr's respirator. After a few minutes, the heart monitor attached to Mr. Dohr indicated a straight line. Joseph Dohr was pronounced dead shortly after 6:00 p.m. that day.

10. Engel had attempted to disconnect Joseph Dohr from the life support system without physician authorization on September 12, 1983, but failed to carry through with this intention when he heard a physician enter the CCU.

11. On May 9, 1984, Engel was found guilty upon a plea of no contest by the State of Wisconsin Circuit Court, Branch 35, for Milwaukee County of the misdemeanor crime of having practiced medicine without a license contrary to sections 448.03(1) and 448.09(1) of the Wisconsin Statutes. The basis for the conviction was Engel's conduct as set forth in paragraph 9 above. Pursuant to the conviction, Engel was placed upon probation for a period of 20 months and ordered to commit "no further crimes".

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this proceeding pursuant to Wis. Stats. sec. 441.07.

2. The conduct of Engel, as set forth in paragraphs 9 and 10 of the Findings of Fact, constitutes a violation of Wis. Stats. sec. 441.07(1)(d), and is grounds for the imposition of disciplinary sanctions against his license.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Thomas Paul Engel to practice as a registered nurse (license #81927) in the State of Wisconsin, shall be and hereby is, revoked; effective ten (10) days following the date of the final decision and order of the Board of Nursing.

FURTHERMORE, IT IS ORDERED that, pursuant to section 441.07(2) of the Wisconsin Statutes, Thomas Paul Engel may not apply to the Board of Nursing for reinstatement of his license for a period of one year following the effective date of the revocation.

OPINION

On August 27, 1983, Mr. Joseph Dohr, age 78, suffered a stroke at his home and was conveyed to St. Michael Hospital in Milwaukee, Wisconsin. Mr. Dohr was placed upon a respirator to mechanically sustain his breathing and transported to the hospital's coronary care unit. Mr. Dohr, who was diagnosed as having incurred irreversible brain damage, remained in a comatose state and dependent upon life support systems for approximately three weeks. In the late afternoon of September 14, 1983 the respondent, Thomas Paul Engel, entered Mr. Dohr's room, deactivated the alarm mechanisms and disconnected the ventilator tube from Mr. Dohr's respirator. After a few minutes, the heart monitor attached to Mr. Dohr showed a straight line. Mr. Dohr was pronounced dead shortly after 6:00 p.m.

Mr. Engel, a registered nurse, is charged with "misconduct or unprofessional conduct" under section 441.07(1)(d) of the Wisconsin Statutes. An affirmative finding may result in the taking of disciplinary action against Mr. Engel's

license to practice as a registered nurse in this state. Mr. Engel has admitted disconnecting Mr. Dohr from the life support system for the purpose of terminating Mr. Dohr's life, without a physician's authorization. Mr. Engel's admission and the testimony received at the hearing clearly indicate that he acted in violation of s. 441.07(1)(d). The primary issue here is the discipline, if any, to be imposed against Mr. Engel.

With regard to discipline, it must be noted that the interrelated purposes for applying sanctions against a professional licensee are to protect the public, deter other licensees from engaging in similar misconduct and promote the rehabilitation of the licensee involved. State v. Aldrich, 71 Wis. 2d 206, 209 (1976). Punishment of the licensee is not a proper consideration. State v. MacIntyre, 41 Wis. 2d 481, 485 (1969). In order to ascertain an appropriate disposition of this case, the facts and circumstances surrounding Mr. Engel's conduct, as adduced at the evidentiary hearing, must be reviewed.

BACKGROUND

Mr. Engel, age 29, received a bachelor's degree in nursing from Marquette University in May of 1981. After graduation, he worked in the State of California at two hospital medical centers where he gained experience in the coronary care setting. In 1982, Mr. Engel returned to Wisconsin, received his license as a registered nurse and became employed by St. Michael Hospital in Milwaukee, Wisconsin where he had been previously employed to assist professional nurses while attending Marquette University. Mr. Engel's primary nursing assignment upon returning to St. Michael Hospital was within the coronary care unit.

Mr. Engel's basic technical competency is not disputed. Respondent's Ex. 1 consists of several pieces of correspondence and evaluations which establish that Mr. Engel's professional abilities are respected by instructors at Marquette University, as well as by health care professionals at St. Michael Hospital, including both nurses and physicians. These materials further indicate that, despite Mr. Engel's conduct at issue here, in their opinion he is an asset to the nursing profession. Respondent's Ex. 1 includes several testimonials to Mr. Engel's ability to recognize, diagnose and positively approach various nursing problems. His rapport with patients and their families in critical illness situations is praised.

