STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Geoffrey S. Ames, MD
Master Case No.: M2014-525
Document: Amended Statement of Charges

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

> Customer Service Center
> P.O. Box 47865
> Olympia, WA 98504-7865
> Phone: (360) 236-4700
> Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

FILED
JUL 01 2016
Adjudicative Clerk Office

In the Matter of the License to Practice as a Physician and Surgeon of: **GEOFFREY S. AMES, MD** License No. MD00026961 Respondent.	**No. M2014-525** **CORRECTED AMENDED STATEMENT OF CHARGES**

The Executive Director of the Medical Quality Assurance Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in file number 2013-1540 and file number 2014-10671. The patients referred to in this Corrected Amended Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On December 27, 1989, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

PATIENT A

1.2 In the summer or early fall of 2009, a psychiatric nurse practitioner referred Patient A to Respondent for the management of specific medical issues. At the time of referral, Patient A was a 44-year-old married female, with a history that included depression, anxiety, panic, insomnia, and substance abuse, and the patient had requested a medical provider who specialized in a natural approach to her physical symptoms. Respondent did not provide the Commission with a copy of Patient A's medical chart as requested, so the details of Respondent's care for Patient A are largely unknown. Other sources establish that Respondent ordered laboratory studies, prescribed medications, and developed a personal and intimate relationship with Patient A.

Boundary Violations and Sexual Misconduct

1.3 During the course of Patient A's office visits with Respondent, Patient A discussed her marital problems. Respondent revealed to Patient A that he had similar

problems in his marriage. Respondent and Patient A began to develop a romantic relationship. Patient A told her psychiatric nurse practitioner that Respondent "swept me off my feet."

1.4 Beginning sometime in 2010, and ending in early 2012, Respondent engaged in a romantic and sexual relationship with Patient A. In order to accommodate a romantic and sexual relationship, Respondent sent a discharge letter to Patient A, dated December 9, 2010. Respondent ostensibly referred Patient A to another provider (who had already been providing medical care for Patient A), in an apparent transfer of Respondent's role in Patient A's medical care. However, the sexual misconduct rules and longstanding ethical principles prohibit a physician from discharging a vulnerable patient who has confided personal information, for the purpose of beginning or continuing a romantic and sexual relationship.

1.5 While Respondent did not see Patient A in his office between December 2010 and the end of the romantic relationship in early 2012, Respondent remained significantly involved in Patient A's medical care. For example, during the portion of the romantic relationship that occurred after the discharge letter, Respondent prescribed for Patient A, interacted with Patient A's other medical providers, ordered and directed the ordering of lab work, and even examined Patient A.

1.6 Respondent also violated appropriate physician-patient boundaries by developing other, potentially conflicting, relationships with Patient A. While also treating her as a patient, Respondent employed Patient A and made business plans with Patient A. Respondent was, at times, simultaneously Patient A's physician, employer, prospective business partner, and romantic and sexual partner. Respondent's business relationships with Patient A contaminated or complicated the doctor-patient relationship by placing Patient A in a position that linked her financially to Respondent.

1.7 After the romantic relationship ended, Respondent began providing medical care for Patient A in his office again in the fall of 2012. Despite the discharge letter, Respondent remained Patient A's physician, in some capacity, from 2009 until Patient A's death in January 2013, and during the entirety of their romantic relationship.

Other Substandard Care

1.8 Respondent failed to appropriately treat Patient A's depression and anxiety, and impeded her opportunity to receive appropriate psychiatric care.

Respondent's affair with Patient A, a psychiatrically and emotionally unstable patient, likely caused further damage to her troubled marriage and child custody issues and exacerbated her psychiatric issues. After Respondent separated from his wife he expressed a desire that Patient A separate from her husband. In March of 2011, Patient A acknowledged to her husband that she was having an affair with Respondent, and asked her husband for a divorce. After the romantic relationship with Respondent concluded, Patient A unsuccessfully sought to save her marriage and restore her family. Rather than helping this vulnerable and troubled patient, Respondent caused further damage to Patient A's already troubled marriage. Respondent's pursuit of his own personal interests regarding Patient A caused her unreasonable harm.

1.9 Respondent failed to coordinate care with other providers who were providing contemporaneous or continuing care for Patient A.

