

**STATE OF RHODE ISLAND AND
PROVIDENCE PLANTATIONS,
DEPARTMENT OF HEALTH,
BOARD OF MEDICAL LICENSURE AND
DISCIPLINE**

**In the Matter Of:
Marguerite Vigliani, M.D.
License #: MD 5559**

Consent Order

Pursuant to R.I. General Laws §5-37-5.2, 1956, as amended, (2004 Reenactment) the Board of Medical Licensure and Discipline (hereinafter referred to as "Board") has been notified by Women and Infants Hospital in which a surgical procedure was performed in error and without the patient's consent. The following constitutes the Investigating Committee's Findings of Fact:

Findings of Fact

1. The Respondent is a Board Certified Obstetrician-Gynecologist with Hospital privileges at Women and Infants Hospital, Rhode Island Hospital and Roger Williams Medical Center. She is a 1976 graduate of the Medical College of Pennsylvania and has been licensed in the State of R.I. since 1979.
2. Respondent first saw the patient, a 53 year-old woman, in outpatient consultation approximately 6 weeks prior to surgery for complaints relating to uterine prolapse. The patient subsequently returned to the office to schedule a vaginal hysterectomy.

3. On the same day as the second visit, a second patient with the same last name was seen by the Respondent in the office and the doctor discussed prophylactic oophorectomy due to a family history of cancer of the Ovaries.
4. On the day of surgery, the Respondent met with the patient in the ASU and discussed the planned surgery with the patient and her husband in the presence of the medical student, and the nurse anesthetist. The Respondent claims to have discussed performing a vaginal hysterectomy with repairs and removal of the ovaries, although this claim could not be confirmed by the Board.
5. The Respondent entered the operating room intending to perform the vaginal hysterectomy and an oophorectomy. The patient had completed informed consent for the vaginal hysterectomy and repairs only.
6. In accordance with the protocol for preventing wrong site, wrong procedure and wrong person surgery, the operating team conducted a preoperative verification process, called a "time-out" in which all team members agreed that the procedure was a vaginal hysterectomy, repairs with oophorectomy. The patient, who was impaired due to heavy sedation was unable to participate in the "time-out". After the "time-out" the patient was fully anesthetized, intubated and prepared for surgery. Before the surgery commenced the circulating nurse called attention to the discrepancy between the planned surgery and the consent form. The charge nurse was called to resolve the situation. Satisfied by the Respondent's assertion that consent had been properly obtained in the ASU prior to transfer to the OR she authorized the procedure to proceed.

7. Respondent felt certain of the planned surgery and concluded that there had been a clerical error in completing the consent form. Respondent amended the consent form to include the oophorectomy and initialed and dated the change.
8. After the surgery the Respondent discussed the surgery with the patient. Upon realizing that the patient had not desired an oophorectomy, the Respondent provided full disclosure to the patient and informed appropriate hospital authorities of the error.
9. The Board finds the Respondent's behavior to be in violation of § 5-37-5.1 of the General Laws of the State of Rhode Island.
10. The Board recognizes that the Respondent self-reported this and has taken responsibility for this event including leading efforts to amend the Hospital policy to prevent such errors from occurring in the future.

The parties agree as follows:

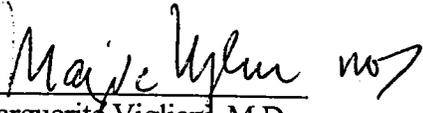
The parties agree as follows:

The Respondent is a physician with an allopathic license No 5559. Respondent admits to the jurisdiction of the Board and hereby agrees to remain under the jurisdiction of the Board.

- (1) Respondent has read this Consent Order and understands that it is a proposal of an Investigating Committee of the Board and is subject to the final approval of the Board. This Consent Order is not binding on Respondent until final ratification by the Board.
- (2) Respondent hereby acknowledges and waives:
 - a. The right to appear personally or by counsel or both before the Board;
 - b. The right to produce witnesses and evidence in his behalf at a hearing;
 - c. The right to cross examine witnesses;
 - d. The right to have subpoenas issued by the Board;
 - e. The right to further procedural steps except for specifically contained herein;
 - f. Any and all rights of appeal of this Consent Order;
 - g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review;
 - h. Any objection to the fact that it will be necessary for the Board to become acquainted with all evidence pertaining to this matter in order to review adequately this Consent Order;

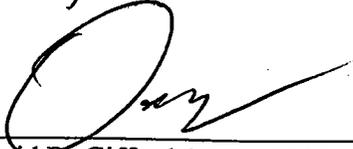
- i. Any objection to the fact that potential bias against the Respondent may occur as a result of the presentation of this Consent Order.
- (3) Acceptance of this Consent Order constitutes an acknowledgement by the Respondent of the findings of the Board.
- (4) This Consent Order shall become part of the public record of this proceeding once it is accepted by all parties and by the Board.
- (5) Failure to comply with this Consent Order, when signed and accepted, shall subject the Respondent to further disciplinary action.
- (6) Respondent shall accept the findings of the Board and continuing to work with the Board and the Women and Infants' Hospital of Rhode Island to improve patient safety in the area of "wrong patient, wrong site, wrong surgery."

Signed this day of , 2006.



Marguerite Vigliani, M.D.

Ratified by the Board of Medical Licensure and Discipline at a meeting held
on *Aug 9th*, 200*6*



David R. Gifford, M.D., MPH
Director of Health