In testifying at the hearing, Mr. Engel demonstrated that he is a highly intelligent and articulate individual. Mr. Engel's basic explanation for his conduct, simply stated, is that his compassion for Joseph Dohr and his family, as well as his nursing training regarding "patient advocacy", led him to take the action he did. Mr. Engel indicates that he now recognizes that he made a mistake and that he would never again engage in similar conduct.

The numerous letters and evaluations in support of Mr. Engel, as well as his explanation for his conduct and expressed remorse, could be perceived as justifying a less harsh or restrictive disciplinary sanction than that which might otherwise be appropriate in this case, if such criteria were considered alone and without resort to the remainder of the evidence in this record. However, in my opinion, the evidence produced at the hearing

establishes that Mr. Engel has not been totally candid in describing the facts and circumstances surrounding the disconnection of Joseph Dohr from the life support system, nor does it satisfactorily assure that Mr. Engel would not engage in similar conduct in the future. The credible testimony at the hearing indicates that Mr. Engel did not remain constantly at Joseph Dohr's bedside during the disconnection of the life support system on September 14, 1983; that, despite Mr. Engel's denial, he attempted to disconnect the respirator on a previous occasion; and that he has given contradictory statements regarding his remorse for his conduct.

CONDUCT ON SEPTEMBER 14, 1983

On September 14, 1983, a conference was held with the family of Joseph Dohr. Participants in that conference included Mr. Dohr's attending physician, Dr. Mehigan; the neurologist, Dr. Kagen; and R.N. Sister Alice, the chaplin at the hospital. (Complainant's Ex. 3, p. 2). Mr. Engel testified as follows regarding his understanding of the nature and result of that conference:

> A. (Mr. Engel) It is my understanding, on that day in question, September 14th, that the family had approached the physician, requested a conference, at which time the proposal was discussed for discontinuation of life-support, as the family felt that in their opinion the continued treatment would not be of value in restoring Mr. Dohr to his condition prior to his debilitating illness. That they did not feel that--if he was able to speak for himself, he would wish this. And that they certainly did not wish to see him maintained in the sort of a state and that a dignified end to his life would be appropriate and in order. And that was a request that they made to the physicians on that day.
>
> Q. (Mr. Coffey) And were you aware of and familiar with the decision that had been made by the doctor in charge?
>
> A. Yes, I was.
>
> Q. And what was that decision?
>
> A. The decision was made by, I believe the attending neurologist, Dr. Kagen, that the life-support systems would not be discontinued due to the fact that the death of Mr. Dohr was imminent within a matter of a few hours to a matter of a few days. And that he would elect to maintain Mr. Dohr on the life-support until such time as he came to a natural death.
> (Trans., 10/2/84, pp. 16-17).

Mr. Engel testified regarding the impact which the outcome of the family conference had upon his decision to terminate Mr. Dohr's life support system later that day:

My decision I believe, as I recall, was made based on the progressive decline of the patient and based on the family's request of that particular day in which they requested, and I believed it to be a valid request, that extraordinary measures, meaning the ventilator be disconnected and Mr. Dohr be allowed to die with dignity. I based my action on those thoughts and on that understanding of what had transpired that day, along with my knowledge of his condition from the time of his admission until that day in question, and also my dealings with the family members. (Trans., 10/29/84, p. 29).

Mr. Engel described the events surrounding the termination of the life support system as follows:

Q. (Mr. Gloe) I'm going to ask you some questions about the occurrences of September 14, 1983. Is it correct that you disconnected the ventilator tube from Mr. Dohr on that night?

A. (Mr. Engel) That's correct.

Q. Is it also correct that previous to that time you had rendered the ventilator and heart monitor alarms inoperative?

A. Immediately prior to the disconnection I would have done so, yes.

Q. What did you do after you disconnected Mr. Dohr?

A. I remained in the room at the patient's bedside monitoring--Essentially, when I disconnected the ventilator tube, I observed for any chest movement which would indicate any air being exchanged by him on his own, and put my hand up next to the end of the E.T. tube to feel for any air movement back and forth, the principle being if there was any such movement, it would indicate to me that he was exchanging air and was able to breath on his own. If that had been the case that I detected any one of those conditions, either the chest rising or falling or any air movement, I would have immediately reconnected him to the machine.

