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BEFORE THE REVIEW COMMITTEE OF THE ARIZONA MEDICAL BOARD

In the Matter of

RONALD A. YUNIS, M.D.

Holder of License No. 25201
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-19-1001A, MD-20-0925A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR PROBATION

The Review Committee of the Arizona Medical Board ("Board") considered this matter at its public meeting on August 2, 2023. Ronald A. Yunis, M.D. ("Respondent"), appeared with legal counsel, Flynn P. Carey, Esq., before the Review Committee for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(P). The Review Committee voted to issue Findings of Fact, Conclusions of Law and Order 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 the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 25201 for the practice of allopathic medicine in the State of Arizona.

MD-19-1001A

3. The Board initiated case number MD-19-1001A after receiving complaints alleging that on October 10, 2019, Respondent brandished a firearm at individuals while in his vehicle in the parking lot of the clinic where he practices medicine. Respondent subsequently timely self-reported criminal charges related to the event.

4. Additionally, the Board received notification that Respondent's clinical privileges had been summarily suspended at a Hospital during an investigation into Respondent's professional conduct arising out of the firearm incident. The Hospital's

report also noted behavioral and quality of care concerns that were identified during the course of the investigation.

5. On October 6, 2021, Respondent pled guilty to one count of disorderly conduct with a weapon or instrument, a class 6 undesignated felony, in the criminal matter arising from the October 10, 2019, event. Respondent was sentenced to 2 years of probation with terms and conditions including completion of counseling. On December 15, 2022, the Court issued an order discharging Respondent from probation and designating the offense as a misdemeanor.

6. The Hospital's file included multiple reports of unprofessional interactions between Respondent and nursing staff occurring between 2018 and 2019.

7. During the course of the Board's investigation, Board staff requested Medical Consultant ("MC") review of Respondent's care and treatment of five obstetrical patients (MR, CB, BL, GCU, and KB) identified by the Hospital's investigation.

8. MR was a 39-year-old gravida 5 para 2 patient admitted at 42+ weeks' gestation. MR labored with the benefit of an epidural and was complete at 0040. Respondent applied a vacuum at 0056 with 2 pop-offs. Respondent then had MR rest and she began pushing again at 0230. Respondent again attempted a vacuum delivery at 0244 with 3 pop-offs noted on the fetal tracing. Respondent then carried out an emergent C-section due to lack of fetal descent.

9. In his response to the Board, Respondent asserted that the nurse incorrectly documented attempted pop-offs when the vacuum seal did not adhere to the baby's head. The MC noted that the patient was not given a significant opportunity to push during the second stage of labor, and opined that the vacuum delivery was not indicated since contemporaneous fetal tracing showed good variability with accelerations.

10. CB was a 28-year-old gravida 6 para 3 patient at 37.6 weeks gestation with a history of three previous C-sections and a known partial placenta accreta as well as anemia. Resection of the focal accreta was reviewed along with hysterectomy and preparation including having a general surgeon available. CB presented with contractions and Respondent carried out the C-section and focal uterine resection successfully with an estimated blood loss ("EBL") of 800cc. Respondent noted that the procedure was not done earlier due to attempts to treat CB's anemia with IV iron.

11. BL was a 33-year-old gravida 1 para 0 patient induced due to oligohydramnios with an amniotic fluid index of 7.6 at 41weeks and 6 days gestation. BL was initially seen at 36 weeks gestation in Respondent's office after having received prenatal care in Mexico. Induction was carried out and during labor, fetal tachycardia was identified, though good variability was present, along with recurrent variable decelerations. Respondent initiated antibiotics for chorioamnionitis after fever was noted, using Azithromycin due to a reported allergy to Penicillin. Respondent carried out a forceps delivery with delivery of a male infant weighing 7'2" and Apgar scores of 7 and 9.

12. GCU was a 23-year-old gravida 1 para 0 patient admitted for induction at 39+ weeks for intrauterine growth restriction/small for gestational age (9%). Respondent had previously diagnosed GCU with Chlamydia and prescribed Azithromycin when she established care at 36-37 weeks after receiving prior treatment in Mexico. Respondent carried out an artificial rupture of membranes ("AROM") and then administered Pitocin and introduced an intrauterine pressure catheter. Labor progressed and when late decelerations were noted, the Pitocin was discontinued by the nursing staff who notified Respondent. The decelerations subsequently resolved. An amnioinfusion was initiated and Respondent evaluated the patient ten minutes later. The cervical examination revealed an anterior lip was present though a prolonged deceleration was noted that

lasted over 7 minutes. When this resolved, GCU started pushing but continued to have significant late decelerations lasting from 1-2 minutes. Nursing documentation indicated continued administration of Pitocin. GCU went on to have a spontaneous vaginal delivery after 30 minutes of pushing and delivered a female infant weighing 5 pounds 2 ounces and Apgar scores of 8/8.

