STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

October 16, 1992

Joseph H. Engle, M.D.
742 Sweitzer Street
Greenville, Ohio 45331

Dear Doctor Engle:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Kevin P. Byers, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of the Minutes of the State Medical Board, meeting in regular session on October 14, 1992, including a Motion approving and confirming the Findings of Fact, amending the Conclusions of Law of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal may be taken to the Franklin County Court of Common Pleas only.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Carla S. O'Day, M.D.

Carla S. O'Day, M.D.
Secretary

CSO:em

Enclosures

CERTIFIED MAIL RECEIPT NO. P746 510 278
RETURN RECEIPT REQUESTED

cc: David C. Greer, Esq.

CERTIFIED MAIL NO. P746 510 279
RETURN RECEIPT REQUESTED

Eric H. Brand, Esq.

CERTIFIED MAIL NO. P746 510 280
RETURN RECEIPT REQUESTED

Mailed 10/27/92

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CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of Kevin P. Byers, Attorney Hearing Examiner, State Medical Board; and an excerpt of Minutes of the State Medical Board, meeting in regular session on October 14, 1992, including a Motion approving and confirming the Findings of Fact, amending the Conclusions of Law of the Hearing Examiner, and adopting an amended Order, constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Joseph H. Engle, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

(SEAL)

Carla S. O'Day, M.D.
Secretary

10/15/92
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF :

:

JOSEPH H. ENGLE, M.D. :

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on the 14th day of October, 1992.

Upon the Report and Recommendation of Kevin P. Byers, Hearing Examiner, Medical Board, in this matter designated pursuant to R. C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board for the above date.

It is hereby ORDERED that:

1. Joseph H. Engle, M.D., is hereby REPRIMANDED.

2. The certificate of Joseph H. Engle, M.D., to practice medicine and surgery in Ohio shall be SUSPENDED for an indefinite period of time, but not less than one (1) year. Such suspension is STAYED, provided that, within one (1) year of the effective date of this Order, Dr. Engle shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to the violation found in this Matter. The exact number of hours and the specific content of the program shall be determined by the Board or its designee based on proposals submitted by Dr. Engle, but such program shall total not less than 25 nor more than 75 hours. The Board may require Dr. Engle to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure.

3. Failure by Dr. Engle to comply with paragraph #2 of this Order within the time specified shall automatically result in the setting aside of the stay and the imposition of the INDEFINITE SUSPENSION of Dr. Engle's certificate. In the event that such indefinite suspension is imposed, the State Medical Board shall not consider reinstatement of Dr. Engle's certificate to practice unless and until all of the following minimum requirements are met:

   a. Dr. Engle shall submit an application for reinstatement, accompanied by appropriate fees.

   b. Dr. Engle shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to the violation found in this Matter. The exact number of hours and the specific content of the program shall be determined by the Board or its designee based on proposals submitted by Dr. Engle, but such program shall total not less than 25 nor more than 75 hours. The Board may require Dr. Engle to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure.

   c. Dr. Engle shall take and pass the SPEX examination or any similar written examination which the Board may deem appropriate to assess his clinical competency.

   d. In the event that Dr. Engle has not been engaged in the active practice of medicine and surgery for a period in excess of two (2) years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Revised Code, and require additional evidence of Dr. Engle's fitness to resume practice.

4. Upon reinstatement, Dr. Engle's certificate shall be subject to the following probationary terms, conditions and limitations for a period of at least two (2) years:

   a. Dr. Engle shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

   b. Dr. Engle shall submit quarterly declarations under penalty of perjury stating whether or not there has been compliance with all the provisions of probation.

c. Dr. Engle shall appear in person for interviews before the full Board or its designated representative at six (6) month intervals, or as otherwise directed by the Board.

d. In the even that Dr. Engle should leave Ohio for three (3) consecutive months or reside or practice outside of the state, he must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside of Ohio will not apply to the reduction of this probationary period unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

e. If Dr. Engle violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of Dr. Engle's certificate to practice.

5. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Engle's certificate will be fully restored.

This Order shall become effective immediately upon the mailing of notification approval by the State Medical Board of Ohio.

Carla S. O'Day

Carla S. O'Day, M.D.
Secretary

(SEAL)

10/05/92

Date

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REPORT AND RECOMMENDATION
IN THE MATTER OF JOSEPH H. ENGLE, M.D.

On March 30, 1992 the Matter of Joseph H. Engle, M.D., came on for hearing before Kevin P. Byers, Attorney Hearing Examiner for the State Medical Board of Ohio.

INTRODUCTION AND SUMMARY OF EVIDENCE

I. Basis for Hearing

A. By letter dated July 10, 1991, mailed July 11, 1991 (State's Exhibit #1), the State Medical Board notified Joseph H. Engle, M.D., that it intended to determine whether to take disciplinary action against his certificate to practice medicine and surgery in Ohio or to reprimand or place him on probation for one or more of the following reasons:

1. On or about June 28, 1986 Dr. Engle undertook the treatment of Patient 1 who had suffered a compound comminuted fracture of the distal tibia and fibula over the anterior medial aspect of the right leg above the ankle. Dr. Engle performed an open reduction and utilized internal metallic fixation and bone cement on the fractured right tibia. The Board alleged that Dr. Engle's use of internal fixation, and especially bone cement, resulted in Patient 1's development of osteomyelitis. The Board also alleged that Dr. Engle failed to recognize the seriousness of a developing infection and this led to the subsequent amputation of Patient #1's right leg.

2. On or about January 31, 1985 Dr. Engle undertook the care and treatment of Patient 2 who had sustained a trimalleolar fracture of the left ankle. Dr. Engle performed a closed reduction and placed the patient in a walking cast. On March 25, 1985 Dr. Engle removed the cast and since union was not achieved, he performed an open reduction utilizing internal fixation of the medial malleolus only. The Board alleged that Dr. Engle failed to consider Patient 2's history of diabetes and foot drop and that he failed to perform an appropriate neurologic examination and address the possibility of impaired sensation around the involved foot. The Board alleged that as a result of Dr. Engle's inappropriate care, fixation was not achieved at Patient 2's lateral, medial, or posterior malleoli and Patient 2 subsequently underwent a left ankle fusion.

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3. On or about May 13, 1985 Patient 3 sustained multiple injuries, including a displaced comminuted fracture of the right distal humerus extending into the elbow joint. Dr. Engle performed an open reduction utilizing internal fixation via Rush pins and bone cement. On or about February 24, 1986 Dr. Engle removed the pins from the elbow and surgically manipulated the right shoulder. The Board alleged that during the course of this manipulation, Dr. Engle fractured Patient 3's shoulder and failed to recognize it for several days until postoperative x-rays indicated the fracture.