Q. Did you say anything to Mr. Dohr during that time or prior to disconnecting him?

A. I don't recall specifically.

Q. Did you observe any independent signs of respiration?

A. No, I did not.

Q. What did you do then?

A. I continued to watch the heart monitor to see what the rate was, to watch what the EKG configuration was. As we described previously, there would be changes in the complexes as oxygen was used up by

the system, and it would get the changing of the complexes. I believe at that time it's my recollection that I may have in a somewhat explanatory way stated to Mr. Dohr, although he didn't respond to me, this was what we're doing, that the end is near, his suffering is almost over, something of that nature. I recall that I was not absolutely silent, that I did address him. I don't remember specific words that I used in that regard.

Q. Did you have any conversation at that time or in that interval with a nurse by the name of Molly Erickson?

A. It's my recollection that as I was in the room continuously from the time that I disconnected him, that Molly Erickson came in to the room, said "What are you doing", and I said to her, "What does it look like?" She said to me, "I don't want to know anything about it", upon which time she left the room.

Q. In your recollection she gave you no order to reconnect Mr. Dohr?

A. I do not recall any such order.

Q. How long did you stay in the room after disconnecting Mr. Dohr?

A. From the time that I disconnected him, it's my recollection that I stayed at his bedside continuously: One, to observe whether there was any respiratory effort on his part, and two, to watch the heart monitor. And as I recall, the period of time until his heart slowed down and finally stopped and became a straight line would have been approximately six to seven minutes.

Q. And you're stating then you stayed there until the heart monitor revealed a straight line?

A. That's my recollection, yes.

Q. Did you reconnect Mr. Dohr after the monitor showed a straight line?

A. Yes, I did. At that time when the heart monitor showed a straight line, which I took to mean no heart complexes, I also noted there was no blood pressure at the time, and I turned off the ventilator machine, turned off the alarms in the ventilator machine, and reconnected Mr. Dohr to the ventilating apparatus, left the heart monitor on with the alarm off so that a continuous straight line would be registering.

Q. You said you turned off the alarm again. Does it need to be turned off every time you reattach the machine?

A. On the ventilator machine there's a little window that you flip up, and when you flip that up, that disables the alarm. So that

by flipping that window back down, the alarm would be armed again, if you will, but that in turning off the machine itself, it wouldn't matter whether the window was up or down because once the machine is off, there's no electricity to power the alarm.

Q. But I guess what I want to be clear on is prior to disconnecting Mr. Dohr from the ventilator machine, you rendered that alarm inoperative?

A. Inactive, that's correct, and it stayed that way during the time Mr. Dohr was disconnected.

Q. And then you turned off the machine and reconnected him to the ventilator?

A. That's correct.

Q. Did you provide any other care to Mr. Dohr at that time?

A. I think at that point in time when the heart monitor was on but the alarm was off, there was a straight line, the ventilator machine was off but reconnected, and at that point in my mind he was dead. I left the room to call the on call resident to notify him that Mr. Dohr had expired and would he be available sometime in the immediate future to come up and pronounce Mr. Dohr dead so that we could contact the family to notify them and have them come in for a view of Mr. Dohr if they wished.
(Deposition of Engel taken 8/2/84--Complainant's Ex. 1, pp. 20-24).

Mr. Engel's testimony that he remained in Mr. Dohr's room continuously during his disconnection of the life support system in order to monitor the response of Joseph Dohr is at variance with the observations of Molly Erickson. Ms. Erickson was a registered nurse at St. Michael who worked with Mr. Engel on the CCU during the P.M. shift. Her testimony indicates that Mr. Engel did not remain in Mr. Dohr's room throughout the disconnection procedure.

Q. (Mr. Gloe) Were you working at St. Michael on September 14, 1983?

A. (Ms. Erickson) Yes.

Q. In what unit?

A. Cardiac care unit.

Q. That afternoon were you involved at all with the care of Mr. Dohr?

A. Not really. It was Tom's patient. He was taking care of him. I'm present. I'm aware. I, you know, know what's going on with him. But, he was giving the care for the patient that evening.

