CONSENT AGREEMENT
BETWEEN
JACK B. QUIGLEY, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO

This Consent Agreement is entered into by and between Jack B. Quigley, M.D., [Dr. Quigley], and the State Medical Board of Ohio [Board], a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

Dr. Quigley enters into this Consent Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

BASIS FOR ACTION

This Consent Agreement is entered into on the basis of the following stipulations, admissions and understandings:

A. The Board is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for a violation of Section 4731.22(B)(22), Ohio Revised Code, which states " [a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand."

B. The Board and Dr. Quigley enter into this Consent Agreement in lieu of further formal proceedings based upon the allegations set forth in the Notice of Opportunity for Hearing issued on March 14, 2007, [March 2007 Notice], attached hereto as Exhibit A and incorporated herein by this reference. The Board expressly reserves the right to institute additional formal proceedings based upon any other violations of R.C. Chapter 4731., whether occurring before or after the effective date of this Consent Agreement.

C. Dr. Quigley is licensed to practice medicine and surgery in the State of Ohio, License No. 35.051017. Dr. Quigley also states that he holds a current, valid license to practice medicine in Arizona.

D. Dr. Quigley admits the legal and factual allegations as set forth in the March 2007 Notice.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of further formal proceedings at this time, Dr. Quigley knowingly and voluntarily agrees with the Board to the following terms, conditions and limitations:

REPRIMAND

1. Dr. Quigley's license to practice medicine and surgery in Ohio is **REPRIMANDED**.

PROBATION

2. **PROBATION**: The certificate of Jack B. Quigley, MD, to practice medicine and surgery in the State of Ohio shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

   a. Dr. Quigley shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Arizona.

   Quarterly Declarations

   b. Dr. Quigley shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices three months from the date of the approval by the Board of this consent agreement. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

   Practice Plan and Monitoring Physician

   c. Before engaging in any medical practice in Ohio, Dr. Quigley shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan must inform the Board as to whether Dr. Quigley intends to perform office based surgeries while in Ohio. Dr. Quigley shall obtain the Board's approval for any alteration to the practice plan approved pursuant to this Consent Agreement.

      At the time Dr. Quigley submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Quigley and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Quigley and his medical practice, and shall review Dr. Quigley's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Quigley and his medical practice to include compliance with the applicable rules and statutes should Dr. Quigley perform office based surgeries while in Ohio, and on the review of Dr. Quigley's patient charts. Dr. Quigley shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Quigley's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Quigley must immediately so notify the Board in writing. In addition, Dr. Quigley shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Quigley shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. Quigley appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including, but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

DURATION/MODIFICATION OF TERMS

Dr. Quigley shall not request termination of this Consent Agreement for a minimum of three years. In addition, Dr. Quigley shall not request modification to the probationary terms, limitations, and conditions contained herein for at least one year. Otherwise, the above-described terms, limitations and conditions may be amended or terminated in writing at any time upon the agreement of both parties.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. Quigley acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., and Ohio Revised Code.

Dr. Quigley hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code, and may be reported to appropriate organizations, data banks, and governmental bodies. Dr. Quigley agrees to provide his social security number to the Board and hereby authorizes the Board to utilize that number in conjunction with that reporting.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

JACK B. QUIGLEY, M.D

8/28/07

DATE

LANCE TALMAGE, M.D.,
Secretary

10-10-07

DATE

PETER M. WITTEKIND, ESQ.
Attorney for Dr. Quigley

DATE

RAYMOND J. ALBERT
Supervising Member

10/10/07

DATE

BARBARA J. PFEIFFER, ESQ.
Assistant Attorney General

10/11/07

DATE

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., and Ohio Revised Code.

