BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of	Case No. 24-62704-MDX
JOEL DWORKIN, M.D. Holder of License No. 62704 For the Practice of Allopathic Medicine In the State of Arizona	**ORDER DENYING REQUEST FOR REHEARING OR REVIEW**

At its public meeting on November 6, 2024, the Arizona Medical Board ("Board") considered JOEL DWORKIN, M.D.'s ("Respondent") Request for Rehearing or Review of the Board's Order dated September 5, 2024, in the above referenced matter. The State was represented by Assistant Attorney General Elizabeth Campbell and Respondent was represented by Melissa Cuddington. The Board had available Assistant Attorney General Lynette Evans for independent legal advice. After considering all of the arguments, 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 September 5, 2024 Findings of Fact, Conclusions of Law and Order for JOEL DWORKIN, M.D. in Case 24-62704-MDX 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 18th day of November, 2024.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed and emailed
this 18th day of November, 2024 to:

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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **Joel Dworkin, M.D.** Holder of License No. 62704 For the Practice of Allopathic Medicine In the State of Arizona. Respondent.	Case No. 24A-62704-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER**

On September 4, 2024, this matter came before the Arizona Medical Board ("Board") for consideration of the Administrative Law Judge's ("ALJ") proposed Findings of Fact, Conclusions of Law and Recommended Order with regarding to Joel Dworkin, M.D., ("Respondent").

The Board, having considered the ALJ's Decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. On April 9, 2024, the Board issued a Complaint and Notice of Hearing setting the above-entitled matter for hearing at 9:00 a.m. on May 23, 2024.[1]

2. Through the Complaint the Board alleges that Respondent committed unprofessional conduct.

3. The Board presented the testimony of Lindsay Baysinger, a credentialing & privileging manager for the Southern Arizona VA Healthcare System (Southern Arizona VA), Kathleen M. Coffer, the Board's medical consultant, and Erinn Downey, the Board's physician health program (PHP) manager. Respondent testified on behalf of

[1] The matter did not conclude on May 23, 2024 and a further hearing was set for May 31, 2024.

himself and presented the testimony of Dr. Lehel Batizy, Dr. Kiyan Rad, and Lupita Cortez-Hoey, RN.[2]

4. In December of 2020, Respondent applied for an Arizona medical license.[3] At the time, Respondent was a licensed physician in the State of Arkansas.[4]

5. Respondent disclosed in the Arizona application that he had undergone an evaluation at the request of the Arkansas Medical Board.[5] Respondent disclosed that in May 2020, he had shared details of his novel manuscript with the adult granddaughter of a patient,[6] which resulted in the family complaining to the hospital and Respondent being referred for an evaluation with Acumen Assessments by the Arkansas State Medical Board.[7]

6. The evaluation identified Respondent's sharing his personal writing with sexual content with the patient's granddaughter as a boundary transgression.[8] During the evaluation, Respondent had shared a nude photograph of him and his brother, which the evaluators cited as an example of conduct that was contextually inappropriate and demonstrated poor judgment.[9] The evaluation determined that Respondent was fit to practice medicine provided that he follow recommendations, including having an external system of accountability to ensure that he is held to professionalism and boundary maintenance standards.[10]

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[2] The Administrative Law Judge has read and considered each page of each admitted exhibit, even if not mentioned in this Decision. The Administrative Law Judge has also considered the testimony of every witness, even if the witness is not specifically mentioned in this Decision.
[3] *See* Board's Exhibit 1; Hearing Transcript (TR) Vol. I (Public) at 31.
[4] *See* id.
[5] *See* Board's Exhibit 2 at MED-009.
[6] The manuscript contained scenes of an explicit sexual nature. (TR Vol. II at 291.)
[7] *See* Board's Exhibit 2 at MED-008 to 009.
[8] *See* Board's Exhibit 4 at MED-033.
[9] *See* Board's Exhibit 4 at MED-033; The evaluators noted that despite Respondent's "best intentions, he still can't stop himself from making a bad call." (*See* Board's Exhibit 4 at MED-033.)
[10] *See* Board's Exhibit 4 at MED-034 to 035.