Q. Did you enter Mr. Dohr's room on that date?

A. Yes.

Q. Could you tell me the circumstances that involved in that situation?

A. M-hm. I was in the nurses' station and happened to walk past the monitors. Saw the monitor for Joe Dohr and his heart rate was slow. I stopped there. Tom had just passed me. Walked past and went over towards the unit clerk's desk. And I asked him, you know, what was going on with Joe. And at that time he said oh, is my therapy working. And he walked back through the station, back towards the room. The curtain was drawn. And as I entered the room he was standing next to the patient on the side of the bed with the monitor and he had the respirator tubing in his hand.

Q. What happened then?

A. He was looking at the monitor. I can remember him saying, he looked up at the monitor and said oh, no, you don't. You know, there was another heartbeat showed. And he had connected the tubing. And then he said oh, no, you don't. And he disconnected the tubing. And I told him to put it back on. I don't remember if I asked him what he was doing. But I know that I told him to put the tubing back on. And then at that time I left the room and said I would get a resident and left.
(Trans., 11/9/84, pp. 50-51).

The testimony of Ms. Erickson is credible and indicates that Mr. Engel did not remain in the presence of Joseph Dohr throughout the disconnection procedure.

CONDUCT ON SEPTEMBER 12, 1983

There is a major conflict in the testimony as to whether or not the only time which Mr. Engel attempted to terminate Joseph Dohr's life support system was on September 14, 1983. The events occuring two days previous, on September 12th, should be discussed next.

As indicated above, Mr. Engel stated that his decision to terminate the life support system of Joseph Dohr on September 14th was made, at least in part, upon "the family's request of that particular day" and on his "understanding of what had transpired that day" with regard to the family conference which resulted in the physician's formal determination not to disconnect the ventilator. At the hearing, Mr. Engel was questioned as to whether or not he had made a similar attempt to disconnect Joseph Dohr on September 12, 1983.

Q. (Mr. Gloe) Isn't it correct, Mr. Engel, that you had previously disconnected this patient on September 12, 1983?

A. (Mr. Engel) It's my recollection at this point in time that on September 12th I had disconnected Mr. Dohr from the respirator for the purposes of suctioning the airway that was in place, the endotracheal tube....

Q. (Pause) Do you recall having a conversation with nurses Diana Sell and Molly Erickson on February 2nd, 1984?

A. Yes, I do. Such a conversation would have occurred at a bar restaurant in the City of Milwaukee.

Q. And during that conversation is it not correct that you indicated something to the effect that, you had tried it on Monday but you almost got caught?

A. I don't recall making a statement such as that. (Trans., 10/2/84, pp. 29-30).

Ms. Erickson did not immediately confront Mr. Engel concerning his conduct on September 14, 1983, nor did she immediately report her knowledge of the incident to her hospital supervisor. She was, however, suspicious of his conduct. The following day, September 15th, she was walking down a hall in the hospital with Mr. Engel and said, "don't ever do that again". According to Ms. Erickson's testimony, Mr. Engel replied, "I would do that over and over again to that man". (Trans., 11/9/84, p. 52).

Ms. Erickson did not inform anyone of her suspicions until December 18, 1983, when she discussed it with another nurse employed at St. Michael Hospital, Diana Sell. Subsequently, the matter was reported to supervisory personnel at the hospital. (Trans., 11/9/84, p. 60). Thereafter, the Milwaukee County District Attorney's Office requested that Ms. Erickson and Ms. Sell discuss the Joseph Dohr matter with Mr. Engel in order to obtain more information. (Trans., 11/9/84, p. 56). Ms. Erickson and Ms. Sell arranged for Mr. Engel to meet them at the Iron Horse, a bar-restaurant in Milwaukee, the evening of February 2, 1984. The nurses arrived between 10:30 p.m. and 11:00 p.m., and Mr. Engel joined them shortly before midnight. (Trans., 11/8/84, p. 61). During the discussion, Mr. Engel admitted, and described, disconnecting the life support system of Joseph Dohr on Wednesday, September 14th. Furthermore, according to Ms. Erickson and Ms. Sell, he also admitted to a previous attempt made on Monday, September 12th. Ms. Erickson testified as follows:

Q. (Mr. Gloe) During the discussion, was there any mention of Mr. Engel's care for Mr. Dohr on Monday, September 12, 1983?

A. (Ms. Erickson) Yes. He said to us that he had tried to do it on Monday. That he had shut off the alarms and pulled the curtain and had stayed in the room with the patient. But that he had heard--he saw scooped T-waves on the monitor, you know, the cardiac monitor, and that he had heard Dr. Tuchman, and I believe the wife and daughter in the unit. And and at that time he

turned, put everything back the way it was and was quite, he expressed to us that he had been quite frightened and scared, you know, because he felt he had almost been caught.
(Trans., 11/9/84, pp. 48-49).

