BEFORE THE ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS

In the Matter of **FRANCIS R. LUCIANO, PA-C** Holder of License No. 5965 For the Performance of Healthcare Tasks In the State of Arizona	Case No. PA-21-0017A **ORDER DENYING REQUEST FOR REHEARING OR REVIEW**

At its public meeting on February 22, 2023 the Arizona Regulatory Board of Physician Assistants ("Board") considered Francis R. Luciano, P.A.'s ("Respondent") Request for Rehearing or Review of the Board's Order dated November 9, 2022 in the above referenced matter. After considering all of the evidence, the Board voted to deny Respondent's Request for Rehearing or Review.

ORDER

IT IS HEREBY ORDERED that:

Respondent's Request for Rehearing or Review is denied. The Board's November 9, 2022 Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation in Case PA-21-0017A is effective and constitutes the Board's final administrative order.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that he has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to title 12, chapter 7, and article 6 of the Arizona Revised Statutes.

DATED AND EFFECTIVE this 23rd day of February, 2023.

ARIZONA REGULATORY BOARD OF
PHYSICIAN ASSISTANTS

By Patricia E McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 23rd day of February 2023 to:

Francis R. Luciano, P.A.
Address of Record

ORIGINAL of the foregoing filed
this 23rd day of February 2023 with:

Arizona Regulatory Board of Physician Assistants
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Robles
Board staff

BEFORE THE ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS

In the Matter of: **FRANCIS R. LUCIANO, P.A.** Holder of License No. 5965 For the Performance of Healthcare Tasks In the State of Arizona	Case No. PA-21-0017A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION; AND CONSENT TO SAME**

The Arizona Regulatory Board of Physician Assistants ("Board") considered this matter at its public meeting on August 24, 2022. Francis R. Luciano, M.D. ("Respondent"), appeared before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-2551(G). The Board voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of physician assistants in the State of Arizona.

2. Respondent is the holder of license number 5965 for the performance of health care tasks in the State of Arizona.

3. The Board initiated case number PA-21-0017A after receiving a complaint regarding Respondent's care and treatment of a 27 year-old male patient ("BB") alleging mismanagement of patient care with subsequent delay in the appropriate evaluation and treatment. Specifically, the Hospital where Respondent was employed reported that Respondent left while under investigation for mismanagement in patient care leading to treatment delay and poor patient outcome.

4. Patient BB, who had experienced a recent relapse of acute myeloid leukemia ("AML") being treated by chemotherapy, was admitted to the Hospital on September 7,

2020 from a State Prison Facility after experiencing shortness of breath in the oncology clinic. The clinic noted that BB's Eastern Cooperative Oncology Group ("ECOG") Performance Status was 0. BB had pancytopenia with a white blood cell ("WBC") count of 20K to 60K. BB's problem list at the time of transfer included cavitary lesion of the lung for which he had been prescribed an antifungal, and chemotherapy induced cardiomyopathy.

5. On September 8, 2020, Respondent referred BB to the ICU for respiratory distress that resulted in intubation.

6. On September 10, 2020, BB was extubated and returned to the general floor. BB's respiratory status was purportedly waxing and waning but seemed to respond to medical care thus avoiding intubation.

7. On September 13, 2020, at 2302, Respondent was notified that BB was requiring nonrebreather at 15 liters and still occasional dropping of oxygen ("O2") saturations with respiratory rate ("RR") in the 40s. Nursing staff suggested an upgrade to the ICU for possible intubation. At 2348, Respondent was notified that BB's O2 saturations were dropping to the high 80s while on nonrebreather 15L. At 2352, Respondent ordered a BiPap but BB was unable to tolerate it. At 2359, Respondent placed BB on 6L of O2 via nasal cannula; however, BB's O2 saturations dropped into the 50s.

8. On September 14, 2020, at 0100, nursing notes documented that Respondent did not want to upgrade or intubate BB. At 0700, nursing noted that BB was found to be severely fatigued and hypotensive. BB continued to decline and Respondent was notified that BB was fatigued, hypotensive, tachypneic and hypoxic. Respiratory therapy applied a Ventimask 10L at 50%, which Respondent did not agree with. BB continued to decline and the Ventimask was removed and a nonrebreather was reapplied at 15K. Respondent attempted several orders for BB's symptoms including a normal saline bolus, Albumin, BiPap, Ativan, and Lasix. Despite all efforts, BB continued to decline. At

0754, BB was noted to be in respiratory distress and a chest x-ray showed bilateral infiltrates. BB was transferred to the ICU, intubated and placed on mechanical ventilation. At 0903, BB coded and CPR was initiated but resuscitative efforts were unsuccessful and BB expired.

9. The standard of care requires a physician assistant to transfer a patient in need of intubation to a higher level of care. Respondent deviated from this standard of care by deviated from the standard of care by failing to timely transfer the patient to the ICU resulting in death from respiratory failure.

10. Actual harm occurred in that BB expired.

11. During the course of the Board's investigation, Respondent failed to respond to Board staff's requests for a narrative response for approximately nine months, resulting in delay of the investigation.

12. During the Formal Interview, Respondent testified regarding his care and treatment of BB. Respondent stated that he was informed by the ICU doctor that BB should not be transferred to the ICU if he did not want to be intubated. Respondent testified that BB did not want to be transferred. With regard to communication, Respondent testified that he used text messaging with his Supervising Physician, spoke by phone to the ICU doctor, and had in-person verbal conversations with the hospitalist. Respondent admitted that he did not document many conversations in BB's chart. Respondent stated that he had copies of emails and texts but when asked why he did not provide them during the course of the Board's investigation, Respondent stated that this was his first Board investigation.

13. With regard to the delay in responding to the Board's investigation, Board staff noted that the assigned investigator attempted to contact Respondent on multiple

occasions without success. Board staff additionally noted that there was no documentation regarding BB's alleged refusal to be intubated in the chart.

14. Also during the Formal Interview, Board members commented that the nursing notes documented that nursing staff were uncomfortable with the decision not to intubate, but neither Respondent nor any other provider documented the patient's alleged refusal to be intubated. Board members recognized that ICU overcrowding due to COVID may have played a role in the outcome of the case, but also noted that it was nonetheless critical to appropriately document conversations regarding critical decision making.

CONCLUSIONS OF LAW

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

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-2501(18)(j) ("Committing any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-2501(18)(p) ("Failing or refusing to maintain adequate records on a patient.").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-2501(18)(aa) ("Failing to furnish legally requested information to the board or its investigator in a timely manner.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand;

2. Respondent is placed on Probation for a period of 6 months with the following terms and conditions:

a. **Continuing Medical Education**

Respondent shall within 6 months of the effective date of this Order obtain no less than 3 hours of Board staff pre-approved Category I CME in the evaluation and management of respiratory distress, and complete no less than 3 hours of Board staff pre-approved Category I CME in medical record documentation. Respondent shall within thirty days of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of licensure.

b. **Probation Termination**

Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority

c. **Obey All Laws**

Respondent shall obey all state, federal and local laws, and all rules governing the performance of healthcare tasks in Arizona.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-2501(18)(ee).

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the board's executive director within thirty (30) days after service of this order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition 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.

DATED AND EFFECTIVE this 9th day of November, 2022.

ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS

By _____ for
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 9th day of November, 2022 to:

Francis R. Luciano, P.A.
Address of Record

ORIGINAL of the foregoing filed this 9th day of November, 2022 with:

Arizona Regulatory Board
of Physician Assistants
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Rosales
Board staff