The Board alleged that the foregoing acts, conduct, and/or omissions as alleged in paragraphs one, two, and three, constitute "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Revised Code.

B. By letter received by the Board on August 9, 1991 (State's Exhibit #2), Dr. Engle, through counsel, requested a hearing in this Matter.

II. Appearances

A. On behalf of the State of Ohio: Lee I. Fisher, Attorney General, by Odella Lampkin, Assistant Attorney General

B. On behalf of the Respondent: Bieser, Greer & Landis, by David C. Greer, Esq.

III. Testimony Heard

A. Presented by the State

1. John T. Makley, M.D.

B. Presented by the Respondent

1. Joseph H. Engle, M.D.

2. Steven N. Buffington, D.O.

3. Hjalmar Pompe van Meerdervoort, M.D.

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IV. Exhibits Examined

In addition to those noted previously, the following exhibits were identified and admitted into evidence in this Matter:

A. Presented by the State

1. State's Exhibit #3: Notice of counsel substitution on behalf of Respondent mailed to the State Medical Board on November 23, 1991.

2. State's Exhibit #4: August 12, 1991 letter to Attorney Wenger from the State Medical Board advising him that a hearing set for August 23, 1991 was postponed until further notice pursuant to Section 119.09, Revised Code.

3. State's Exhibit #5: August 20, 1991 letter to Mr. Wenger from the State Medical Board scheduling Dr. Engle's hearing for October 7, 1991.

4. State's Exhibit #6: September 24, 1991 Entry by the State Medical Board granting Dr. Engle's August 29, 1991 motion for continuance and rescheduling the hearing for December 9, 1991.

5. State's Exhibit #7: November 27, 1991 Entry by the State Medical Board granting Dr. Engle's request for another continuance due to his retention of new counsel to represent him in this Matter. The hearing was rescheduled for January 14, 1992.

6. State's Exhibit #8: December 10, 1991 Entry by the State Medical Board noting that three days would be reserved for hearing to commence on January 14, 1992.

7. State's Exhibit #9: January 10, 1992 Entry by the State Medical Board granting the respective continuance requests filed by the State and Respondent. The Matter was rescheduled for pre-hearing telephone conference on January 21, 1992 in order to finalize a hearing date.

8. State's Exhibit #10: January 22, 1992 Entry scheduling the Matter for firm hearing date of March 30, 1992.

9. State's Exhibit #11: Thirteen-page curriculum vitae of John T. Makley, M.D.

* 10. State's Exhibit #12A: Dr. Engle's office records for Patient 1.

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* 11. State's Exhibit #12B: Hospital records from the June 28, 1986 admission of Patient 1.

* 12. State's Exhibit #12C: Records from Dr. Buffington relative to Patient 1.

* 13. State's Exhibit #12D-1 through D-13: X-ray films of Patient 1.

* 14. State's Exhibit #13A: Dr. Engle's office records for Patient 2.

* 15. State's Exhibit #13B: Hospital records for Patient 2.

* 16. State's Exhibit #13C: Subsequent treating physician records for Patient 2.

* 17. State's Exhibit #13D-1 through D-18: X-ray films of Patient 2.

* 18. State's Exhibit #14A: Dr. Engle's office records for Patient 3.

* 19. State's Exhibit #14B: Hospital records for Patient 3.

* 20. State's Exhibit #14C: Hospital records of February, 1986 admission for Patient 3.

* 21. State's Exhibit #14D: Subsequent treating physician records for Patient 3.

* 22. State's Exhibit #14E-1 through E-61: X-ray films of Patient 3.

* 23. State's Exhibit #14F-1 and F-2: X-ray films of Patient 3.

* 24. State's Exhibit #15: January 9, 1990 two-page letter from Dr. Engle to the State Medical Board.

* THE ABOVE EXHIBITS HAVE BEEN SEALED TO PROTECT PATIENT CONFIDENTIALITY.

V. Other Matters

Upon Respondent's motion, the record was held open to allow the deposition of two expert witnesses. By entries of May 6, June 12, and June 30, 1992, the parties were granted additional time for depositions and written closings. The foregoing entries are hereby made a part of the record which closed on July 20, 1992.

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FINDINGS OF FACT

1. Dr. Engle received his undergraduate degree from Dickinson College in 1952. He attended Temple Medical School, graduated with an M.D. in 1956, and completed a one-year rotating internship in 1957. Dr. Engle then served for two years in Africa and followed that with a one-year surgical residency which he completed in 1960. From 1960 through 1963, Dr. Engle was an orthopedic resident at Geisinger Medical Center. From 1963 through 1969 he practiced orthopedics in Harrisburg, Pennsylvania then served two more years in Africa. Upon returning to the United States, Dr. Engle resumed practicing in Pennsyslvania. In 1982, Dr. Engle moved his practice to Greenville, Ohio and continued practicing general orthopedic surgery until his retirement in 1992. Dr. Engle became board certified in orthopedic surgery in 1966 and has maintained certification since that time. In 1968 Dr. Engle became a member of the American Academy of Orthopedic Surgery. During Dr. Engle's 10 years of practice in Greenville, Ohio he was the only orthopedic surgeon in the county. During the course of his orthopedic career, Dr. Engle estimates that he has treated approximately 25,000 to 30,000 traumatic fractures. The three cases involved in this Matter were not the catalyst for Dr. Engle's 1992 retirement.

   These facts are established by the testimony of Dr. Engle (Tr. at 91-95).

2. Dr. Engle commenced treatment of Patient 1 on June 28, 1986 when he saw the patient in the local emergency room for a compound comminuted fracture of the right distal tibia and fibula. The injury was caused in an automobile accident and Dr. Engle saw Patient 1 about six hours after the injury. At the initial contact with this patient, Dr. Engle learned that the patient had suffered from sciatic pain for approximately 20 years. Dr. Engle was also aware that Patient 1 had fractured both heels in 1960 or 1961 and thereby had deformed heels. When Dr. Engle examined Patient 1 he found a compound comminuted fracture with bones grossly out of place and a deformed ankle lacking normal motion. In considering repair of these fractures, Dr. Engle weighed the benefits of an external fixation device versus internal fixation and determined it to be in the patient's best interest to use internal fixation. He decided this due to his belief that Patient 1 would be very intolerant of an external fixator due to his bitter complaints of pain and his apparent low pain threshold. Dr. Engle also concluded that the chance of infection with external pins piercing the skin were higher than with internal fixation. Dr. Engle also believed that internal fixation would lessen the likelihood of a stiff ankle after healing and that the likelihood of a solid union of the fracture site was greater if he used internal fixation. Dr. Engle chose a Lottes nail and to ensure proper fixation with the nail, he decreased the inside

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diameter of the bone with cement so that the nail would seat properly in both the cement and bone. In employing this technique Dr. Engle relied on his own experience with a previous patient which resulted in successful fracture treatment in a woman with thin bones and rheumatoid arthritis. He also relied on literature which supported cement augmentation of nails. Dr. Engle was successful in achieving union of the fracture site in Patient 1.