1.10 Though Respondent had been prescribing psychotropic medications and acting as her de facto mental health provider, Respondent failed to respond with appropriate urgency to a psychiatric crisis that Patient A communicated to Respondent. On January 10, 2013, Patient A sent a text message to Respondent indicating that she was experiencing "acute depression," and that she was "So tired of this ride." In his reply later that day, Respondent asked: "Are you less depressed now?" Patient A's response was: "No, still very depressed. Not sure what the [g]enesis of this one is." At 11:25 a.m., the following morning, January 11, 2013, Patient A texted Respondent the following: "Hi Naten, heal all those waiting to see you. Nef." Respondent and Patient A used the pet names Naten and Nef in some of their communications. Respondent was obligated to respond more actively, to clinically intervene and obtain appropriate and safe treatment options for Patient A. Later that afternoon, Patient A fatally shot herself in the chest while sitting in her parked car.

1.11 Respondent failed to maintain and secure medical records for Patient A, a patient experiencing severe psychological issues and risk factors, and a patient with whom Respondent had a romantic relationship.

Failure to Cooperate/Failure to Maintain a Patient Record

1.12 In a letter dated June 11, 2013, the Commission investigator requested that Respondent send a complete copy of his office record for Patient A within 14 days. Respondent failed to provide a copy of his medical record for Patient A.

1.13 In a letter dated July 18, 2013, the Commission investigator requested that Respondent provide a response to the complaint in this case. The investigator provided Respondent with citations to the Commission's legal authority, including the requirement under RCW 18.130.180(8) that Respondent provide the Commission with a complete explanation covering the matter under investigation. Having asked Respondent to respond concerning his relationship with Patient A, the investigator specifically requested that Respondent address his "medical treatment of [Patient A] to include beginning and ending dates of treatment, diagnosis, and treatment rationale." The investigator also requested a copy of Patient A's chart, in the event that Respondent had located the chart. Respondent failed to provide a copy of Patient A's chart as requested, and failed to provide a complete explanation addressing the complaint as sought by the Commission's investigator.

Interference With Investigation By Misrepresentation

1.14 On June 23, 2013, Respondent wrote to the Department of Health and the Commission investigator. In this letter, Respondent asserted that he did not have sex with Patient A, and that she was his "friend and employee only." Respondent's express denial of a sexual relationship with Patient A, and his assertion to the Commission, during the course of the investigation, that Patient A was his "friend and employee only," were willful misrepresentations.

PATIENT B

Substandard Care

1.15 *Improper diagnosis of hypothyroidism.* Patient B began treating with Respondent in August of 2013. Respondent diagnosed her with hypothyroidism, despite having normal thyroid laboratory studies (T4 and T3) and negative thyroid antibodies. He then treated her for hypothyroidism, a condition that she did not have.

1.16 Hypothyroidism is diagnosed (for patients without a pituitary issue) with symptoms and a thyroid stimulating hormone (TSH) above the reference range. There is no record of Respondent having ordered a TSH, nor clear documentation from his visit of the signs and symptoms consistent with hypothyroidism.

1.17 *Improper dosing of thyroid medication.* Respondent's unnecessary treatment, due to his misdiagnosis, caused significant harm to Patient B. Respondent's

dosing of thyroid medication for Patient B demonstrates his lack of understanding of proper dosing of thyroid medication. Levothyroxine is one of the most commonly prescribed medications in the United States, and Respondent notes on his website that four of his ten patients have hypothyroidism. Despite this, his prescribing of thyroid medications shows he lacks a basic grasp of its pharmacology and half-life elimination: Euthyroid 6 to 8 days; Hypothyroid: 9 to 10 days. Despite this, Respondent treated Patient B with dosing of levothyroxine as frequently as three times daily. He also used liothyronine – again, without evidence of hypothyroidism – at a dosing interval of up to five times daily.

1.18 *Excessively frequent and unguided adjustments.* Respondent frequently adjusted thyroid medication more frequently than is clinically indicated. In addition, his notes reflect changes in thyroid medication without any reference to labs – and, in assessment and plans, he does not give any description of the symptoms, signs, or laboratory values guiding his clinic decisions. The dosing frequency and lack of clear guidance to explain the decisions for this dosing fall below the standard of care.