7. On or about December 2, 2020, Respondent entered into an agreement with the Arkansas Medical Foundation (AMF) based upon the recommendations of Acumen Assessments.[11]

8. The AMF's monitoring program was "designed to monitor and verify that [Respondent] is rehabilitated and/or the impairment is no longer interfering with safety to practice.[12] The AMF Agreement required that Respondent have a worksite monitor with reports sent to the AMF.[13]

9. Under the AMF Agreement, an initial contact report was to be followed by monthly reports for one year and then quarterly reports.[14] The AMF Agreement was effective December 2, 2020.[15]

10. In the written statement provided with his Arizona application, Respondent assured the Board that he would adhere to the evaluation's recommendations and that he would remain in full compliance with the AMF Agreement.[16]

11. On July 14, 2022, Respondent entered into a Stipulated Health Agreement (SHA) with the Arizona Board as a condition for obtaining Arizona licensure.[17] The SHA provided, in relevant part, as follows:[18]

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> This SHA is effective on its acceptance by the Executive Director and [Respondent] as evidenced by their respective signatures thereto. The effective date of this SHA is the date it is signed by the Executive Director, after signature by the Applicant, provided that the Board approves [Respondent's] application for licensure currently pending Board review. While this SHA is not a disciplinary action, [Respondent] acknowledges that any violation of the SHA constitutes

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[11] *See* Board's Exhibit 3.
[12] *See* Board's Exhibit 2 at MED-011.
[13] *See* Board's Exhibit 3.
[14] *See* Board's Exhibit 3 at MED-012.
[15] *See* Board's Exhibit 3 at MED-011.
[16] *See* Board's Exhibit at MED009.
[17] *See* Board's Exhibit 5.
[18] *See* id.

> unprofessional conduct as defined in A.R.S. § 32-1401(27)(s), and may result in disciplinary action pursuant to A.R.S. § 32-1451.
> ……

12. The Board issued a medical license to Respondent.

13. On February 16, 2021, Respondent started work at the Southern Arizona VA.[19] While employed by the Southern Arizona VA, Respondent engaged in repeated instances of inappropriate and unprofessional conduct.

14. On April 20, 2021, Respondent received a Clarification of Supervisory Expectations Memorandum.[20] Respondent received the Clarification of Supervisory Expectations Memorandum after a female medical resident complained that he had invited her to his house to see his plant collection.[21] The Clarification of Supervisory Expectations Memorandum instructed Respondent that he was to "display professional behavior at all times towards all staff" and that he was to "avoid inappropriate conversations."[22]

15. On August 8, 2022, Respondent received a Notice of Written Counseling after sharing "artistic nude" pictures of himself and his brother with other members of hospital staff on June 16, 2022.[23] Respondent had shared the same nude picture that the Acumen Assessment had cited as an example of poor judgement when he showed the picture during the evaluation.[24] The Notice of Written Counseling informed Respondent that his behavior was inappropriate and unprofessional conduct in a work setting.[25]

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[19] *See* TR Vol. 1 at 45.
[20] *See* Board's Exhibit 12 at MED-100 to 101.
[21] *See* Board's Exhibit 7 at MED-054. At hearing, Respondent initially claimed not to remember what event initiated the April 20, 2021, Clarification of Supervisory Expectations Memorandum, but subsequently claimed that he had invited a group of people, both male and female. (TR Vol. 1 at 46.)
[22] *See* Board's Exhibit 12 at MED-100.
[23] *See* Board's Exhibit 12 at MED-098.
[24] *See* TR at 47- 48.
[25] *See* Board's Exhibit 12 at MED-098.

16. On December 8, 2022, a female resident submitted a complaint against Respondent.[26] The resident complained that Respondent made multiple comments and jokes of a sexual nature and read her love scenes from his manuscript.[27] Respondent acknowledged making the comments and jokes, but denied sharing explicit love scenes from his manuscript.[28]

17. Following completion of the Southern VA's investigation, the Southern VA's Professional Standard Board recommended that Respondent be separated from the Southern VA. The Professional Standard Board determined:[29]

> [Respondent] demonstrated unprofessional behavior on multiple occasions while performing official duties. This included sharing of nude pictures with administrative staff in credentialing office, reading inappropriate manuscript to a medical resident in a closed room, and telling inappropriate jokes. He was issued a Letter of Expectations in April 2021 and a Written Counseling in August 2022 for similar misconduct during his 2 years of service at this facility. The PSB did not see him learning from his mistakes and taking corrective actions to improve his conduct. His behavior and actions do not create a culture of safety as expected and listed on page 12 of the Facility Medical Staff Bylaws & Rules and Regulations. Behavior or behaviors that undermine a culture of safety can interfere with patient care.

18. Effective February 15, 2023, Respondent was separated from the VA.[30]

19. In an April 4, 2023 text message to Gateway Recovery Institute (Gateway), the Board's monitoring contractor, Respondent claimed that he was monitored throughout his tenure with the VA.[31] However, Respondent was not monitored as required by the AMF Agreement and the Board's SHA.