Dr. Quigley hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code, and may be reported to appropriate organizations, data banks, and governmental bodies. Dr. Quigley agrees to provide his social security number to the Board and hereby authorizes the Board to utilize that number in conjunction with that reporting.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

JACK B. QUIGLEY, M.D	LANCE TALMAGE, M.D., Secretary
DATE	DATE
PETER M. WITTEKIND, ESQ. Attorney for Dr. Quigley	RAYMOND J. ALBERT Supervising Member
9/17/07 DATE	DATE
	BARBARA J. PFEIFFER, ESQ. Assistant Attorney General
	DATE

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

March 14, 2007

Jack (a.k.a. John) B. Quigley, M.D.
1020 N. San Francisco #200
Flagstaff, AZ 86001

Dear Doctor Quigley:

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

(1) Following treatment and procedural failures related to the care of a patient who ultimately expired, on or about February 28, 2003, the Arizona Medical Board adopted a Consent Agreement and Interim Order for Practice Restriction [Arizona Consent Agreement] which limited and restricted your medical practice in order to protect the public and ensure your ability to safely engage in the practice of medicine. Subsequently, on or about February 17, 2004, the Arizona Medical Board issued a Letter of Reprimand and Civil Penalty [Arizona Reprimand] based upon your inadequate monitoring of the aforementioned patient's ventilatory respiratory status during a surgical procedure, as well as for inadequately documenting that status. The Arizona Medical Board's findings of fact included that your care fell below the standard of care, and that the patient was harmed because she stopped breathing, suffered a cardiac arrest and hypoxic encephalopathy. Copies of the Arizona Consent Agreement and the Arizona Reprimand are attached hereto and incorporated herein.

The Arizona Consent Agreement and the Arizona Reprimand as alleged in paragraph (1) above, individually and/or collectively, constitute "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Mailed 3.15.07

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 days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, 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 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, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Lance A. Talmage, M.D.
Secretary

LAT/DSZ/flb
Enclosures

CERTIFIED MAIL #7004 2510 0006 9803 5163
RETURN RECEIPT REQUESTED

Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmdboard.org • Email: questions@azmdboard.org

STATE MEDICAL BOARD OF OHIO
2003 APR 15 A 11:43

Governor

Janet Napolitano

Members of the Board

Patrick N. Connell, M.D.
Chairman
Physician Member

Edward J. Schwager, M.D.
Vice Chairman
Physician Member

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Physician Member

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Physician Member

Sharon B. Megdal, Ph.D.
Public Member

Dona Pardo, Ph.D., R.N.
Public Member/R.N.

William Wong, M.D.
Physician Member

Executive Staff

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Executive Director

Amanda J. Diehl
Assistant Director/Operations

William R. Anderson
Assistant Director/Enforcement

Randi Orchard
Chief Financial Officer

Cherie Pennington
Director of Human Resources

Tina D. Wilcox
Legislative Liaison

I, Sandra Waitt, of the Arizona Medical Board, hereby certify that I am the official custodian of the records of the agency; and that the attached documents are true and complete copies of the actions requested regarding:

Physician Name: Jack B. Quigley, M.D.

License Number: 20243

Attached are the following document(s):

Consent Agreement and Interim Order for Practice Restriction dated February 28, 2003 (6 pages),

DATED this 11th day of April, 2003.

ARIZONA MEDICAL BOARD

[SEAL]

Sandra Waitt
Custodian of Records

Physician Profile

Protecting the Public's Health

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona · 85258-5539
480-551-2700 · Toll Free: 877-255-2212

General Information

John Quigley MD
1020 N San Francisco St # 200
Flagstaff AZ 86001-3281
Phone: **928-774-2300**

License Number: **20243**
License Status: **Active with Restrictions**
License Date: **8/16/1991**
License Renewed: **3/26/2002**
Renew By: **03/2004**
License Expires: **07/2004**

Education and Training

Note: Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

Medical School: **SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE**
Graduation Date: **6/4/1983**
Residency: **7/1/1983 - 6/30/1988** (General Surgery)
WESTERN RESERVE CARE SYSTEM
YOUNGSTOWN, OHIO
Residency: **1/1/1989 - 6/30/1989** (Hand Surgery (Orthopedic Surgery))
MEDICAL COLLEGE OF OHIO/ST. VINCENT MEDICAL CENTER
TOLEDO, OHIO
Residency: **7/1/1989 - 6/30/1991** (Plastic Surgery)
MEDICAL COLLEGE OF OHIO/ST. VINCENT MEDICAL CENTER
TOLEDO, OHIO
*Specialty: **General Surgery**
*Specialty: **Plastic Surgery**
*Specialty: **Hand Surgery (Orthopedic Surgery)**