Ms. Erickson's recapitulation of Mr. Engel's admission concerning the attempt of September 12th is corroborated by the testimony of Ms. Sell.

Q. (Mr. Gloe) And during that discussion did Mr. Engel tell you anything about his care for Mr. Dohr on Monday, September 12th, 1983?

A. (Ms. Sell) Yes.

Q. What did he tell you?

A. He said in reference to what he did to Joseph Dohr two days later he said I tried it on Monday. And he said he disconnected the respirator for a few minutes and the T-waves became very scooped. He became afraid. Besides Dr. Tuchman walked into the unit and Joseph Dohr's daughter and wife were also at the hospital at that time. So he reconnected the patient.
(Trans., 11/9/84, pp. 75-76).

As indicated earlier, Mr. Engel denies that he attempted to terminate the life support system of Joseph Dohr on September 12th, and that he did not formulate his decision until after he was aware that the family conference of September 14th had resulted in the physician decision not to terminate life support. Given the credible testimony of Ms. Erickson and Ms. Sell, it appears that Mr. Engel has not been totally candid with regard to the specifics of his conduct. Although this lack of candor on behalf of Mr. Engel may not substantially detract from finding that his motives for disconnecting Joseph Dohr from the life support system were altruistic--there being nothing in this record to suggest that Mr. Engel's conduct stemmed from anything other than deep compassion for Joseph Dohr and his family--it does bring into question the credibility of Mr. Engel's currently stated position that he would never again engage in similar conduct.

FUTURE CONDUCT

One of the difficult issues in this case is the extent to which it can be determined whether or not Mr. Engel would engage in similar conduct in the future. As set forth above, Mr. Engel informed Ms. Erickson the day after he terminated the life support system for Joseph Dohr that he "would do that over and over again to that man". (Trans., 11/9/84, p. 52). The day following his meeting with Ms. Erickson and Ms. Sell at the Iron Horse, Mr. Engel was questioned by Deputy District Attorney Schneider of Milwaukee County. Mr. Engel admitted that "(i)n my statement to Mr. Schneider on that day I said, in quotes, I would do it again and again and again". (Trans., 10/2/84, p. 23). Since his statement to Mr. Schneider, Mr. Engel

has taken the position before the court considering criminal charges brought against him, as well as before this Board during the hearing, that "under no circumstance would I ever in the future consider or carry out such an act again". (Trans., 10/2/84, p. 21).

In my opinion, it cannot be determined with any degree of certainty, the extent to which Mr. Engel is truly repentive for his conduct. His most recent statements to the court and this Board must be reviewed in the context in which they were offered; that is, a contrary statement to either the court or Board would most likely result in a harsher criminal sanction than that he received and would certainly not be looked upon with favor by a licensing board charged with the responsibility of protecting the public. Perhaps the course evaluation dated October 13, 1980 of Carol Bartelt at Marquette University is as true today as it was four years ago, in that Mr. Engel needs "to reflect upon his own value system and its effect on his professional role". (Respondent's Ex. 1).

DISCIPLINE

In a society of laws, rather than one governed by the whims or personal philosophies of individuals, it is axiomatic that issues of great public concern and difference of opinion must be resolved in a rational, thoughtful and deliberative manner. The moral and legal dilemma created by the technology of a society capable of sustaining life beyond its normal or personally acceptable limits is one which must be resolved through such a rational, thoughtful and deliberative approach. There currently appears to be no clear line between life and death which is universally accepted by a consensus of the public. By his conduct, Mr. Engel thrust himself into this public debate by imposing his personal decision to terminate life support systems without authority to do so upon Mr. Dohr, Mr. Dohr's family, the hospital, the hospital's health care personnel, and society at large. No matter an individual's personal decision as to when they believe life support systems should be terminated, few, if any, would argue that such a decision rests solely with the professional nurse.