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[26] *See* Board's Exhibit 12 at MED-091 to -092; TR at 50, 52.
[27] *See* the Board's Exhibit 12 at MED-091.
[28] *See* Board's Exhibit 12 at MED-196 to -197; TR at 57-59.
[29] *See* the Board's Exhibit 12 at MED-075.
[30] *See* the Board's Exhibit 12 at 205-206.
[31] *See* the Board's Exhibit 17.

20. Respondent acknowledged at hearing that he did not have an initial contact report as required by the AMF Agreement.[32] Respondent also failed to have worksite monitor reports sent monthly for the first year and quarterly thereafter as required by the AMF Agreement.[33]

21. Respondent claims that Dr. Lehel Batizy was his worksite monitor from February 2021 through August 2022.[34] Approximately two months after Respondent started work at the VA, Dr. Batizy submitted a first report dated April 7, 2021, on an AMF Worksite Monitor Report form.[35]

22. Dr. Batizy testified at hearing that he issued the first worksite monitor report immediately after Respondent approached him about being the worksite monitor.[36]

23. Dr. Batizy testified that Respondent gave him a blank worksite monitor report form, telling Dr. Batizy that he needed to fill it out as the direct supervisor.[37] However, Dr. Batizy testified that he never asked for or received a copy of the AMF Agreement and never asked Respondent why he was being monitored.[38] Dr. Batizy initially testified on direct that Dr. Dworkin had provided him with a copy of a monitoring agreement at the start of Dr. Dworkin's employment with the VA.[39] However, on cross, Dr. Batizy admitted that he had never received a copy of the AMF Agreement and did not even know why Respondent was being monitored.[40]

24. Respondent and Dr. Batizy acknowledged that no worksite monitor reports were sent to the AMF for some period of time.[41] On April 7, 2022, Dr. Batizy sent an

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[32] *See* TR Vol. 1 at 63.
[33] *See* Board's Exhibit 3 at MED-012.
[34] *See* Board's Exhibit 18 at MED-243; TR Vol. 1 at 63, 72-73.
[35] *See* Board's Exhibit 8.
[36] *See* TR Vol. II at 247.
[37] (TR Vol. II at 253-254.)
[38] *See* TR Vol. II at 252, 255.
[39] *See* TR Vol. II at 225-226.
[40] *See* TR Vol. IInot at 252, 255.
[41] *See* TR Vol. II at 257, 310.

email to the AMF stating he had "no concerns" about Respondent's employment.[42] However, Dr. Batizy testified that the April 7, 2022, email was a reference letter and not a worksite monitor report.[43] Although Respondent would subsequently claim to the AMF that Dr. Batizy was "intimately familiar with my activities and actions"[44] Dr. Batizy's April 7, 2022, email contains no mention of the April 20, 2021, Clarification of Supervisory Expectations Memorandum.[45] Dr. Batizy testified that he was unaware of the April 20, 2021, Clarifications of Supervisory Expectations Memorandum issued to Respondent and he did not recall receiving any complaints about Respondent.[46]

25. Mr. Batizy testified that he stopped sending worksite monitoring reports for Respondent because Dr. Batizy's immediate supervisor (Dr. Won Han) informed him that the worksite monitor reports should be handled by the Privileging and Credentialing Department and not by him.[47]

26. On April 24, 2022, Respondent provided the VA's Privileging and Credentialing Department with a copy of the AMF Agreement for the first time.[48] Ms. Baysinger testified that once she received the AMF Agreement from Respondent, she began following up on what was necessary for the VA to perform the monitoring – requesting information about why Respondent was under monitoring and what the AMF was wanting the VA to monitor and obtaining release forms.[49] Ms. Baysinger testified that, when a VA physician is under a monitoring contract, the Chief of Staff (Dr. John

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[42] *See* Board's Exhibit 9.
[43] *See* TR Vol. II at 259.
[44] *See* Respondent's Exhibit 18 at MED-061.
[45] *See* TR Vol. II at 239, 262.
[46] *See* TR Vol. II at 234, 263.
[47] *See* TR Vol. II at 234, 263.
[48] *See* Respondent's Exhibit 20, Board's Exhibit 11 at MED-067; TR Vol. 1 at 97.
[49] *See* TR Vol. 1 at 102-103.