***The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: http://www.abms.org/ to determine if the physician has earned a specialty certification from this private agency.**

Board Investigations and Actions

BOARD ACTIONS: 1
(while licensed in Arizona)

2/28/2003: Interim Order for Practice Restriction - Shall not perform office-based or outpatient

surgery requiring IV sedation/analgesia or general anesthesia without anesthesiologist/CRNA present to administer anesthesia and monitor patient throughout procedure.

(Document images [PDF] of Board Actions since 7/98 may be viewed by clicking the action date. Viewable with Adobe's free Acrobat Reader.)

NON DISCIPLINARY ACTIONS: 1
(while licensed in Arizona; Advisory Letters within last five years)
Note: Prior to 1999, "Advisory Letters" were known as "Letters of Concern"

1/29/1999: Advisory Letter - Inadequate Records.

(Document images [PDF] of Physician responses to Advisory Letters since 8/99 may be viewed by clicking the action date.
Viewable with Adobe's free Acrobat Reader.)

OPEN INVESTIGATIONS: 1
IMPORTANT: Open investigations represent unproven allegations - Upon investigation many complaints are found to be without merit and dismissed.

CASES DISMISSED: NONE
(within last five years)

Malpractice/Criminal Information

MALPRACTICE CASES RESULTING IN PAYMENT: 1
(within last five years)

The settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action does not create a presumption that medical malpractice occurred.

CRIMINAL CONVICTIONS/"NO CONTEST" PLEAS: NONE
(within last five years)

Questions? See our Glossary of Terms.

The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. Arizona Revised Statutes 32 - 1403 (C) provides that the Board is not liable for errors or for any damages resulting from the use of the information contained herein.

TERRY GODDARD
Attorney General
Firm Bar No. 14000

STEPHEN A. WOLF
Assistant Attorney General
State Bar No. 018722
1275 W. Washington
Phoenix, Arizona 85007-2926
Tel: (602) 542-7027
Fax: (602) 364-3202
Attorneys for Arizona Medical Board

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of: **JOHN QUIGLEY, M.D.** Holder of License No. 20243 For the Practice of Allopathic Medicine In the State of Arizona, Respondent.	Board Case No. MD-03-0085 **CONSENT AGREEMENT AND INTERIM ORDER FOR PRACTICE RESTRICTION**

RECITALS

By mutual agreement and understanding, the Arizona Medical Board ("Board") and John Quigley, M.D. ("Respondent") stipulate to the following interim disposition of the above-referenced matter:

1. Respondent has read and understands this Consent Agreement as set forth herein, and has had the opportunity to discuss this Consent Agreement with an attorney or has waived the opportunity to discuss this Consent Agreement with an attorney. Respondent voluntarily enters into this Consent Agreement for the purpose of avoiding the expense and uncertainty of summary proceedings pursuant to A.R.S. § 32-1451(D).

2. Respondent understands that he has a right to a public administrative hearing concerning each and every allegation set forth in this Consent Agreement which supports the Interim Order. Respondent also understands that at such an administrative hearing he

could present evidence and cross-examine witnesses. By entering into this Consent Agreement, Respondent freely and voluntarily relinquishes all rights to an administrative hearing concerning the allegations set forth herein insofar as those allegations support the Interim Order, as well as all rights of rehearing, review, reconsideration, appeal, judicial review or any other administrative and/or judicial action. However, Respondent retains the right to an administrative hearing concerning the allegations set forth herein, and any other allegations that may arise during the Board's investigation of this matter, as to whether those allegations constitute unprofessional conduct warranting disciplinary action pursuant to A.R.S. § 32-1401 et seq. Respondent affirmatively agrees that this Consent Agreement shall be irrevocable.