13. KB was a 25-year-old gravida 3 para 1 at 39+ weeks' gestation with spontaneous rupture of membranes ("SROM") who desired a trial of labor after C-section ("TOLAC"). KB was admitted in labor with a hemoglobin of 9.2 noted. KB had established care with Respondent in the first trimester and at 14 weeks, her hemoglobin and hematocrit ("H&H") was noted to be 11/8/35.7 and Respondent's progress notes also noted a glucose of 112. KB lost nearly 1000cc of blood at delivery. KB's post-partum hemoglobin was 5.6 though progress notes stated that she was without symptoms. KB's blood pressure post-partum was 83/52 with a heart rate of 102. A follow up the next day showed a blood pressure of 103/67 and heart rate of 85.

Deviations from the Standard of Care

14. The standard of care when performing a vacuum delivery when appropriate indications are present is to limit the number of pop-offs to a maximum of three, and to allow sufficient opportunity for labor to progress prior to repeating use of the vacuum. Respondent deviated from the standard of care for Patient MR by improper performance of a vacuum delivery without proper indication, and by not giving the patient sufficient opportunity to push in the second stage of labor.

15. The standard of care when a placenta accreta is identified is to deliver at 34-36 weeks gestation in a stable patient after maximization of preoperative hemoglobin levels. Respondent deviated from the standard of care for Patient CB by the inappropriate performance of a uterine wedge resection outside of accreta policy guidelines.

16. The standard of care requires a physician to obtain a group B strep culture at 36 weeks gestation. Respondent deviated from the standard of care for Patient BL by failing to obtain a group B strep culture prior to induction.

17. The standard of care requires a physician to treat a patient with appropriate antibiotics for chorioamnionitis. Respondent deviated from the standard of care for Patient BL by failing to use the proper antibiotic regimen when chorioamnionitis was diagnosed.

18. The standard of care requires a physician to appropriately use an intrauterine pressure catheter. Respondent deviated from the standard of care by use of intrauterine pressure catheter for Patient GCU during the latent phase without any evidence of fetal stress.

19. The standard of care requires a physician to appropriately use Pitocin during labor. Respondent deviated from the standard of care for Patient GCU by continuing to use Pitocin when she experienced recurrent decelerations.

20. The standard of care requires a physician to adequately monitor fetal stress during labor. Respondent deviated from the standard of care for Patient GCU by the inadequate fetal monitoring during the second stage of labor in a high-risk pregnancy.

21. There was the potential for patient harm in that MR's fetus was at risk for injury from multiple attempts made with the vacuum. Patient CB was at increased risk of significant hemorrhage. Patient BL was at risk of incomplete resolution of chorioamnionitis due to the choice of antibiotics. Patient GCU's fetus was at risk of fetal stress and its associated consequences. Patient KB was at risk of post-partum complications from severe anemia.

MD-20-0925A

22. The Board initiated case number MD-20-0925A after receiving a complaint regarding Respondent's care and treatment of a 33-year-old female patient ("AG") alleging

inappropriately attempting to perform an external cephalic version ("ECV") in an office setting and failure to explain the procedure and the risks. Based on the complaint, Board staff requested MC review of Respondent's care and treatment of AG.

23. On July 1, 2020, AG presented to Respondent for prenatal care at 34 weeks. AG's prenatal course included numerous ultrasounds and a breech presentation that had been identified at 30 weeks gestation. Respondent documented that an ECV was performed and that the fetus was easily turned counterclockwise to a transverse lie.

24. On July 15, 2020, AG presented to Respondent's office at 36 weeks. Respondent observed that the head was in the right upper quadrant and performed an ECV. Respondent was able to turn it to the left lower quadrant with a clockwise rotation. The MC noted that informed consent was not documented.

25. On July 22, 2020, AG presented to Respondent's office at 37 weeks and the fetus was noted to be breech. The treatment plan included an ECV under epidural at 39 weeks by another obstetrician.

26. On August 7, 2020, AG was admitted to the Hospital for the planned ECV. The procedure was attempted under epidural anesthesia with the use of Terbutaline but was unsuccessful and a C-section was performed with spinal anesthesia.

27. On April 8, 2021 the Board reviewed MD-20-0925A. After reviewing the case and hearing Respondent's statements, the Board requested that the case be returned for review by a second MC.

28. Both MCs opined that the standard of care requires a physician to attempt ECV only in settings in which cesarean delivery services are readily available. Respondent deviated from the standard of care by inappropriately attempting to perform an external cephalic version in an office setting.

