State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline

IN THE MATTER OF:
VINCENT J. ZIZZA, D.O.
License Number DO 00487
Complaint # C181021

SUMMARY Suspension

The Director of the Rhode Island Department of Health (hereafter "Director") has reviewed the information contained in Complaint # C181021 regarding the professional activities of Dr. Vincent Zizza (hereinafter "Respondent") and makes the following:

FINDINGS OF FACT

1. Respondent is a licensed physician in the State of Rhode Island and was issued his license on February 11, 1998. He graduated from the University of New England College of Osteopathic Medicine in 1992. He was board certified in urology in 2007, and he has hospital privileges at Kent County Hospital. His office is located at Tri-County Urology, Suite 301, 176 Toll Gate Road, Warwick, Rhode Island.
2. The Board received notification from Kent County Hospital regarding a National Practitioner Data Bank report. It was noted in this report, among other things, that Respondent's privileges were summarily suspended March 15th, 2018.
3. Based thereon, Complaint # C180352 was opened, reviewed and investigated by the Board, which determined and proceeded as follows:
    a. Respondent was the attending physician for Patient A (alias), a 60-year-old male, who presented to Respondent for partial nephrectomy of the right kidney due to a renal tumor. Respondent conducted an appropriate pre-op evaluation and obtained

informed consent regarding treatment for renal cell carcinoma, including an evaluation for metastatic disease.

b. Respondent did conduct an initial time-out with the surgical team per the hospital's universal protocol. Respondent noted that certain equipment was missing, and a circulating nurse left the room to obtain this additional equipment and placed it on the left side of Patient A. Respondent notes the instrument is usually placed on the side of the patient where the operation is to occur.

c. Respondent had placed 3 of the 4 drapes needed for this operation. The fourth drape was placed by the surgical technician, which covered the initial marking of the correct side for the incision. Respondent did not conduct another time out per hospital protocol and made an incision on the incorrect side of Patient A. The assisting surgeon entered the room immediately after this incision and identified that Respondent made the incision on the incorrect side. Respondent immediately stopped the surgery confirmed laterality with the assistant and sutured the incision site. Then Respondent performed the planned surgical procedure on the correct side of the patient. Patient A and family were notified of the wrong site incision immediately after completion of the surgery.

d. Respondent appeared before the Investigative Committee on May 30th, 2018 and admitted he did make an incision on the incorrect side of Patient A.

e. On August 3, 2018 Respondent signed a Consent Order to resolve Complaint # C180352, which was presented to the full Board for ratification on the morning of August 8, 2018.

4. RIDOH was notified on August 7th, by Respondent as well as Blackstone Valley Surgicare that a new incident had occurred earlier that morning at this ambulatory surgical care center.

5. Respondent was the attending physician for Patient B (alias), a 64-year-old male with a kidney stone in the left ureter.

6. Patient B was scheduled to undergo a Left ureteroscopy laser litho basket retrograde stent insertion on August 7th, 2018. Patient B signed a consent form for the procedure and a "Time-Out" procedure was completed prior to the procedure.
7. Respondent completed the procedure on Patient B, and at the procedure debrief with the operating room staff, it was learned that Respondent had done the procedure on the Right side.
8. Patient B at this point was unaware the wrong side had been completed and Respondent re-scrubbed and completed the procedure on the Left side, which was the intended side and the side agreed upon on the consent form and the operating room team.
9. Patient B was informed of the error post-operatively.
10. The post-operative medical record does not include a specific notation that the incorrect procedure was done initially and then the correct side was completed.
11. Respondent had 6 other cases scheduled that morning at Blackstone Valley Surgicare and all other procedures that day were canceled.

ORDER

After considering the above findings, the Director has determined that the continuation of the practice of medicine by Respondent constitutes an immediate danger to the public. It is accordingly ordered that:

1. Pursuant to R.I.G.L. § 5-37-8, Respondent is hereby suspended from practicing medicine until further Order of the Department of Health and/or the Board of Medical Licensure and Discipline.

2. Respondent is responsible for ensuring his patients' transition to other health care providers and for ensuring transfer of any requested medical records of his patients forthwith.

Respondent is entitled to an administrative hearing before the Board within ten (10) days of this Order by contacting the Board and requesting such a hearing in writing.

Signed this 8th day of August 2018.

Nicole Alexander-Scott, MD, M.P.H.
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CERTIFICATION OF SERVICE

I hereby certify that a copy of this **SUMMARY SUSPENSION** was delivered, by agreement, to Respondent's attorney, Stephen Zubiago, on this 8th day of August 2018 as follows:

Stephen Zubiago, Esq.
SZubiago@nixonpeabody.com