3. Respondent agrees that the Board may adopt this Consent Agreement, or any part thereof, pursuant to A.R.S. §§ 32-1401 *et seq.* Respondent understands that this Consent Agreement, or any part thereof, may be considered in any future disciplinary action against him.

4. Respondent understands that this Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. Respondent also understands that acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this state from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

5. Respondent acknowledges and agrees that, upon signing this Consent Agreement and returning it to the Board's Executive Director, Respondent may not revoke his acceptance of this Consent Agreement or make any modifications to it, regardless of whether this Consent Agreement has been issued by the Executive Director. Any modification to this original document is ineffective and void unless mutually approved by

the parties in writing.

6. Respondent understands that the foregoing Consent Agreement shall not become effective unless and until adopted by the Board and signed by its Executive Director.

7. Respondent understands and agrees that if the Board does not adopt this Consent Agreement, he will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

8. Respondent understands that this Consent Agreement is a public record that may be publicly disseminated as a formal action of the Board, and shall be reported as required by law to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

9. Respondent understands that any violation of this Consent Agreement constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(24)(r)(violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter) and may result in disciplinary action pursuant to A.R.S. § 32-1451.

DATED: 2/28/03

John Quigley, M.D.

Reviewed and Approved as to Form:

By: Melinda C. Beckler
Peter Wittekind, Esq.

FINDINGS OF FACT

1. The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. John Quigley, M.D., is the holder of License No. 20243 for the practice of allopathic medicine in the State of Arizona.

3. On November 8, 2002, Respondent performed several surgical procedures on Patient P.M. at the Northern Arizona Surgicenter. The surgical procedures included an endoscopic carpal tunnel release of the right wrist, lipodystrophy of the abdomen, flanks and neck, a CO_2 laser procedure of the face, and a revision of a right blepharoplasty incision in the upper eyelid. The surgery took place between approximately 0751 and 959 hours.

4. The patient received local intravenous sedation using Fentanyl and Versed. During the surgery, the patient's condition was monitored by a registered nurse.

5. Following the surgery at approximately 1004 hours, the patient experienced cardiopulmonary arrest and required emergency resuscitation. A certified registered nurse anesthetist was called to assist with the patient's resuscitation.

6. At approximately 1030 hours, the patient was emergently transported to Flagstaff Medical Center for evaluation and further treatment. The patient was placed on life support and did not regain consciousness.

7. The patient was pronounced dead on November 12, 2002, at approximately 1330 hours.

8. The Coconino County Medical Examiner's Office has stated that the cause of death was "cerebral edema and increased intracranial pressure due to anoxic encephalopathy and bradycardia due to bronchospasm."

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter and over Respondent pursuant to A.R.S. § 32-1401 *et seq.*

2. Pursuant to A.R.S. § 32-1451(F), the Board is authorized to enter into a consent agreement to limit or restrict a doctor's practice to protect the public and ensure the doctor's ability to safely engage in the practice of medicine.

1 **ORDER**

2 IT IS HEREBY ORDERED THAT:

3 1. Respondent shall not perform office-based or out-patient surgery requiring I.V.
4 sedation, I.V. sedation/analgesia, or general anesthesia unless an anesthesiologist or certified
5 registered nurse anesthetist is present to personally administer the sedative, analgesia or
6 anesthesia and monitor the patient throughout the entire procedure.

7 2. This is an interim order and not a final decision by the Board regarding the
8 pending investigation and as such is subject to modification and further consideration by the
9 Board.

10 DATED and effective this 28th day of February, 2003.

11 ARIZONA MEDICAL BOARD

12 [SEAL]

13 By: Barry Cassidy

14 BARRY CASSIDY, PH.D., P.A.-C
Executive Director

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ORIGINAL OF THE FOREGOING FILED
this 28th day of February 2003, with:

ARIZONA MEDICAL BOARD
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY OF THE FOREGOING MAILED
this 28th day of February 2003, to:

John Quigley, M.D.
1020 N. San Francisco Street, Suite 200
Flagstaff, Arizona 86001
Respondent