These facts are established by the testimony of Dr. Engle (Tr. at 110-117) and State's Exhbits #12A, #12B and #12D-D13.

3. At the time of discharge from the hospital on July 2, 1986, Dr. Engle noted a "very minimal drainage" from Patient 1's surgical site. Dr. Engle followed the patient regularly and compiled comprehensive notes and records. On October 8, 1986 he again noted a small area of drainage. He considered this to be a possible stitch abcess and prescribed the antibiotic Duricef. At the next visit six days later, the patient was again prescribed Duricef due to the continued drainage although Dr. Engle noted that it was not "active drainage". The next visit on November 5, 1986 reveals that Dr. Engle noted "patient having no more drainage". The next notation of any drainage is on February 24, 1987 when Dr. Engle notes "had one episode of minimal drainage from an open area which subsequently subsided. This was over the pretibial area just above the ankle". Approximately six weeks later, on April 7, 1987, Dr. Engle observed continuing drainage from the fracture site and probed it in the office removing some necrotic tissue although he could not get a suture to hold. Dr. Engle also noted that the drainage site did not appear to be directly over a pin or a prominence from a pin or a screw. About two months later, the patient returned and Dr. Engle noted recurrent drainage although it was not actively draining on the day of the office visit. Patient 1 reported to Dr. Engle on June 16, 1987 that he felt he had better motion in the ankle after the accident than he did before. On August 17, 1987 Dr. Engle noted continuing drainage and that the patient wanted the hardware removed if the drainage persisted. Dr. Engle discouraged this as he felt the drainage would subside once the fracture was healed completely. Dr. Engle also advised that the fracture had not healed to the point where removal of the Lottes nail should be attempted. He also noted that he debrided the drainage site on August 17, 1987. Patient 1 was advised to return in three months or sooner if the drainage increased. Dr. Engle noted at this time that the drainage was minimal with occasional episodes of significant increase. On November 19, 1987 Dr. Engle noted that drainage was continuing but decreasing. Radiographs at that time indicated a firm union. Dr. Engle noted that with the decreasing drainage removal of the hardware and cement was not indicated. On January 4, 1988 the patient was seen and minimal drainage again

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was noted by Dr. Engle. The patient was continued on Duricef for five more days and was instructed to return in two weeks. Dr. Engle also probed the wound and removed necrotic-looking material. On the following visit, January 18, 1988, Dr. Engle observed much less drainage at the site and again probed the area and found virtually no dead tissue and did not suture. On March 22, 1988 Dr. Engle noted minimal drainage over the pretibial area and the patient claimed increased swelling when the drainage subsides. Dr. Engle discussed with Patient 1 the possible removal of the cement and hardware as well as the potential need for a cast and bone graft. On April 11, 1988 Dr. Engle cultured the wound after the patient advised him that he was seeking a consultation with an infectious disease specialist. Patient 1 was instructed to return in four days and a culture report would be available at that time. The patient returned on April 15 as instructed and was informed by Dr. Engle that the culture showed a rare staph aureus sensitivity and the antibiotic Cipro was prescribed. Dr. Engle had no further contact with Patient 1 as he began treating elsewhere. Dr. Engle believes that the union attained through his use of internal fixation devices augmented by bone cement was the best possible under the circumstances. He also does not believe that his use of cement at the fracture site in this compound comminuted fracture acted in a catalytic fashion relative to the osteomyelitis which ultimately claimed the patient's foot and ankle.

These facts are established by the testimony of Dr. Engle (Tr. at 113-119, 137-142, 152-153) and State's Exhibits #12A, #12B, #12C and #12D1-D13.

4. Stephen N. Buffington, D.O., subsequently treated Patient 1. Dr. Buffington graduated from the Kansas City College of Osteopathic Medicine, completed a rotating internship and a four-year orthopedic surgery residency. He has been practicing general orthopedic surgery in Ohio continuously since 1983. He became board certified in 1987.

Dr. Buffington first saw Patient 1 on April 28, 1988, 13 days after the patient's last visit with Dr. Engle. He found a marked valgus deformity with skin discoloration in the distal tibial region. He also observed much purulent drainage and removed purulent material from the extremely red sinus tract on the anterior medial leg. He debrided the wound and left it open for visualization. On May 4, 1988 Dr. Buffington removed the internal hardware installed by Dr. Engle approximately two years earlier. He also initiated I.V. antibiotics at this time in an attempt to clear up the infection at the wound site. In following the patient, Dr. Buffington determined that further surgery would be necessary. Patient 1 rejected a muscle transfer which could stimulate healing and elected for amputation. On July 11, 1988 Patient 1 underwent an amputation approximately six inches below the right knee due to the unresponsive nature of the infection.

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Dr. Buffington generally does not utilize bone cement in open fractures but believes that cement alone does not cause osteomyelitis. He further testifed that it is his practice to always use external fixation for comminuted fractures when the site has been contaminated. Otherwise his preferred method of fixation is with internal devices and hardware. Dr. Buffington believes that there is approximately a 25% chance of infection at the site of a compound fracture regardless of how well it is cleansed and debrided prior to fixator application. Furthermore, a culture at the time of initial treatment of a comminuted compound fracture will not impact upon Dr. Buffington's choice of internal versus external fixation. It is his practice to culture any subsequent drainage if it appears suspicious. It was Dr. Buffington's understanding of the records and from his conversations with Patient 1 that Dr. Engle did not culture or diagnose the infection until approximately two years after the injury. He also noted that Dr. Engle's records contain no descriptive information about the drainage during the 18 months Dr. Engle was following it. Dr. Buffington was of the opinion that Dr. Engle's use of bone cement did not have any adverse impact on the infection although he did believe that early aggressive antibiotic treatment may have saved Patient 1's leg.

These facts are established by the testimony of Dr. Buffington (Depo. at pp. 5-36) and State's Exhibit #12C.

5. Dr. van Meerdervoort reviewed the records of Patients 1 through 3 and testified on behalf of Dr. Engle. He received his M.D. in 1965 in South Africa. He completed a four-year orthopedic residency in South Africa and then completed one and one-half years of fellowship training in Canada. For six years he chaired a university orthopedic surgery department in South Africa then moved to Dayton and became a professor of orthopedic surgery at Wright State University in 1979. Dr. van Meerdervoort also maintains the highest volume orthopedic surgical practice at his hospital in Dayton. He is board certified in Canada, South Africa, and the United States.