Kettelle) is informed and the Chief of Staff with the advice and recommendation of the Medicine Service Chief (Dr. Raymond Kacich) assigns the physician monitor.[50]

27. Ms. Baysinger testified that Dr. Batizy was never assigned as Respondent's worksite monitor through the VA's process.[51] Although Respondent was employed at the VA when the Arizona SHA became effective on July 14, 2022, he failed to immediately provide a copy of the SHA to the VA, as required by the SHA.[52] In addition, under the SHA, Respondent was required to immediately notify Board staff if he was non-compliant with any aspect of monitoring.[53] Respondent was being monitored for boundary issues,[54] but he did not notify the Board of the Written Counseling he received on August 8, 2022 in connection with sharing the nude photo with VA staff.[55] Unaware of the Arizona SHA, Ms. Baysinger assisted in preparing and sending the VA's August 23, 2022, worksite monitor report to the AMF.[56] The August 23, 2022, worksite monitor report included descriptions of the April 20, 2021 Clarification of Supervisory Expectations Memorandum and the August 4, 2022 Notice of Written Counseling.[57] Ms. Baysinger testified that she learned from the AMF (and not from Respondent) that they were no longer monitoring Respondent only after the VA sent the August 23, 2022, worksite monitor report.[58]

28. On September 27, 2022, Respondent informed the VA that his monitoring program was being transferred from the AMF to Arizona. On October 10, 2022, Respondent had still not established worksite monitoring under the SHA at the VA.[59] As

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[50] *See* TR Vol. 1 at 101-102.
[51] *See* TR Vol. 1 at 125, 130-131.
[52] *See* Board's Exhibit 5 at MED-044, ¶4; Board's Exhibit 11 at MED-067; TR at 114-115.
[53] *See* Board's Exhibit 5 at MED-041, ¶1.
[54] *See* Board's Exhibits 3, 4, and 5; TR Vol. 1 at 49.
[55] *See* Board's Exhibit 12 at MED-098, TR Vol. 1 at 49.
[56] *See* Board's Exhibit 6 at MED051, Board's Exhibit 11; TR Vol. 1 at 107-108.
[57] *See* Board's Exhibit 6 at MED-051.
[58] *See* Board's Exhibit 11 at MED-067; TR Vol. 1 at 112.
[59] *See* Respondent's Exhibit 19.

of December 9, 2022, Respondent knew that he was under investigation by the VA based upon the complaint made by the resident.[60] However, he did not notify the Board of the resident's December 2022 complaint and the VA's ongoing investigation.[61] Ms. Baysinger testified that the VA did not receive a copy of the SHA until December 27, 2022.[62] On March 6, 2023, Ms. Baysinger sent a last worksite monitor report for Respondent to Gateway.[63] The March 2023 worksite monitor report stated that "[D]espite repeated counseling related to prior events . . . Respondent repeatedly made inappropriate remarks with a female trainee."[64] The Southern VA reported that Respondent had been terminated on February 15, 2023.[65]

29. Under the SHA, Respondent was required to immediately provide a copy of the SHA to his employer and provide a signed statement of compliance from his employer.[66]

30. On March 17, 2023, Gateway contacted Respondent by email stating that, per his text message, March 17 was supposed to be his first day with his new employer.[67]

31. On March 20, 2023, Respondent stated that he had accepted employment with Arizona Physician Group, but had not yet started seeing patients.[68] On March 28, 2023, Respondent copied Gateway on his email to Dr. Kiyan Rad at Arizona Physician Group attaching a copy of his unsigned SHA.[69] On March 29, 2023, Respondent sent Gateway and email providing contact information for his new employer, informing Gateway that Dr. Rad would be his worksite monitor, and reporting that his start date had

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[60] *See* Board's Exhibit 12 at MED084; TR Vol. 1 at 53.
[61] *See* TR Vol. 1 at 53-54.
[62] *See* Board's Exhibit 11 at MED-067, TR Vol. 1 at 114-115.
[63] *See* Board's Exhibit 7 at MED-055 to -056; TR at 116.
[64] *See* Board's Exhibit 12 at MED-056.
[65] *See* id.
[66] *See* Board's Exhibit 5 at MED-044, ¶4.
[67] *See* Board's Exhibit 13 at MED-211.
[68] *See* Board's Exhibit 13 at MED-211.
[69] *See* Board's Exhibit 14.

been March 22, 2023.[70] On April 5, 2023, Dr. Rad notified Gateway that he was aware of the SHA agreement and was monitoring Respondent.[71]