Peter M. Wittekind, Esq.
KENT & WITTEKIND P.C.
40 N. Central Avenue, Suite 1400
Phoenix, Arizona 85004-4441
Attorneys for Respondent

Stephen A. Wolf, Esq.
Assistant Attorney General
1275 W. Washington, CIV/LES
Phoenix, AZ 85007
Attorneys for the State of Arizona

Planning & Operations

Janet Napolitano
Governor

Timothy C. Miller, J.D.
Executive Director

Amanda J. Diehl, M.P.A., C.P.M.
Deputy Executive Director

Bernadette E. Phelan, Ph.D.
Assistant Director

Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • Email: questions@azmd.gov

Robert P. Goldfarb, M.D., F.A.C.S.
Chair

William R. Martin, III, M.D.
Vice-Chair

Douglas D. Lee, M.D.
Secretary

I, Lynanne Chapman, of the Arizona Medical Board, hereby certify that I am the official custodian of the records of the agency; and that the attached documents are true and complete copies of the documents requested regarding:

Physician Name: John Quigley, M.D.

License Number: 20243

Attached are the following document(s):

Document Name:
Physician Profile
Letter of Reprimand and Civil Penalty, Dated February 17, 2004

Document (# of pages) 12

DATED this 23rd day of June, 2006

ARIZONA MEDICAL BOARD

OHIO STATE MEDICAL BOARD
JUL 05 2006

[SEAL]

Lynanne Chapman
Custodian of Records

Arizona Medical Board
Physician Profile

Printed: 6/21/2006 9:45:52 AM from http://www.azmd.gov

General Information

John Quigley MD
1020 N San Francisco St # 200
Flagstaff Arizona 86001-3281
Phone: 928-774-2300

License Number: 20243
License Status: Active
License Date: 8/16/1991
License Renewed: 2/10/2006
Renew By: 03/2008
License Expires: 07/2008

Education and Training (a)

Medical School: SOUTHERN IL UNIV SCH OF MED
SPRINGFIELD, IL
Graduation Date: 6/4/1983

Residency: 7/1/1983 - 6/30/1988 (General Surgery)
WESTERN RESERVE CARE SYSTEM
YOUNGSTOWN, OHIO

Residency: 1/1/1989 - 6/30/1989 (Hand Surgery (Orthopedic Surgery))
MEDICAL COLLEGE OF OHIO/ST. VINCENT MEDICAL CENTER
TOLEDO, OHIO

Residency: 7/1/1989 - 6/30/1991 (Plastic Surgery)
MEDICAL COLLEGE OF OHIO/ST. VINCENT MEDICAL CENTER
TOLEDO, OHIO

(b) Area of Interest: General Surgery (ABMS Board Certified)
(b) Area of Interest: Hand Surgery (Orthopedic Surgery) (ABMS Board Certified)
(b) Area of Interest: Plastic Surgery (ABMS Board Certified)

Board Investigations and Actions

BOARD ACTIONS: 1
* OPEN INVESTIGATIONS: 0
NON DISCIPLINARY ACTIONS: 0

*** Open investigations represent unproven allegations - Upon investigation many complaints are found to be without merit and dismissed.**

BOARD ACTIONS (c)

3/23/2004 : Letter of Reprimand-Unprofessional Conduct (inadequately monitored patient's ventilatory respiratory status during plastic surgery; inadequately documenting that status; for the code & subsequent events) Pay $1000 Civil Penalty w/in 60days-Paid 4/16/04

Malpractice/Criminal Information

CRIMINAL CONVICTIONS / "NO CONTEST" PLEAS: 0

(d) MALPRACTICE CASES RESULTING IN JUDGEMENT, SETTLEMENT OR PAYMENT: 1

OHIO STATE MEDICAL BOARD
JUL 05 2006

The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

(a) Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

(b) The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

(c) Advisory Letters and Physician Responses to the Advisory Letters are only available on-line for a 5 year period from date of issuance by the Board.

(d) The settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action does not create a presumption that medical malpractice occurred.