Relative to Patient 1, he testified that this injury involved significant bone and tissue loss and that the end result of amputation was not unforseeable or unusual. He did acknowledge that he would not have used bone cement in repairing this complicated fracture although Dr. Engle's use was not violative of minimal standards of care. Dr. van Meerdervoort acknowledged the higher risk of infection in the presence of a compound fracture and also testified that a wound of this type is virtually impossible to decontaminate. Therefore, it is crucial to closely follow the patient after the repair in order to detect early signs of infection. Dr. van Meerdervoort felt that a serous discharge

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approximately three and one-half months after the injury was not an indication of a developing or ongoing infection, although he would have cultured it. The doctor also testified that a culture should have been done before the 22nd month after surgery although such "non-culturing" is standard practice among physicians and he therefore felt Dr. Engle did not violate minimal standards by failing to culture the drainage earlier than April of 1988. Dr. van Meerdervoort testified that the only feasible more aggressive treatment at the time of initial injury would have been amputation--clearly not indicated at that point. He also noted that the use of bone cement may cause necrosis and therefore promote infection in the immediate area due to the heat generated during polymerization. Dr. van Meerdervoort testified that Dr. Engle's use of cement increased the risk of infection, although cement and hardware do not cause osteomyelitis.

These facts are established by the testimony of Dr. van Meerdervoort (Depo. at pp. 7-9, 13-45) and State's Exhibits #12A, #12B, #12C and #12D1-D13.

6. John T. Makley, M.D., testified on behalf of the State in support of the allegations against Dr. Engle. Dr. Makley received his bachelor's degree from the University of Dayton in 1957 and graduated with an M.D. from the University of Cincinnati in 1961. He completed an internship at the Cincinnati General Hospital and then entered the United States Air Force for two years. After his discharge from the Air Force he completed a three-year residency at the University Hospital in Cleveland in 1968. He then completed a one-year fellowship in orthopedic pathology at the University of Florida from 1968 through 1969. Since 1969 he has been on the staff at the Case Western Reserve University Hospitals and also has privileges at the Cleveland VA Hospital and the Cleveland Metropolitan Health Center. He is a professor of orthopedics and orthopedic pathology at Case Western Reserve.

Dr. Makley reviewed the records relative to the treatment of Patients 1 through 3 and testified about the care rendered them by Dr. Engle. Relative to Patient 1, Dr. Makley felt that the use of bone cement and the attendant heat of polymerization caused necrosis and infection and violated minimal standards of care. Dr. Makley acknowledged that the fracture which Dr. Engle faced on June 28, 1986 was complicated by the patient's prior history. He testified that external fixation should have been utilized in view of the contaminated injury site and the time gap between injury and treatment. Dr. Makley also felt that bone cement was inappropriate to use in a traumatic fracture where compound wounds were apparent. He noted that Dr. Engle did achieve union at the fracture site although he felt that the wrong hardware was used by Dr. Engle for internal fixation. He testified that a Lottes nail

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is designed for use in mid-shaft fractures and Patient 1's fracture was distal to the usual location for Lottes nail utilization. Dr. Makley highlighted the absence of any cultures during the approximate year and one-half that Dr. Engle was following the intermittent drainage. Dr. Makley opined that Dr. Engle's care of Patient 1, primarily through the use of bone cement, was deficient and not in conformance with minimal standards of care.

These facts are established by the testimony of Dr. Makley (Tr. at 9-22, 40-58) and State's Exhibits #12A, #12B, #12C and #12D1-D13.

7. Dr. Engle undertook the treatment of Patient 2 on January 31, 1985 when she presented in the local emergency room with ankle pain subsequent to a fall out of her car. Dr. Engle diagnosed a trimalleolar fracture with minimal displacement of the medial malleolus. At that time Patient 2's history indicated three prior back surgeries, chronic pain with foot drop in the involved left foot, as well as diabetes, Librium prescription regularly, and history of smoking and obesity. Dr. Engle initially repaired the fractures by closed reduction and estimates he was able to align the posterior malleolus to obtain approximately a three to four mm. gap, which he felt was adequate to allow the patient's recovery. He was not able to obtain a complete reduction of the medial malleolus although the gap, as indicated by radiographs, was not substantial. Dr Engle believes the lateral malleolus fracture was reduced to less than one mm. during his initial treatment in the emergency room. He applied a walking cast and told the patient to return to his office in one week for follow-up. Dr. Engle did not initially perform an open reduction because of his belief that Patient 2 would be a poor candidate for surgery due to her history of foot drop as a result of prior back operations and also her diabetic and obese conditions. Dr. Engle preferred to treat the fractures conservatively and then follow-up with an open reduction if necessary.

Approximately three weeks after the cast was applied, there was a definite displacement of the lateral malleolus as indicated by radiographs. Dr. Engle also detected sclerosis at the medial fracture site. On March 25, 1985 the cast was removed and x-rays showed that there was a clear non-union of the medial malleolus with obvious displacement. On March 29, 1985 Dr. Engle undertook an open reduction, used a cancellous bone screw in the medial malleolus, and then recasted the patient's ankle. Although the bone positioning after the open reduction was not anatomically correct, Dr. Engle felt it was acceptable and he never considered surgically addressing the posterior malleolus as it was simply not of primary concern to him for the course of a successful recovery of Patient 2. Dr. Engle chose the cancellous bone screw due to the good adhesion this type of screw attains in bone and the

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ability to tightly compress the bone pieces together. He did not use multiple screws because he felt that in this patient the possibility of the bones breaking under the pressure of multiple screws was too great to justify the risk.

Dr. Engle candidly admits that he failed to perform a neurological examination on Patient 2 prior to performing surgery and admitted that in a patient with a history of diabetes, obesity, three prior back surgeries with consequent low back and leg pain and foot drop, such a neurological exam was required to conform with the minimal standards of care. However, Dr. Engle also testified that regardless of the outcome of the neurological exam, he would not have changed his treatment approach. He was aware of her foot drop and the potential for impaired sensation in the injured ankle. Dr. Engle further testified that Patient 2 had been recommended for ankle fusion of the involved foot approximately 10 to 15 years prior to the fractures which brought her under his care. Another physician fused Patient 2's ankle approximately eight months after Dr. Engle's open reduction and internal fixation.

These facts are established by the testimony of Dr. Engle (Tr. at 95-109, 131-137, 144, 148-149) and State's Exhibits #13A, #13B, #13C and #13D1-D18.