The discipline imposed by this Board must be sufficient to inform the public and the profession that licensees who unilaterally make such momentus and far-reaching decisions without proper authority will not be treated lightly. To do otherwise may only serve to induce other health care professionals to engage in similar inappropriate conduct, given that the "cost" of such action will be minimal. I believe that the public would not be, and would not believe itself to be adequately protected if the discipline levied is not sufficiently strong to discourage other professional nurses from contemplating engaging in such conduct. Limitations upon, or a short suspension of Mr. Engel's license would endorse an individualistic, rather than a collective approach to resolving the major societal issue of termination of life support systems. Although resolution of this issue in the public arena may not be quick or ultimately satisfactory to all, clearly unauthorized conduct such as Mr. Engel's cannot be accepted and must be strongly discouraged. To take it upon oneself to disregard known physician instructions and disconnect life support systems is not an acceptable means of resolution. The Board must state this clearly to both the public and its licensees so that there can be no misinterpretation of its position.

The concept that a professional nurse has a responsibility to be an advocate for patients and their families with respect to their health care desires is not a strong factor mitigating from the necessity for imposing strict discipline in a case of this nature. There were less drastic alternatives to unilaterally deciding to disconnect Mr. Dohr's life support system which Mr. Engel might have employed as a patient advocate. It is conceded that any of those alternatives may have been difficult to implement. It is not always easy to change a physician's decision in which a nurse does not agree. In this case, however, there is no evidence that Engel even attempted to approach other health care professionals at the hospital with his concerns at any time prior to his disconnection.

With regard to Mr. Engel's current ability to practice nursing, it must be recognized that not only training and technical competence are required of a professional nurse, but also positive judgmental qualities. Mr. Engel's conduct demonstrates a lack of exercise of such judgment in this case. Technical competency may be of little value if it is not accompanied by sound professional judgment. Mr. Engel's inability to separate his own personal value system from his professional responsibilities may have contributed to his decision to terminate the life support system of Joseph Dohr. To the extent that a nurse's personal values, or judgments, differ from those expressed by the health care institution or primary physician, the nurse must attempt to operate within the accepted framework provided to pursuade others to his or her viewpoint. Otherwise, the institutional health care system becomes chaotic and directed by individual value preferences, rather than by the considered judgment and interaction with other associated health care professionals. Patients, their families and the public have a right to expect such critical decisions to be made thoughtfully and pursuant to established criteria within the institutional setting.

A reprimand, short suspension, or the imposition of limitations in this case would not adequately assure the public that this Board is committed to its protection. Although the conduct of Mr. Engel, taken in its best light and viewed in isolation, may appear to justify the Board's compassion and leniency, to apply such a sanction would not give sufficient weight to the overriding principle that a nurse may not disobey clear instructions and disconnect life support systems. Public confidence in health care professionals will be drastically eroded if the Board appears to condone--as complainant's attorney phrases it--"nurse vigilantism".

It is recommended that the Board of Nursing revoke the license of Mr. Engel to practice as a registered nurse in this state. The effect of such revocation, as set forth in section 441.07(2) of the Wisconsin Statutes, is as follows:

> A certificate or license revoked may, after one year, upon application be reinstated by the board.

A revocation does not necessarily forever bar Mr. Engel from practicing as a professional nurse. Rather, it permits him to reapply after a period of one year at which time the Board would be provided with the opportunity to assess his ability to practice in the best interests of the public. In my

opinion, such an evaluation is necessary in this case given the serious conduct in which Mr. Engel engaged, as well as the current uncertainty regarding his understanding of the appropriate relationship between his personal value system and his position as a professional nurse.

A suspension would not afford such an opportunity for evaluation, nor are there adequate limitations which could be placed upon his license such as would sufficiently serve as deterrence to other licensees. The Board must take strong measures in order to inform its licensees that such serious misconduct will not be met only with limitations on practice. In my opinion, unauthorized disconnection of life support systems should be followed by revocation of license. In a case such as this, as argued by complainant's counsel, to apply any disciplinary sanction short of revocation would place the Board upon the treacherous ground of attempting to assess and distinguish among the relative proprieties involved in any given disconnection. For the Board to attempt to determine under what circumstances an unauthorized disconnection will result in a short suspension or supervisory limitations, for example, as opposed to revocation of licensure, may only serve to encourage licensees to weigh the perceived "benefits" of unauthorized disconnection against the uncertain impact upon their licensure. Such a state of uncertainty would not be protective of the public interest. Unauthorized disconnection of life support systems must be followed by revocation of licensure in order to strongly discourage licensees from unilaterally determining when a patient's life should be terminated.

Dated at Madison, Wisconsin this 5th day of February, 1985.

Respectfully submitted,

Donald R. Rittel

Donald R. Rittel
Hearing Examiner

DRR:dms
374-291