(e) Prior to 1999, "Advisory Letters" were known as "Letters of Concern"

OHIO STATE MEDICAL BOARD

JUL 0 5 2006

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOHN QUIGLEY, M.D.** Holder of License No. **20243** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-03-0085A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand and Civil Penalty)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 11, 2003. John Quigley, M.D., ("Respondent") appeared before the Board with legal counsel Peter Wittekind for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 20243 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-0085A after receiving information regarding the death of a 44 year-old female patient ("PM"). On November 8, 2002 Respondent performed endoscopic right carpal tunnel release, touch liposuction to the neck, liposuction to the arms, abdomen and flanks, revision of the right blepharoplasty incision in the upper eyelid and facial CO2 laser on PM. PM experienced respiratory arrest and was successfully intubated and her blood pressure and pulse were

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maintained. Paramedics arrived at Respondent's office and transferred PM to the hospital where she expired on November 12, 2002.

4. Respondent testified that PM was an employee of his as well as a friend. Respondent noted that he had performed previous surgeries on PM and that, since she had done well with IV sedation, Respondent and PM decided to again use IV sedation on November 8, 2002. Respondent testified that at the start of the case he administered Versed 2 milligrams and Fentanyl 1cc, which is approximately 50 mics. Respondent noted that if PM complained of pain, he would give increments of 1 milligram of Versed and 1cc of Fentanyl. Respondent stated that near the end of the two-hour case PM was to have laser treatment for a multiple attendant keratosis on the face. Respondent stated that at this point the O2 was turned off to prevent the laser from causing an oxygen fire.

5. Respondent testified that at 9:37 (as indicated in PM's chart) PM received 2 milligrams of Versed and 1cc of Fentanyl. Respondent noted that PM complained of pain at 9:54 and was given one more milligram of Versed and more Fentanyl. According to Respondent, the O2 monitor was still turned on at this point. Respondent stated that at 10:04 the nurse noted that the O2 sats went down quickly, and within a few seconds went down to 40 percent from the high 80s. Respondent noted that the nurse tried PM's other finger at that point and he tried a jaw thrust maneuver and had the nurse give an amp of Narcan. Respondent stated that when the jaw thrust did not stimulate PM he placed an oral airway. Respondent noted that when PM did not gag when he placed the airway, he immediately knew that the situation was extremely serious. Respondent stated that the CRNA in the next room was called in and they began CPR.

6. Respondent testified that PM was quickly ventilated and the O2 sats returned to 100 percent. PM was then transferred to the hospital. Respondent stated that at this point, he thought PM was going to be fine, but she developed seizure activity

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at the hospital and over the course of four days her condition worsened and cerebral edema eventually led to brain death. Respondent noted that approximately three months after PM's procedure the Board requested that he voluntarily restrict his IV sedation privileges outside the hospital setting and that he had done so.

7. Respondent noted that the nurse that treated PM was a pediatric ICU nurse for five years before she joined Respondent's office and that she had often given Versed and Fentanyl. Respondent stated that the nurse performed 25 proctored cases and had done approximately 80 additional cases before PM's case. Respondent also noted that the Department of Health Services conducted a surprise investigation of the facility after PM's death and found no substantiation of the allegations regarding the monitoring of PM. Respondent noted that his facility had done over 6,000 cases, with 4,000 having an anesthesiologist or anesthetist present or general anesthesia and 2,000 with IV sedation. Respondent testified that he believed he followed the guidelines of the American Society of Anesthesia, the American College of Emergency Room Physicians, and the guidelines from the Mayo Clinic. Respondent testified that he felt that the surgical technique, the dosing of the medication and the stopping of oxygen at the time the laser was utilized were consistent with the standard of care.

8. Respondent was asked whether he performed an unusual number of procedures on PM in one sitting. Respondent stated that many of the procedures, such as the eyelid procedure, he was simply revising a scar and that much of the liposuction was touch-up since PM had had the procedures done on the neck and part of the flanks in the past. Only the procedure on PM's arms was "new." Respondent noted that the critical issue is the amount of liposuction and that there is disagreement over whether the proper amount is 5 or 6 liters, but he tends to go with 5 liters. Respondent stated that in PM's case he did 1.5 liters.