29. There was potential for patient harm in that ECV can result in complications such as placental abruption, fetal distress, and rupture of the membranes which would result in need for urgent delivery and associated complications and severe risks to mother and fetus.

Evaluation

30. On October 12 and December 7, 2022, Respondent underwent a competency evaluation with a Board-approved Evaluating Facility. The Evaluating Facility determined that Respondent's performance was mostly satisfactory, with room for improvement, consistent with a Pass Category 2. The Evaluating Facility made recommendations regarding Respondent's physical examination skills and medical recordkeeping. Respondent reported to the Board that he has reviewed the Evaluating Facility's Report and has been integrating the recommendations into his practice.

Formal Interview

31. During a Formal Interview on this matter, Respondent testified regarding his practice of performing ECVs in an office setting, the care and treatment rendered to the five patients reviewed in case MD-19-1001A, and the October 10, 2019, firearm incident. Respondent testified that he does not currently have admitting or obstetrical privileges at any hospitals, and stopped providing obstetrical services for prenatal patients after 14 weeks with the intent of eliminating obstetrics from his practice. Respondent testified that he planned to reapply for privileges to the Hospital across the street from his office.

32. Regarding ECVs, Respondent testified regarding his process for performing the procedures both in an office and hospital setting. Respondent stated that he would not make any changes to his practice if he were to reengage in obstetrical care. Respondent stated in the event of a complication, he would consult with his partners who have admitting privileges and transfer the patient to a nearby hospital.

33. With regard to the firearm incident, when asked about anger management training completed pursuant to probation, Respondent stated that the training helped him be contemplative and mindful, but denied that the event was related to anger management issues.

34. With regard to the peer interaction complaints documented by the Hospital, Respondent asserted that the Hospital solicited the complaints from Hospital staff. Respondent stated that he is passionate about his patients, and admitted that he could be abrasive at times. Respondent denied that that his communication style required remediation, but recognized that he could communicate better with his peers.

35. Regarding his care of CB, Respondent noted the Hospital policy requiring the procedure to be performed in the main operating room, rather than an operating room in the obstetrical unit. Respondent stated that CB's blood loss was due to an anesthesiologist that he was unfamiliar with transfusing the patient too soon. Respondent stated his preferences for selecting his own anesthesiologists with appropriate specialization.

36. Respondent additionally testified regarding the evolution of his approach with regard to vacuum deliveries, and his C-section rate.

37. Board staff noted that the literature submitted by Respondent in support of his position regarding in office ECVs speak in favor of performing ECVs in a hospital setting.

38. During that same Formal Interview, the Review Committee agreed that the lack of documented informed consent for Patient AG in MD-20-0925A was sufficient to sustain a violation of A.R.S. § 32-1401(27)(e). Review Committee members also noted that two separate MCs found that performance of an ECV in an office setting on Patient AG constituted a deviation from the standard of care. With regard to MD-19-1001A,

Review Committee members noted that the standard of care deviations identified in MD-19-1001A were consistent with the Hospital's quality of care review. Review Committee members agreed that the firearm incident supported a violation of both A.R.S. §§ 32-1401(27)(d) and (r).

39. Additionally, during the Formal Interview, Committee members agreed that the matter rose to the level of discipline based on the pattern of conduct and gravity of the concerns identified in the case. Committee members agreed that Respondent appeared to be a passionate physician who wanted the best for his patients, but also expressed concern about the Respondent's ability to work in a team setting. Committee members agreed that education would assist Respondent to improve his inter-professional communication skills.

CONCLUSIONS OF LAW

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

2. The conduct and circumstances described in MD-19-1001A above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(d) ("Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.").

3. The conduct and circumstances described in MD-20-0925A above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

4. The conduct and circumstances described in MD-19-1001A and MD-20-0925A 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 placed on Probation for a period of six months with the following terms and conditions:

a. Continuing Medical Education

Within six months of the effective date of this Order, Respondent shall complete the Improving Inter-professional Communications offered by the Center for Personalized Education for Physicians ("CPEP"). 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 medical licensure.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

c. 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.

2. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s).

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 6th day of October, 2023.

ARIZONA MEDICAL BOARD

By [signature]
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 6th day of October, 2023 to:

Ronald A. Yunis, M.D.
Address of Record

Flynn P. Carey, Esq.
Mitchell Stein Carey Chapman, P.C.
2600 North Central Avenue, Suite 1000
Phoenix, Arizona 85004
Attorney for Respondent

ORIGINAL of the foregoing filed
this 6th day of October, 2023 with:

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

Michelle Robles

Board staff