8. Dr. van Meerdervoort testifed that the closed reduction which Dr. Engle initially attempted with Patient 2 was the preferred method of treatment because the risk of infection with a diabetic patient with an open wound is greater than with a non-diabetic patient. Thus, anytime a closed reduction can be reasonably accomplished, it should be attempted before performing surgery on a diabetic patient. Dr. van Meerdervoort noted that diabetics do not heal well and that neuropathy is a common complication in diabetics which further contraindicates surgery. He felt that Dr. Engle initially achieved an excellent reduction. He also testified that "no matter how skillful the surgeon was, this situation was doomed to failure", referring to Dr. Engle's two attempts at reduction. Dr. van Meerdervoort testified that a neurologic exam was appropriate for this patient and should have been conducted prior to surgery.

   These facts are established by the testimony of Dr. van Meerdervoort (Depo. at pp. 9-10) and State's Exhibits #13A, #13B, #13C and #13D1-D18.

9. Dr. Makley testifed that Patient 2 presented to Dr. Engle with a history of prior back surgeries and a consequent foot drop thereby indicating neurologic dysfunction or peripheral neuropathy. Dr. Makley testified that a patient with impaired sensation walking on a fractured ankle in a weight-bearing case could end up damaging

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the fractured bones if they were not in good alignment and tightly held in place by the fixation utilized. Dr. Makley testified that his review of the radiographs indicates that Patient 2's fracture was displaced after Dr. Engle casted it and that there was poor alignment among the three fracture sites and anatomic reduction was never achieved by Dr. Engle through the closed reduction technique. Dr. Makley testified that the patient should have immediately undergone an open reduction with internal fixation. This was particulary so because of the trimalleolar nature of the fractures. The medial malleolus was fractured at the plafond and could therefore not serve as a stable foundation for reducing the malleolar fractures on each side of the ankle structure as is usually done in a bimalleolar fracture. Because Patient 2's fracture was higher up at the joint level, it was Dr. Makley's opinion that closed reduction was doomed to fail and that open reduction should have been the initial treatment choice as well as the application of internal fixation hardware. Dr. Makley also testified that when Dr. Engle obtained x-rays one week after the closed reduction, showing increased displacement of the involved bones, the patient should have immediately undergone an open reduction at that time rather than approximately eight weeks after the date of injury.

These facts are established by the testimony of Dr. Makley (Tr. at 23-31, 58-72, 81-84 and 86-88) and State's Exhibits #13A, #13B, #13C and #13D1-D18.

10. Dr. Engle assumed the care and treatment for Patient 3 on May 13, 1985 when the patient was brought to the emergency room by the local rescue squad. Patient 3 had fallen approximately 12 feet from a scaffold while at work and suffered a compound fracture of the distal right humerus, a closed comminuted displaced fracture of the left wrist, and a fracture of the right wrist which was in good position and did not require reduction. Both of the wrist injuries were placed in casts while the injured humerus was repaired by Dr. Engle through the use of two Rush pins and bone cement. Upon exposing the humerus, Dr. Engle found that there were multiple fractures which were displaced and that there was T fracture extending into the joint with a small fragment of bone in the center of the T. Dr. Engle found that this fragment articulated with the ulna and after attempting to incorporate it into the reduction, he believed it would be safer to remove it rather than risk an irregular joint surface if it did not hold its position. Thus, Dr. Engle removed this fragment of bone and also removed other small fragments of bone which had been displaced. The major medial and lateral fragments were aligned on two Rush pins which were then driven through the medial and lateral epicondyles across the fractures and into the humeral shaft. After near anatomical reduction was obtained, Dr. Engle utilized bone cement for additional fixation and in particular he used the

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cement to affix the medial articular fragment which was not incorporated by the use of the Rush pins. After allowing the cement to harden, Dr. Engle noted good alignment although extension of the elbow showed that the olecranon might impinge on the cement that Dr. Engle had used to affix the medial articular fragment. Therefore, a small portion of the tip of the olecranon was excised in order to permit good extension of the elbow. Dr. Engle used cement to augment internal fixation pins because he believed this method required less traumatic surgical exposure than the use of a large plate. Dr. Engle followed the recovery of Patient 3 closely after his hospital discharge and he made extensive progress notes during this course of recovery. The patient complained of lingering pain and Dr. Engle began to suspect that an offset in the anterior humerus was being caused by a blocking flexion at the elbow and that excision of this boney block may be necessary at the time the Rush pins were removed.

Approximately two months after the injury, the patient began to persistently complain about pain and stiffness in his shoulder which continued through September of 1985, four months after the injury. Dr. Engle ordered an arthrogram of the shoulder due to a suspected rotator cuff tear. During October 1985, Patient 3 gained some additional movement in his shoulder though Dr. Engle noted the motion was "still quite limited". In January 1986, Patient 3 was scheduled for a release of scar tissue along the right elbow, however Dr. Engle postponed this surgery due to Patient 3's upper respiratory infection. In late January, 1986 Dr. Engle again postponed the surgery because of the Patient 3's upper respiratory problems. On February 24, 1986 Patient 3 was admitted to the hospital to undergo removal of the Rush pins and manipulation of the shoulder. Dr. Engle initially intended to perform an arthroscopy and began the procedure with a stab wound over the end of the Rush pin in the medial humerus. This pin was then removed and Dr. Engle attempted to visualize the elbow. He was unable to do so adequately and abandoned the arthroscopy and made an incision from just above the lateral condyle of the humerus distally over the lateral elbow curving posteriorly toward the ulna about three inches below the elbow. Dissection was carried through the skin, subcutaneous tissue, and along the anterior aspect of the flexor carpae ulnaris. Dissection was then carried along the lateral epicondyle of the humerus, the joint was entered and the anterior capsule was excised. It appeared tight and the joint surface was maintained with no boney block visualized on flexion of the elbow. However, Dr. Engle only attained flexion through about 60 degrees because of the tightness of the posterior structures. Dissection was then carried along the bone posteriorly where the radial pin was identified and removed. The volar capsular structures which had been released were then reattached. After closing the tissue and skin,

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Dr. Engle manipulated Patient 3's shoulder. He found that it was very tight with only about 60 to 70 degrees of abduction. Dr. Engle noted in his operative report, "after considerable pressure, it could be felt to give and a pop was felt. After the pop, good stability of the humerus was noted with a good range of motion. The arm was placed in a compression dressing. The patient tolerated the procedure well and left the operating room in good condition". Dr. Engle manipulated the shoulder because the patient had been complaining of shoulder pain and an arthrogram was negative for a tear of the rotator cuff but did indicate a very small capacity of the shoulder, a typical finding in a frozen or stiff shoulder. Dr. Engle did not suspect an iatrogenic fracture, however routine x-rays taken two days after the manipulation showed a fracture near the shoulder. This injury healed without complication and was treated with immobilization.

These facts are established by the testimony of Dr. Engle (Tr. at 120-131, 142-145, 147-148 and 150-152) and State's Exhibits #14A, #14B, #14C, #14E1-E61.