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9. Respondent was asked whether the two-hour length of the procedure was an extended amount of time. Respondent stated that it is, but studies in plastic surgery literature say some of the procedures go up to 5 hours. And as long as you continue to monitor the patient there have not been problems. Respondent was asked to refer to the American Society of Anesthesiologists ("ASA") standards for conscious sedation and to briefly review the basic elements and how he complied. Respondent noted that with regard to employees and their training he previously explained his nurse's experience. According to Respondent, ASA wants someone to have ACLS or PALS certification, someone who can handle airway problems and also want someone who, within 5 minutes, can intubate the patient.

10. Respondent was asked whether ASA's standards note that there should be continuous EKG monitoring and continuous pulse oximetry. Respondent agreed and stated that PM had both. Respondent was asked about the allegation that the pulse oximetry monitor was turned off during PM's procedure. Respondent stated that the monitor was not turned off, just the alarm was muted, however, even if the alarm was muted, if the O2 sats went below 85 percent the alarm would sound again. Respondent stated that in essence the O2 monitor was on the whole time. Respondent noted that the last O2 reading was at 9:55 and was still at 90 percent, but that after PM was taken to the hospital, the machine was turned off and the rest of the information after 9:55 was lost.

11. Respondent was asked to explain the difference between monitoring the oxygenation and ventilation and how he monitors each. Respondent testified that oxygen can be checked with O2 sats, and ventilation in general anesthetics is checked by CO2. Respondent noted that the problem with patients who are awake is that CO2 monitors are not always accurate, so you can look at the respiratory rate and can also talk to the patient. Respondent noted that the ASA Guidelines talk about monitoring criteria every

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15 minutes. Respondent stated that at 9:54 PM complained of pain and he knew she was breathing, but hurting from the laser procedure. In sum, Respondent noted that a CO2 monitor would be the only other thing that could be used.

12. The Board noted that from the time PM received her last Fentanyl dose at about 9:54 until 10:05 when she was found to be in respiratory arrest there was no documentation of ventilation and no documentation of what her O2 sats were during that particular interval of 10 to 12 minutes. Respondent agreed that the respiratory rate was not documented. Respondent also noted that it is not necessarily standard of care to check it every minute or every 5 minutes.

13. Respondent was asked what his experience was with using Versed in this particular setting and what kinds of complications or problems does Versed produce. Respondent noted that the major concern with Versed is respiratory depression and, although he had never seen it with one of his patients, he has seen other physicians vigorously rub the sternum to get the patient to take a deep breath. Respondent was asked if it would be reasonable to hypothesize that in this particular case, sometime shortly after the 9:54 doses of Fentanyl and Versed, PM simply stopped breathing for about 5 minutes, perhaps maintained her O2 sats, but stopped breathing, became acidotic and went into cardiac and respiratory arrest. Respondent noted that it was one of the possibilities and that there was also talk of a bronchospasm. Respondent stated that at the very beginning of the case the patient had a red flush to her face and he had to give her Benadryl, but her lungs were clear.

14. In regard to the issue of possible bronchospasm, Respondent was asked if it would be prudent with someone he thought maybe had an allergic reaction to go ahead and give them IV sedation for two hours if he was concerned about reactive airways.

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Respondent stated that was precisely the reason he listened to PM's lungs and he did not hear anything unusual, they were clear.

15. Respondent was asked whether PM talked at all after the 9:54 doses of Versed and Fentanyl. Respondent stated that she did not. Respondent was asked whether he felt that his documentation after 9:54 of PM's vital signs, electrocardiac status, ventilatory status, and O2 sats and what happened thereafter until she left the operating room met the standard of care. Respondent stated that PM was still on the EKG monitor and the O2 sat monitor. Respondent was asked what rhythm PM was on at 10:04 when she was discovered to not be breathing. Respondent stated that PM still had a normal sinus rhythm and then shortly after the anesthetist came into the room she started to brady down. Respondent was asked whether there was a monitor strip to show that PM had a normal sinus rhythm. Respondent again noted that the monitor was turned off at the end of the code when the patient left the operating room and after 9:55 all the information was lost.