1.19 *Unresponsiveness to laboratory studies showing iatrogenic hyperthyroidism.* On February 4th, 2014, Respondent ordered laboratory studies that revealed a TSH of 0.015. This indicates significant over replacement. A TSH suppressed to that level is clearly associated with increased risk of palpitations, arrhythmias, anxiety, and a litany of other adverse clinical symptoms and signs. Respondent's records show no evidence that this abnormal laboratory value was assessed and/or acted upon.

1.20 *Excessive iatrogenic hyperthyroidism leading to ER visit and hospitalization.* On March 20, 2014, Patient B presented to the emergency room with a "fluttering" heartbeat. She had palpitations, lightheadedness, dizziness, fatigue and near-syncope. As a result of this presentation, the patient incurred the cost and imaging exposure of an MRI and a CT scan. She had laboratory studies that showed a TSH < 0.01, highly suppressed, and an elevated free T4 of 2.0. These both demonstrate very significant iatrogenic hyperthyroidism. The following day, on March 21, 2014, cardiology notes noted the palpitations and chest pain, and they diagnosed iatrogenic thyroid toxicity and recommended to cut all thyroid doses in half. Her workup continued to include an exercise treadmill test and an echocardiogram. Her visit with Dr. Zuroske,

cardiology, on March 31, 2014, noted that she had iatrogenic thyroid toxicity. On April 8, 2014, however, the notes from Respondent suggested that he wished her to return to the same toxic thyroid doses.

1.21 Had the laboratory study of February 4, 2014, been recognized and acted upon, and Patient B's thyroid medication dose significantly reduced, she would not have had the cardiac symptoms that brought her to the emergency room on March 20, 2014, nor would she have had the ensuing hospital admission from that visit.

1.22 Respondent's prescribing of excessive doses of thyroid medication, despite laboratory evidence of significant iatrogenic hyperthyroidism, led to the harm of the hospitalization of March 20-21, 2014, the extensive neuroimaging, and cardiac testing. He put her at risk of harm for atrial fibrillation and other adverse cardiac and neuropsychological effects from iatrogenic hyperthyroidism. Despite this sentinel event of a cardiac admission for iatrogenic hyperthyroidism, he promptly re-escalated her thyroid medication doses in April of 2014.

1.23 *Documentation of risks/benefits/alternatives.* Respondent's records demonstrate a pattern of very poor documentation of medical decision-making. The visits do not include assessments, and the plans are very skeletal – it is very hard to garner the clinical decision-making, the interpretation of symptoms, signs, and objective data, or the inclusion of the patient in the proposed benefits, risks, and alternatives of the treatments offered.

1.24 An independent medical examination of Patient B for short and long term disability and to determine medical necessity of treatment on December 14, 2014, also raised concerns regarding Respondent's negligent and incompetent practice in his treatment of Patient B. The report documented Patient B's normal thyroid function and Respondent's misdiagnosis of hypothyroidism and improper treatment with escalating doses of hormone supplementation which caused palpitations requiring treatment through the hospital emergency department in March of 2014.

Failure to Cooperate

1.25 In a letter dated December 14, 2015, the Commission investigator requested that within 14 days, Respondent send a complete copy of his charts for five additional named patients for whom he had prescribed thyroid medication. Respondent failed to provide a copy of the requested charts.

1.26 On January 4, 2016, the Commission investigator followed up with a final request for records within three days. Respondent failed to provide a copy of the requested charts.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (4), (7), (8)(a) and (b), (22), and (24); and WAC 246-919-630(2)(a) and (d) and (3), which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
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> ...
>
> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
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> ...
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> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
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> ...
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> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
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> ...
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> (8) Failure to cooperate with the disciplining authority by:
> (a) Not furnishing any papers or documents;
> (b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;
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> ...
>
> (22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or

any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

...

(24) Abuse of a client or patient or sexual contact with a client or patient;

... .

WAC 246-919-630 Sexual misconduct.

...

(2) A physician shall not engage in sexual misconduct with a current patient or a key third party. A physician engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party:

(a) Sexual intercourse or genital to genital contact; and

(d) Kissing in a romantic or sexual manner;

(3) A physician shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the physician:

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.

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2.2 The above violation provides grounds for imposing sanctions under RCW 18.130.160.

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3. NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: June 30, 2016.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

MELANIE DE LEON
EXECUTIVE DIRECTOR

KRISTIN G. BREWER, WSBA # 38494
ASSISTANT ATTORNEY GENERAL

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named below. RCW 42.56.240(1)

Patient A

Patient B

[redacted]