11. Dr. van Meerdervoort reviewed the records and x-rays relative to Dr. Engle's treatment of Patient 3 and testified that the care and rendered by Dr. Engle was not below minimal standards of care for Ohio practitioners. Dr. van Meerdervoort testified that the fracture evident in Patient 3's elbow was a very difficult one to treat because it was located at the supracondylar area of the humerus and there was some comminution between the two halves of the distal humerus. In other words, it was not a simple, clean oblique fracture line which Dr. Engle was facing. Dr. Engle utilized two pins and augmented this fixation with the use of bone cement. Dr. van Meerdervoort testified that he would not have used bone cement in this instance but felt that Dr. Engle did an acceptable job of repairing the difficult fracture. Dr. Engle utilized bone cement in order to replace a missing piece of bone. Dr. van Meerdervoort testified that a known risk of surgical manipulation of the shoulder is a fracture of the humerus, precisely what happened with Patient 3 when Dr. Engle surgically manipulated the shoulder in February, 1986. He noted that when a fracture occurs during manipulation, the sound usually notifies everyone in the O.R. what has just happened due to the loud snapping noise. He further testified that the usual course of treatment upon suspecting a manipulation fracture is to obtain an immediate x-ray. However, Dr. van Meerdervoort opined that there is generally nothing to do to immediately treat the fracture other than immobilization.

These facts are established by the testimony of Dr. van Meerdervoort (Depo. at pp. 11-12 and 51-52) and State's Exhibits #14A, #14B, #14C, #14D and #14E1-E61 and #14F1 and F2.

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12. Dr. Makley testified that Dr. Engle's use of bone cement in the treatment of Patient 3's complex fracture of the elbow was contraindicated due to his belief that use of the cement actually promoted spreading of the elbow joints after removal of the Rush pins. Dr. Makley testified that initial internal fixation with a Y plate was a better choice and would have served to assist Patient 3's recovery so that his elbow would be reasonably functional. He felt that a Y plate was the better choice to allow reattachment of the many fragments of bone rather than utilizing two large pins augmented by cement because the Rush pins do not allow adequate immobilization of the fracture fragments. Dr. Makley also testified that surgical manipulation of an immobile shoulder carries with it the known complication of a fracture of the proximal humerus. From his review of Dr. Engle's notes, it didn't appear that Dr. Engle was aware or suspected that he had fractured Patient 3's humerus during the shoulder manipulation in February, 1986. On cross-examination, Dr. Makley admitted that Dr. Engle's use of bone cement in Patient 3 did not promote infection and that there indeed was no problem with infection during the course of recovery by Patient 3. The complication with the treatment rendered by Dr. Engle was a non-union at the fracture site. Dr. Makley was aware that Patient 3's non-union of the elbow came to light after he was placed on weight-bearing crutches by another physician due to a subsequent knee injury. Dr. Makley admitted that using weight-bearing crutches while recovering from a comminuted humerus fracture could indeed cause complications including a non-union. However, Dr. Makley consistently testified that Rush pins were inappropriate since a plate should have been used to fix the proximal portion of the fracture and then used as a stable base to skewer the smaller fragments with pins and secure them in an anatomic location. Dr. Makely was of the opinion that Dr. Engle's use of the Rush pins, crossed one over the other, actually held the bone fragments apart and caused the non-union which eventually led to further internal fixation by another surgeon. Dr. Makley admitted that it is fair to characterize orthopedic surgeons' use of bone cement as very common and in virtually all types of fractures. However, Dr. Makley uses it primarily in pathologic fractures where there are no other options for stabilization and he merely wants to accomplish a stable fracture site until the patient succumbs from the underlying disease process.

These facts are established by the testimony of Dr. Makley (Tr. at 31-36, 73-79, 84-86) and State's Exhibits #14A, #14B, #14C, #14D, #14E1-E61 and #14F1 and F2.

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CONCLUSIONS

1. The State has shown by reliable, probative, and substantial evidence that Dr. Engle's care and treatment of Patient 1 constituted "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances", as that clause is used in Section 4731.22(B)(6), Revised Code. Specifically, Dr. Engle's use of bone cement in a compound comminuted fracture, which was open for six hours prior to reduction, violated minimal standards of care. Additionally, his failure to culture a persistent drainage during the course of 18 months postoperatively, resulted in drastic subsequent medical treatment to address the osteomyelitis evident in Patient 1.

2. Dr. Engle's failure to perform a neurological examination on Patient 2 at anytime during the treatment of her trimalleolar fracture constitutes "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances", as that clause is used in Section 4731.22(B)(6), Revised Code. Dr. Engle candidly admitted that he failed to perform a neurological examination on Patient 2 but emphasized that he treated her with the assumption that she suffered from impaired sensation in the left foot and with full knowledge that she already suffered from foot drop as a consequence of prior back surgeries and neuropathy associated with her diabetes.

3. Dr. Engle's failure to immediately recognize the fracture of the proximal humerus of Patient 3, caused during surgical manipulation, constitutes "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances", as that clause is used in Section 4731.22(B)(6), Revised Code. Again, Dr. Engle's candid testimony reveals that he did not suspect a fracture occurred during surgical manipulation in February, 1986, although he noted that a distinct pop was felt and heard during the course of manipulation. X-rays taken two days late in the routine course of hospitalization revealed the fracture which subsequently healed without complication.

* * * * *

Although Dr. Engle sold his practice and retired in early 1992, he continues to hold an Ohio certificate which could be endorsed to other jurisdictions. His medical and surgical judgements in the three cases at issue indicate problem areas which may be rectified by remedial clinical education undertaken during a period of suspension.

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PROPOSED ORDER

It is hereby ORDERD that:

1. The certificate of Joseph H. Engle, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than one (1) year.

2. The State Medical Board shall not consider reinstatement of Dr. Engle's certificate to practice unless and until all of the following minimum requirements are met:

   a. Dr. Engle shall submit an application for reinstatement, accompanied by appropriate fees. Dr. Engle shall not make such application for at least one (1) year from the effective date of this Order.

   b. Dr. Engle shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to the violations found in this Matter. The exact number of hours and the specific content of the program shall be determined by the Board or its designee, but shall total not less than 25 nor more than 75 hours. The Board may require Dr. Engle to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Educational requirements for relicensure.

   c. Dr. Engle shall take and pass the SPEX examination or any similar written examination which the Board may deem appropriate to assess his clinical competency.

   d. In the event that Dr. Engle has not been engaged in the active practice of medicine and surgery for a period in excess of two (2) years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Revised Code, and require additional evidence of Dr. Engle's fitness to resume practice.