32. Respondent and Dr. Coffer both agreed that it is the standard of practice for physicians to conduct themselves in a professional manner while at work and maintain appropriate boundaries with patients and other members of the healthcare team.[72] Dr. Coffer testified that when Respondent shared nude photographs of himself and his brother with other hospital staff on June 16, 2022,[73] he deviated from the standard of practice.[74] Dr. Coffer testified that Dr. Dworkin's conduct had the potential to make staff feel uncomfortable.[75] Dr. Coffer testified that hospital staff needs to have a safe environment to communicate about patients and patient situations.[76] Dr. Coffer also testified that Respondent making comments and jokes of a sexual nature and sharing excerpts from his manuscript, including love scenes, with the resident deviated from the standard of practice.[77] Dr. Coffer testified that his behavior and had the potential to impact patient care because the resident may be less able to function in her patient care role.[78] She testified that the resident may have been less comfortable reporting patient issues to Dr. Dworkin, obtaining answers to medical questions from him, and may have potentially avoided him because of her discomfort.[79] Dr. Coffer agreed with the following statements from the VA's Code of Conduct: (1) that the manner in which practitioners interact with other can significantly impact patient care, and (2) that behaviors such as foul language; rude, loud or offensive comments; and intimidation of

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[70] *See* Board's Exhibit 15 at MED-230.
[71] *See* Board's Exhibit 16 at MED-233.
[72] *See* TR Vol. 1 at 40 and 137.
[73] *See* Board's Exhibit 12 at MED098.
[74] *See* TR at Vol. 1 147, 158-159.
[75] *See* TR at Vol. 1 148-149.
[76] *See* TR Vol. 1 at 149.
[77] *See* TR Vol. 1 at 150-152.
[78] *See* id.
[79] *See* TR Vol. 1 at 150-151.

staff, patients and family members are commonly recognized as detrimental to patient care.[80]

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in this case under Arizona Revised Statutes (A.R.S.) § 32-3202.

2. Pursuant to A.R.S. § 41-1092.07(G)(2) and A.A.C. R2-19-119(B), the Board has the burden of proof in this matter. The standard of proof is by clear and convincing evidence. A.R.S. § 32-1451.04.

3. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct, in violation of 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), by failing to failing to provide an initial contact report followed by monthly reports for one year to the AMF, as required under the AMF agreement. The evidence presented at hearing shows that no more than two worksite monitoring reports were submitted to the AMF.

4. The Board established by clear and convincing evidence, as set forth previously in findings of fact 27 and 28, that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(r)(Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public) and A.R.S. § 32-1401(27)(s) (Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter.)

5. The Board established by clear and convincing evidence, as set forth previously in findings of fact 14, 19, and 22-28, that Respondent engaged in unprofessional conduct, by sending a text on April 4, 2023, that "I was monitored throughout my tenure at the VA", which is a violation of A.R.S. § 32-1401(27)(kk)

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[80] *See* Board's Exhibit 12 at MED-122, TR Vol. 1 at 154.

(Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board).

6. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct, by failing to comply with the SHA in connection with his employment by Arizona Physician Group, which is a violation of 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) and A.R.S. § 32-1401(27)(s) (Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter.)

7. As set forth previously in finding of fact 32, the Board established by clear and convincing evidence that Respondent engaged in conduct might be harmful or dangerous to the health of patient or the public because hospital staff needs to have a safe environment to communicate about patients and patient situations and his conduct may have made the resident less able to function in her patient care role, which is a violation of A.R.S. § 32-1401(27)(r).

8. Because Respondent has committed acts of unprofessional conduct, the Board has authority to discipline his license. A.R.S. § 32-1451(M).

9. The Board has established by clear and convincing evidence that Respondent repeatedly engaged in inappropriate behavior in connection with the practice of medicine and that, even when he was on notice that sharing his manuscript and photo were an issue, he repeated the conduct. Respondent has consistently failed to comply with the AMF Agreement and the Board's SHA intended to address his boundary issues. In the April 4, 2023 text, Respondent was not candid regarding his worksite monitoring.

ORDER

IT IS ORDERED that on the effective date of the final order in this matter, Respondent's License No. 62704 for the practice of allopathic medicine in the State of Arizona is revoked.

IT IS FURTHER ORDERED that, pursuant to A.R.S. § 32-1451(M), Respondent be charged $3,658.83 for the cost of the formal hearing. Respondent shall pay the Board $3,658.83 by certified funds within 90 days of the effective date of this Order.

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 this 5th day of September, 2024.

THE ARIZONA MEDICAL BOARD

By Patricia E. McSorley

Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this 5th day of September, 2024 with:

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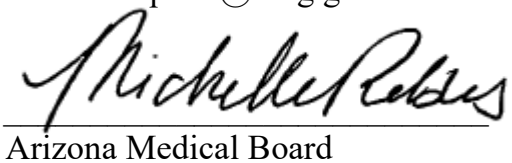
By: 
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