16. Respondent was asked if it would be important to document in the record the patient's rhythm during the course of a cardiac and respiratory arrest. Respondent agreed and stated that he would have assumed they had the monitoring strips. Respondent noted that there was a code sheet documented and that one of the Board's experts thought this sheet was adequate under the circumstances.

17. Respondent was asked to respond to the criticism that since he was responsible for both the surgery and the anesthesia he was managing too much and should have had a CRNA or physician anesthesiologist for a case of this length and complexity. Respondent testified that IV sedation, as long as it is monitored, tends to be a very safe procedure. Respondent was asked whether he had changed his practice in light of PM's case. Respondent stated that his practice uses the CO2 monitor, which

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although not always accurate on a patient who is awake, it is important to have as many parameters as possible.

18. Respondent was asked whether the nurse who monitored PM had more than a duty to monitor the patient. Respondent noted that during the period of questions she was always at the patient's side, but if she is needed to go get sutures, she will do that as well. Respondent noted that since PM's case he has a nurse that stays at the patient's head as well as a circulating nurse. Respondent noted that in PM's case, the nurse was at the patient's side from 9:37 on.

19. Respondent was asked what he believed ultimately caused PM's demise. Respondent stated that he did not know, but that one of the Board's consultants who reviewed the case talked about a combination of the O2 being off, the sedation, and the patient having an irritable airway. Respondent stated that all those things probably played into it, but whether there was something else, he does not know. Respondent stated that it is frustrating for him because he treated PM two years previously with almost the exact same medication and had no problems at all. Respondent noted that he has been doing these procedures for 12 years and he would have told the Board this could not happen because normally the O2 monitor would go down and he would be able to resuscitate the patient right away.

20. Respondent was asked if it was possible that there may have been a one or two minute period where PM was not being monitored and may not have been being oxygenated and when the nurse realized it and alerted Respondent he may have in essence started a couple of minutes more behind the curve than he thought he was. Respondent noted that was a possibility, but he could not prove it one way or the other.

21. PM's records indicate that at one point the pulse oximeter was reported to be at 46, but there are no reports that the alarm went off and only a verbal report to

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Respondent was noted. PM's records also indicate three readings of respiration every fifteen minutes throughout the procedure until 9:45 at which point there is no documentation of any episode of respiration rate. The lack of a documented respiration rate indicates that there was possibly a 19-minute gap (9:45 to 10:04) during which PM was not monitored for respirations.

22. The Board noted that Respondent appeared to be a very knowledgeable and caring physician with a good knowledge of pharmacology.

23. The standard of care, based on ASA guidelines, is that when a patient is given sedation, the patient's heart rate, EKG rhythm, respiratory rate, pulse oximetry, blood pressure, level of consciousness or response and ventilatory status are to be monitored continually during the procedure and that such monitoring be documented.

24. Respondent fell below the standard of care because the patient was not adequately monitored during the last part of the procedure and any monitoring was not adequately documented.

25. PM was harmed because she stopped breathing, suffered a cardiac arrest and hypoxic encephalopathy.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

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3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(26[1])(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

1. Respondent is issued a Letter of Reprimand for inadequate monitoring of the patient's ventilatory respiratory status during the last part of a plastic surgery procedure and for inadequately documenting that status from the last part of the procedure and for the code and subsequent events.

2. Respondent shall pay a $1,000 civil penalty within 60 days of the effective date of this Order.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

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[1] Formerly A.R.S. § 32-1401(24). Renumbered effective September 18, 2003.

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DATED this 17th day of February, 2004.

THE ARIZONA MEDICAL BOARD

By Amanda Diehl
for BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 17th day of February, 2004 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 17th day of February, 2004, to:

Peter Wittekind
Kent & Wittekind
111 West Monroe – Suite 1000
Phoenix, Arizona 85003-0001

Executed copy of the foregoing mailed by U.S. Mail this 17th day of February, 2004, to:

John Quigley, M.D.
Address of Record

Lisa McGraw

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