

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

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

3 **RONALD A. YUNIS, M.D.**

**ORDER DENYING PETITION FOR
REHEARING OR REVIEW**

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

7
8 At its public meeting on December 8, 2023 the Arizona Medical Board ("Board")
9 considered Ronald A. Yunis, M.D.'s ("Respondent") Petition for Rehearing or Review of
10 the Board's Order dated October 6, 2023 in the above referenced matter. Board members
11 considered Respondent's Petition, as well as the oral arguments of his counsel present at
12 the meeting. Board members commented that at the Formal Interview was well discussed
13 and all materials submitted during the investigation were considered and weighed by the
14 Committee including the opinions of Respondent's expert witness. The Board recognized
15 that Respondent completed the continuing medical education course required by the
16 Order, but noted that this does not qualify as newly discovered material evidence since
17 Respondent did not complete the course until after the Committee issued the Order. The
18 Board agreed that the penalty imposed by the Committee was reasonable and designed to
19 address the conduct at issue in the case. After considering all of the evidence, the Board
20 voted unanimously to deny Respondent's Petition for Rehearing or Review.

21 **ORDER**

22 IT IS HEREBY ORDERED that:

23 Respondent's Petition for Rehearing or Review is denied. The Board's Findings of
24 Fact, Conclusions of Law and Order for Probation in Case MD-19-1001A and MD-20-
25 0925A is effective and constitutes the Board's final administrative order.

1 RIGHT TO APPEAL TO SUPERIOR COURT

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

6 DATED AND EFFECTIVE this 14th day of December, 2023.

7 ARIZONA MEDICAL BOARD

8
9
10 By Patricia E. McSorley
11 Patricia E. McSorley
Executive Director

12 EXECUTED COPY of the foregoing mailed
13 this 14th day of December, 2023 to:

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

16 Flynn P. Carey, Esq.
17 Mitchell Stein Carey Chapman, P.C.
18 2600 North Central Avenue, Suite 1000
Phoenix, Arizona 85004
Attorney for Respondent

19 ORIGINAL of the foregoing filed
20 this 14th day of December, 2023 with:

21 Arizona Medical Board
22 1740 West Adams, Suite 4000
Phoenix, Arizona 85007

23 Michelle Hobbes
24 Board staff

1 **BEFORE THE REVIEW COMMITTEE OF THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **RONALD A. YUNIS, M.D.**

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

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

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR
PROBATION**

6 The Review Committee of the Arizona Medical Board ("Board") considered this
7 matter at its public meeting on August 2, 2023. Ronald A. Yunis, M.D. ("Respondent"),
8 appeared with legal counsel, Flynn P. Carey, Esq., before the Review Committee for a
9 Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(P).
10 The Review Committee voted to issue Findings of Fact, Conclusions of Law and Order
11 after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of
14 the practice of allopathic medicine in the State of Arizona.

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

17 **MD-19-1001A**

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

22 4. Additionally, the Board received notification that Respondent's clinical
23 privileges had been summarily suspended at a Hospital during an investigation into
24 Respondent's professional conduct arising out of the firearm incident. The Hospital's
25

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

3 5. On October 6, 2021, Respondent pled guilty to one count of disorderly
4 conduct with a weapon or instrument, a class 6 undesignated felony, in the criminal matter
5 arising from the October 10, 2019, event. Respondent was sentenced to 2 years of
6 probation with terms and conditions including completion of counseling. On December 15,
7 2022, the Court issued an order discharging Respondent from probation and designating
8 the offense as a misdemeanor.

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

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

14 8. MR was a 39-year-old gravida 5 para 2 patient admitted at 42+ weeks'
15 gestation. MR labored with the benefit of an epidural and was complete at 0040.
16 Respondent applied a vacuum at 0056 with 2 pop-offs. Respondent then had MR rest and
17 she began pushing again at 0230. Respondent again attempted a vacuum delivery at
18 0244 with 3 pop-offs noted on the fetal tracing. Respondent then carried out an emergent
19 C-section due to lack of fetal descent.

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

25

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

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

16 12. GCU was a 23-year-old gravida 1 para 0 patient admitted for induction at
17 39+ weeks for intrauterine growth restriction/small for gestational age (9%). Respondent
18 had previously diagnosed GCU with Chlamydia and prescribed Azithromycin when she
19 established care at 36-37 weeks after receiving prior treatment in Mexico. Respondent
20 carried out an artificial rupture of membranes ("AROM") and then administered Pitocin and
21 introduced an intrauterine pressure catheter. Labor progressed and when late
22 decelerations were noted, the Pitocin was discontinued by the nursing staff who notified
23 Respondent. The decelerations subsequently resolved. An amnioinfusion was initiated
24 and Respondent evaluated the patient ten minutes later. The cervical examination
25 revealed an anterior lip was present though a prolonged deceleration was noted that

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

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

15 **Deviations from the Standard of Care**

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

22 15. The standard of care when a placenta accreta is identified is to deliver at 34-
23 36 weeks gestation in a stable patient after maximization of preoperative hemoglobin
24 levels. Respondent deviated from the standard of care for Patient CB by the inappropriate
25 performance of a uterine wedge resection outside of accreta policy guidelines.

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

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

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

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

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

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

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

25

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

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

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

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

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

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

1 Review Committee members noted that the standard of care deviations identified in MD-
2 19-1001A were consistent with the Hospital's quality of care review. Review Committee
3 members agreed that the firearm incident supported a violation of both A.R.S. §§ 32-
4 1401(27)(d) and (r).

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

12 **CONCLUSIONS OF LAW**

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

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

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

23 4. The conduct and circumstances described in MD-19-1001A and MD-20-
24 0925A above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r)

1 (“Committing any conduct or practice that is or might be harmful or dangerous to the health
2 of the patient or the public.”).

3 **ORDER**

4 IT IS HEREBY ORDERED THAT:

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

7 **a. Continuing Medical Education**

8 Within six months of the effective date of this Order, Respondent shall complete the
9 Improving Inter-professional Communications offered by the Center for Personalized
10 Education for Physicians (“CPEP”). Upon completion of the CME, Respondent shall
11 provide Board staff with satisfactory proof of attendance. The CME hours shall be in
12 addition to the hours required for the biennial renewal of medical licensure.

13 **b. Obey All Laws**

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

17 **c. Probation Termination**

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

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

3 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

4 Respondent is hereby notified that he has the right to petition for a rehearing or
5 review. The petition for rehearing or review must be filed with the Board's Executive
6 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
7 petition for rehearing or review must set forth legally sufficient reasons for granting a
8 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after
9 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
10 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

11 Respondent is further notified that the filing of a motion for rehearing or review is
12 required to preserve any rights of appeal to the Superior Court.

13 DATED AND EFFECTIVE this 6th day of October, 2023.

14
15 ARIZONA MEDICAL BOARD

16 By Pat E. McSorley
17 Patricia E. McSorley
18 Executive Director
19
20
21
22
23
24
25

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

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

5 Flynn P. Carey, Esq.
6 Mitchell Stein Carey Chapman, P.C.
7 2600 North Central Avenue, Suite 1000
8 Phoenix, Arizona 85004
9 Attorney for Respondent

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

12 Arizona Medical Board
13 1740 West Adams, Suite 4000
14 Phoenix, Arizona 85007

15 Michelle Prodes

16 Board staff
17
18
19
20
21
22
23
24
25