3. Upon reinstatement, Dr. Engle's certificate shall be subject to the following probationary terms, conditions, and limitations for a period of at least two (2) years:

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a. Dr. Engle shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

b. Dr. Engle shall submit quarterly declarations under penalty of perjury stating whether or not there has been compliance with all the provisions of probation.

c. Dr. Engle shall appear in person for interviews before the full Board or its designated representative at six (6) month intervals, or as otherwise directed by the Board.

d. In the event that Dr. Engle should leave Ohio for three (3) consecutive months or reside or practice outside of the state, he must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside of Ohio will not apply to the reduction of this probationary period unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

e. If Dr. Engle violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of Dr. Engle's certificate to practice.

4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Engle's certificate will be fully restored.

This Order shall become effective immediately upon the mailing of notification of approval by the State Medical Board of Ohio.

KEVIN P. BYERS
Kevin P. Byers
Attorney Hearing Examainer

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EXCERPT FROM THE MINUTES OF OCTOBER 14, 1992

REPORTS AND RECOMMENDATIONS

Dr. Gretter announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Dr. Gretter asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Carol Sue Rivers, M.D., and Joseph H. Engle, M.D. A roll call was taken:

ROLL CALL:	Dr. O'Day	- aye
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Stephens	- aye
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Hom	- aye
	Dr. Agresta	- aye
	Dr. Gretter	- aye

Dr. Gretter asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. O'Day	- aye
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Stephens	- aye
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Hom	- aye
	Dr. Agresta	- aye
	Dr. Gretter	- aye

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

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All Assistant Attorneys General and all Enforcement Coordinators left the meeting at this

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time.

REPORT AND RECOMMENDATION IN THE MATTER OF JOSEPH H. ENGLE, M.D.

Dr. Gretter stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and order in the above matter. No objections were voiced by Board members present.

DR. AGRESTA MOVED TO APPROVE AND CONFIRM MR. BYERS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF JOSEPH H. ENGLE, M.D. DR. GARG SECONDED THE MOTION.

Dr. Gretter asked if there were any questions concerning the proposed findings of fact, conclusions, and order in the above matter.

Dr. Stienecker stated that he had problems with the conclusions as presented, specifically paragraph #4. Dr. Stienecker stated that Dr. Engle is retired, and he has a problem with the Board's suspending the license of a retired physician.

DR. STIENECKER MOVED THAT THE CONCLUSIONS IN THE MATTER OF JOSEPH H. ENGLE, M.D., BE AMENDED BY SUBSTITUTING THE FOLLOWING:

> The evidence presented for Board consideration regarding Dr. Engle's medical and surgical judgments in the three cases at issue is, at best, controversial and opinionated. Expert testimony of equal weight differed. Thus, although significant concerns existed to substantially justify the Board's initiation of formal action in this matter, the State has not met its burden of proving by reliable, probative and substantial evidence that Dr. Engle's care of the specified patients constituted "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

DR. STIENECKER FURTHER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF JOSEPH H. ENGLE, M.D., BE AMENDED BY SUBSTITUTING THE FOLLOWING:

> It is hereby ORDERED that the allegations against Joseph H. Engle, M.D., as set forth in the Medical Board's July 10, 1991 notice of opportunity for hearing be and are hereby DISMISSED.

DR. GARG SECONDED THE MOTION.

Dr. Stephens spoke against the motion, stating that as a practicing orthopaedist involved in academics and teaching residents he cannot in good conscience say that

some of the things cited in the Hearing Examiner's report are controversial. Although he is aware that there was testimony that certain things weren't below minimal standards of care, those giving the testimony were quick to point out that they would not do those things themselves. Dr. Stephens stated that some of the things with which Dr. Engle was charged were clearly below minimal standards of care for an orthopaedist.

Dr. Gretter noted that the three paragraphs of the Conclusions refer to three different patients. He suggested that the Board may wish to comment on the standard of care as applied to each of the three patients.

Dr. Stephens indicated that he had particular concerns about the care given to Patient 1. He does not have the same concerns about Patients 2 and 3. Dr. Stephens stated that his review of the case, taking into account review of the testimony of both expert witnesses, indicates that Dr. Engle's treatment of Patient 1 did fall below minimal standards of care.

Dr. Stephens added that he has no comments to make concerning patients 2 and 3.

Dr. Garg asked Dr. Stephens what his problems were with Dr. Engle's treatment of Patient 1.

Dr. Stephens stated that in dealing with a compound fracture, there is a high incidence of infection, whether the fracture is taken care of immediately or not. In this case, introducing a foreign substance into a compound fracture that is over six hours old and closing the wound is below minimal standards of care.

Dr. Agresta stated that he is not an orthopaedic surgeon, but he, too, felt that the care given Patient 1 was below minimal standards. Dr. Agresta stated that he can understand the variance of expert opinion regarding Patients 2 and 3.

Dr. Agresta added that, although Dr. Engle is not practicing at this time, he wouldn't feel comfortable dismissing the case against him. Something has to be done in this case or it sends the wrong message out to other physicians in similar circumstances.

Dr. Stephens stated that he didn't think this situation could be visited without a strong statement. Dr. Engle's treatment of Patient 1 is clearly below minimal standards of care. He again noted that although Dr. Engle's experts testified that Dr. Engle's treatment of Patient 1 did not fall below minimal standards of care, they did preface their statements by saying that they wouldn't have acted in the same way.

Dr. O'Day asked why there was a six-hour delay in treating Patient 1.

Dr. Stienecker stated that it was due to transport time.

Dr. Stephens added that the patient should have been managed differently because of the six-hour delay.

Dr. Stienecker stated that he can only look at the evidence given to him by way of testimony. Two professors in the same field testifed at hearing, telling different stories. He weighed the evidence and made his decision accordingly.

Dr. Garg stated that there was definitely a problem in Dr. Engle's treatment of Patient 1.

Dr. Gretter suggested that the Board may wish to table this matter, should it fail to pass Dr. Steinecker's amendment.

Mr. Bumgarner stated that if the Board finds that the standards of care were violated in only one of the cases, it should make that statement.

DR. KAPLANSKY MOVED TO TABLE THE REPORT AND RECOMMENDATION IN THE MATTER OF JOSEPH H. ENGLE, M.D., IN ORDER TO FORMULATE AN AMENDMENT TO THE AMENDMENT.

Dr. Stienecker stated that if he bases his amendment on Patients 2 and 3 as presented, it would at least allow the Board to clear out those cases. The Board can then focus on Patient 1.

Dr. Stephens stated that he thinks the amendment can be done in a cleaner fashion.

DR. O'DAY SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Day	- aye
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Stephens	- aye
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Hom	- aye
	Dr. Agresta	- aye

The motion carried.

.....

