STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Geoffrey A. Ankeney, MD
Master Case No.: M2023-63
Document: 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:

> Investigative, law enforcement, and crime victim information is exempt from public inspection and copying pursuant to RCW 42.56.240(1).

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
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **GEOFFREY A. ANKENEY, MD** License No. MD.MD.60048348 Respondent.	**No. M2023-63** **STATEMENT OF CHARGES**

The Executive Director of the Washington Medical Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in Commission file number 2022-7116. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On November 10, 2008, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is board certified in family medicine and practices as a primary care provider.

1.2 In or around July of 2020, Respondent signed a contract with a licensed marriage counselor and family therapist, "Dr. S," wherein Respondent agreed to prescribe and administer transcranial magnetic stimulation (TMS)[1] to Dr. S's patients and to perform medical oversight of the Dr. S's TMS program. Respondent began providing TMS services at Dr. S's office in December of 2020.

1.3 Respondent does not have a background in psychiatry and is not a psychiatrist. Respondent's CV does not reflect any specific experience or expertise in mental health treatment. The extent of Respondent's training in TMS therapy appears to be a three-day clinical training program provided by the company that supplies TMS devices.

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[1] TMS is a procedure that uses magnetic fields to stimulate areas of the brain to treat symptoms of major depression. TMS is a therapy option for patients with treatment-resistant depression.

Patients A through E

1.4 Patient A began TMS treatment in or around June of 2021 after an initial evaluation performed by Dr. S. According to Patient A, she was only treated by Dr. S and was never a patient of Respondent. Patient A was asked if she received any care whatsoever from Respondent and she replied "no, not unless he ever filled in for one of the operators without me being aware of it."

1.5 Patient B began TMS treatment in or around June of 2021 after an initial evaluation performed by Dr. S. According to Patient B, he did not recall any encounters with Respondent and did not receive any care from Respondent. Patient B did not recall Respondent being available for any follow-up care.

1.6 Patient C began TMS treatment in or around November of 2021. There is no record of an initial evaluation of Patient C. According to Patient C, he was not evaluated by Respondent and had no interactions with Respondent.

1.7 Patient D began TMS treatment in or around December of 2020 after an initial evaluation performed by Dr. S. According to Patient D, she had only a brief encounter with Respondent and Respondent did not personally observe any of the treatment sessions. Patient D also noted that Respondent did not provide any follow-up after Patient D's treatments concluded.

1.8 Patient E began TMS treatment in or around June of 2022. There is no record of an initial evaluation of Patient E. Patient E stated that she had a single encounter with Respondent and did not speak with him thereafter. She directed her questions about TMS therapy to the therapist.

1.9 Patient F began TMS treatment in or around January of 2022. There is no record of an initial evaluation of Patient F. Patient F stated that he had a single encounter with Respondent to determine the appropriate TMS settings for therapy. According to Patient F, that was the only time he encountered Respondent.

Inadequate Documentation

1.10 Respondent's documentation practices create an unreasonable risk of harm. Treatment records are incomplete and none of the patient records for Patients A through F document that Respondent evaluated the patient. The only time Respondent's name appears in the patient record is on insurance preauthorization forms.

1.11 In his statement to the Commission Dated October 11, 2022, Respondent claimed that he would have "a thorough discussion with the patient about the risks and benefits of the [TMS] procedure." However, there is no documentation showing that such a discussion occurred.

1.12 The TMS treatment consent form signed by Patients A through F does not mention Respondent. Instead, each form states that Dr. S conducts the informed consent discussion.

1.13 Patient Records for Patients A through F do not document that Respondent performed a review of the patient's health status, reviewed the patient's health records, or performed a physical examination of the patient. Patient Records for Patients A through F also do not document that Respondent assessed the medical safety and necessity of TMS for these patients or that Respondent assessed these patients for counterindications to TMS therapy.

Inadequate Patient Assessment, Monitoring, and Follow-Up

1.14 Respondent's failure to properly assess and monitor TMS patients created an unreasonable risk of harm. In his statement to the Commission dated October 11, 2022, Respondent claimed that he personally evaluated potential TMS patients to determine whether they were suitable candidates for TMS. None of the patient records show that Respondent personally evaluated patients A through F or deemed them medically appropriate and safe to proceed with TMS. According to Patients A, B, and C, they were never evaluated by Respondent. According to Patient F, he met only once with Respondent when Respondent determined the appropriate TMS settings for therapy.

1.15 Respondent claims that he performed the initial motor threshold determination for each patient.[2] However, the motor threshold determination forms do not document who performed the initial assessment and appear to be completed by at least three different individuals. Patients A, B, and C stated that they were not evaluated or treated by Respondent. Patient C noted that "a female doctor" conducted the exam to determine the appropriate TMS settings for therapy.

[2] During the initial motor threshold determination, the provider determines the proper TMS device settings and proper intensity of the magnetic stimulation.

1.16 Respondent claims that before initiating TMS, he confirmed with each patient that the patient had a primary care provider who was accessible for general medical care needs and medication management. Treatment records for Patients A through F do not identify the patient's primary care provider or otherwise indicate that the patient's primary care provider was available for medication management.

1.17 Respondent did not monitor Patients A through F during their treatment to assess the efficacy of TMS sessions, to adjust TMS treatments, or to make additional treatment recommendations. Similarly, Respondent did not follow-up with TMS patients after completion of TMS therapy to evaluate whether the therapy was successful.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4):

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
> …
> (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;
> … .

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

3. NOTICE TO RESPONDENT

The charges in this document affect the public health and safety. 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.

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DATED: October 11, 2023.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

Kyle Karinen
KYLE S. KARINEN
EXECUTIVE DIRECTOR

MAURICE S. KING, WSBA # 47780
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 [redacted]

Patient B

Patient C

Patient D

Patient E

Patient F