1 BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **TIFFANY A. DI GIACOMO, M.D.** Holder of License No. 50408 For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-20-0006A, MD-20-0151A** **ORDER FOR LETTER OF REPRIMAND; AND CONSENT TO THE SAME**

Tiffany A. Di Giacomo, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for a Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

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 number 50408 for the practice of allopathic medicine in the State of Arizona.

MD-20-0006A

3. The Board initiated case number MD-20-0006A after receiving notification of a malpractice settlement regarding Respondent's care and treatment of a 36 year-old female patient ("MB") alleging improper performance of a laparoscopic assisted vaginal hysterectomy ("LAVH") with subsequent complications.

4. On August 15, 2016, MB was seen by Respondent for a history of menstrual bleeding for three weeks and pelvic pain. MB's past medical history was significant for asthma, elevated white blood cell count, urinary tract infections, bilateral tubal ligation, cholecystectomy, tonsillectomy, and loop electrical excision procedure ("LEEP"). MB's body mass index was 45.78. Respondent prescribed norethindrone and discussed ways to control the bleeding, noting that oral contraceptives were not an option due to the patient

history of smoking. An endometrial biopsy was scheduled with Cytotec given due to the history of a LEEP in the past.

5. On September 2, 2016, Respondent performed a pap smear and biopsy on MB. The results were unremarkable and Respondent discussed treatment options with MB, who elected a hysterectomy.

6. On September 20, 2016, Respondent performed an LAVH on MB. The laparoscopic portion was carried out using the Ligasure without complications. Respondent then carried out a posterior colpotomy, placing a Deaver in the anterior cul-de-sac after dissection. Respondent encountered difficulty due to MB's body habitus when attempting to incise the remaining pedicles and returned to the laparoscopic approach. Respondent used the LigaSure to ligate the remaining attachments. At completion of the LAVH, a cystoscopy was performed, and a trigone defect was observed. Respondent consulted an urogynecologist during the procedure, who performed a repeat cystoscopy and identified a large defect with charring, but was unable to visualize the ureteral orifices. A urology consult was then obtained and attempts at retrograde pyelograms and stent insertions were unsuccessful due to the inability to identify the ureters.

7. On September 22, 2016, MB underwent an exploratory laparotomy with bilateral ureterolysis, open repair of the iatrogenic bladder injury, bilateral ureteral reimplantation and dissection of the bladder wall from the anterior vaginal wall with vaginal closure of the cuff and pericystic fat flap placement between the bladder and vagina.

8. The standard of care requires a physician to perform a LAVH procedure without injury. Respondent deviated from the standard of care by attempting to use the LigaSure device prior to attempting alternative techniques and without properly visualizing the pedicles and bladder position.

9. Actual patient harm was identified in that the patient's bladder and ureters were injured, requiring repair. Additional surgical procedures will be required.

MD-20-0151A

10. The Board initiated case number MD-20-0151A after receiving notification of a malpractice settlement regarding Respondent's care and treatment of a 35 year-old female patient ("MN") alleging failure to identify fetal distress with subsequent death.

11. On February 8, 2016, MN was seen by Respondent for prenatal care. MN's estimated due date was determined to be October 3, 2016. The prenatal course was uneventful and the patient was scheduled for induction at 41 weeks.

12. On October 11, 2016, at 1025, MN presented to the Hospital and induction was initiated with Pitocin. At 1352, an artificial rupture of membranes was performed, and at 1503 an epidural was administered. At 1540, MD was examined and decelerations were noted. Pitocin was turned off and a position change helped resolve the problem. Pitocin was restarted approximately one hour later.

13. At 2140, the fetal tracings were notable for variable decelerations. At 2155, the fetal tracings were notable for deep variables; overall, the variables continued including ones with overshoots.

14. At 2229, Respondent was at MN's bedside and assessed the patient.

15. At 2305, the fetal heart rate was 170 from a baseline of 130 with late decelerations. Respondent initiated interventions to resolve these including position change and oxygen. Respondent attempted a vacuum delivery with rotation; however she was unsuccessful. The head did not descend farther than +2 and Respondent ordered a C-section at 2352.

16. On October 12, 2016, at 0007, the fetal tracings were notable for a seven minute decelerations.

17. At 0025, Respondent performed a C-section delivery on MN. Apgars of 2/7/8 and no tone was noted for the infant. The infant's cord blood had a pH of 6.9-7.0 according to Respondent who also noted that there was a delay in receiving the results. A consult was carried out with Children's Hospital neonatology, and blood gas pH at 5 hours of age was reportedly 7.37. When seizure activity was identified, phenobarbital was started and the infant was transferred to the Children's Hospital.

18. At 0215, Respondent was called and assessed MN for post-partum hemorrhage. MN was transferred to the ICU for management after misoprostil and methergine were administered and a Bakri balloon was placed.

19. At 0524, MN's bleeding was not abating and she was taken to the OR. A dilation and curettage was initially carried out but was unsuccessful at stopping the bleeding; therefore, a hysterectomy was performed. MN was diagnosed with disseminated intravascular coagulation ("DIC") and uterine atony. MN's blood loss was estimated at 4 liters she required 12 units of packed red blood cells, as well as fresh frozen plasma and platelets. Pathology was normal.

20. On October 20, 2016, MN returned to the Hospital with complaints of shaking chills. She was noted to be febrile and tachycardic, and diagnosed with pyelonephritis. MN's blood cultures were positive for E. coli. MN was admitted for treatment and discharged on October 24, 2016.

21. The infant was diagnosed with a global hypoxic injury secondary to birth injury with subsequent ongoing status epilepticus. The infant died at 13 days of age with an autopsy showing anoxic ischemic injury.

22. The standard of care requires a physician to monitor a patient in labor to assess progress, evaluate fetal status, and respond to signs of fetal distress. Respondent

deviated from the standard of care by failing to identify and appropriately respond to fetal distress.

23. Actual patient harm was identified in that the infant experienced an anoxic ischemic injury leading to death.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e)("Failing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r)("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 10th day of June, 2021.

ARIZONA MEDICAL BOARD

By [signature]
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges she has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent in this Order are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Notwithstanding any language in this Order, this Order does not preclude in any way any other State agency or officer or political subdivision of this state from instituting proceedings, investigating claims, or taking legal action as may be appropriate now or in the future relating to this matter or other matters concerning Respondent, including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent acknowledges that, other than with respect to the Board, this Order makes no representations, implied or otherwise, about the views or intended actions of any other

state agency or officer or political subdivisions of the State relating to this matter or other matters concerning Respondent.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. ***Respondent has read and understands the terms of this agreement.***

TIFFANY A. DI GIACOMO, M.D.

DATED: 5/7/2021

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EXECUTED COPY of the foregoing mailed
this 11th day of June, 2021 to:

Tiffany A. Di Giacomo, M.D.
Address of Record

Samantha Butler, Esq.
Quinteros Prieto Woods & Boyer, P.A.
2390 East Camelback Road, Suite 440
Phoenix, Arizona 85016
Attorney for Respondent

ORIGINAL of the foregoing filed
this 11th day of June, 2021 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Robles
Board staff