DR. GARG MOVED TO REMOVE THE MATTER OF JOSEPH H. ENGLE, M.D., FROM THE TABLE. DR. STEPHENS SECONDED THE MOTION. A roll call vote was taken:

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ROLL CALL VOTE:		
	Dr. O'Day	- aye
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Stephens	- aye
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Hom	- aye
	Dr. Agresta	- aye

The motion carried.

DR. STIENECKER WITHDREW HIS MOTION TO AMEND. DR. GARG, AS SECOND, AGREED.

DR. STIENCKER MOVED THAT THE CONCLUSIONS IN THE MATTER OF JOSEPH H. ENGLE, M.D., BE AMENDED BY DELETING CONCLUSION #2, CONCLUSION #3 AND THE FINAL, UNNUMBERED CONCLUSIONARY PARAGRAPH AND SUBSTITUTING THE FOLLOWING:

2. Although significant concerns existed to substantially justify the Board's initiation of formal action on the basis of Dr. Engle's care of Patients 2 and 3, the evidence presented, including the disparate expert testimony, was inconclusive. Thus, the State has not met its burden of proving by reliable, probative and substantial evidence that Dr. Engle's care of those patients constituted "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

DR. STIENECKER FURTHER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF JOSEPH H. ENGLE, M.D., BE AMENDED BY SUBSTITUTING THE FOLLOWING:

It is hereby ORDERED that:

1. Joseph H. Engle, M.D., is hereby REPRIMANDED.

2. The certificate of Joseph H. Engle, M.D., to practice medicine and surgery in Ohio shall be SUSPENDED for an indefinite period of time, but not less than one (1) year. Such suspension is STAYED, provided that, within one (1) year of the effective date of this Order, Dr. Engle shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to the violation found in this Matter. The exact number of hours and the specific content of the program shall be determined by the Board or its designee based on proposals submitted by Dr. Engle, but such program shall total not

less than 25 nor more than 75 hours. The Board may require Dr. Engle to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure.

3. Failure by Dr. Engle to comply with paragraph #2 of this Order within the time specified shall automatically result in the setting aside of the stay and the imposition of the INDEFINITE SUSPENSION of Dr. Engle's certificate. In the event that such indefinite suspension is imposed, the State Medical Board shall not consider reinstatement of Dr. Engle's certificate to practice unless and until all of the following minimum requirements are met:

   a. Dr. Engle shall submit an application for reinstatement, accompanied by appropriate fees.

   b. Dr. Engle shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to the violation found in this Matter. The exact number of hours and the specific content of the program shall be determined by the Board or its designee based on proposals submitted by Dr. Engle, but such program shall total not less than 25 nor more than 75 hours. The Board may require Dr. Engle to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure.

   c. Dr. Engle shall take and pass the SPEX examination or any similar written examination which the Board may deem appropriate to assess his clinical competency.

   d. In the event that Dr. Engle has not been engaged in the active practice of medicine and surgery for a period in excess of two (2) years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Revised Code, and require additional evidence of Dr. Engle's fitness to resume practice.

4. Upon reinstatement, Dr. Engle's certificate shall be subject to the following probationary terms, conditions and limitations for a period of at least two (2) years:

   a. Dr. Engle shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

b. Dr. Engle shall submit quarterly declarations under penalty of perjury stating whether or not there has been compliance with all the provisions of probation.

c. Dr. Engle shall appear in person for interviews before the full Board or its designated representative at six (6) month intervals, or as otherwise directed by the Board.

d. In the event that Dr. Engle should leave Ohio for three (3) consecutive months or reside or practice outside of the state, he must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside of Ohio will not apply to the reduction of this probationary period unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

e. If Dr. Engle violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of Dr. Engle's certificate to practice.

5. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Engle's certificate will be fully restored.

This Order shall become effective immediately upon the mailing of notification approval by the State Medical Board of Ohio.

DR. STEPHENS SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Day	- aye
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Stephens	- aye
	Dr. Garg	- aye
	Dr. Kaplansky	- abstain
	Dr. Hom	- aye
	Dr. Agresta	- aye

The motion carried.

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EXCERPT FROM THE MINUTES OF OCTOBER 14, 1992
IN THE MATTER OF JOSEPH H. ENGLE, M.D.

DR. STEPHENS MOVED TO APPROVE AND CONFIRM MR. BYERS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF JOSEPH H. ENGLE, M.D. DR. AGRESTA SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:

Dr. O'Day	- aye
Mr. Albert	- aye
Dr. Stienecker	- aye
Dr. Stephens	- aye
Dr. Garg	- aye
Dr. Kaplansky	- abstain
Dr. Hom	- aye
Dr. Agresta	- aye

The motion carried.

STATE MEDICAL BOARD OF OHIO

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July 10, 1991

Joseph H. Engle, M.D.
742 Sweitzer Street
Greenville, OH 45331

Dear Doctor Engle:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

(1) On or about June 28, 1986 Patient 1, as identified in the attached Patient Key (Key confidential -- not for public disclosure), sustained a compound comminuted fracture of the distal tibia and fibula over the anterior medial aspect of the right leg just above the ankle for which you performed an open reduction with internal fixation of the fractured right tibia with metallic fixation devices and bone cement. Your employment of internal fixation, particularly in your use of bone cement, resulted in the development of osteomyelitis. Further, your failure to recognize the seriousness of and to appropriately treat this infection resulted in the subsequent amputation of the right leg of Patient 1.

(2) On or about January 31, 1985 Patient 2 sustained a trimalleolar fracture of the left ankle for which you performed a closed reduction and placed Patient 2 in a walking cast. On or about March 25, 1985 you removed the cast. However, as union was not achieved, you performed an open reduction with internal fixation of the medial malleolus only. In spite of the fact that Patient 2 presented a history of diabetes and a foot drop of the involved left foot, you failed to perform an appropriate neurologic examination to determine if Patient 2 suffered from impaired sensation about the foot. Further, you failed to address the possible impaired sensation about the foot in your treatment and ultimately failed to achieve fixation in the lateral, medial or posterior malleoli. As a result, Patient 2 subsequently underwent surgery to fuse her left ankle.

Mailed 7/11/91

(3) On or about May 13, 1985 Patient 3 sustained multiple injuries including a displaced comminuted fracture of the right distal humerus extending into the elbow joint for which you performed an open reduction with internal fixation by the use of rush pins and bone cement. On or about February 24, 1986 you removed the rush pins from the elbow and surgically manipulated the right shoulder. During the course of this manipulation you fractured the shoulder of Patient 3 and failed to recognize it for several days until postoperative x-rays showed the presence of the fracture.

Such acts, conduct, and/or omissions as alleged in paragraphs (1), (2) and (3) above, individually and/or collectively, constitute "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty (30) days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.