BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
TIMOTHY J. GELEY, M.D.
Holder of License No. 21851
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-18-0454A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 16, 2019. Timothy J. Geley, M.D. ("Respondent"), appeared with legal counsel, Paul Giancola, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand 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 21851 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-18-0454A after receiving a complaint regarding Respondent's care and treatment of a 38 year-old female patient ("MY") alleging misrepresentation of a procedure and inadequate follow-up.

4. On November 8, 2016, Respondent initially evaluated MY for infertility. MY had ovarian tissue harvested in 2004 prior to undergoing a bone marrow transplant for leukemia. Tests completed showed residual ovarian function; however, MY had been unable to conceive. Respondent discussed egg donation versus use of the frozen ovarian tissue.
5. On March 14, 2018, Respondent diagnosed MY with premature ovarian failure ("POF") and planned to perform a diagnostic hysteroscopy, D&C, diagnostic laparoscopy with possible lysis of adhesions and re-implantation of the ovarian tissue, which was stored frozen in Respondent's office.

6. On April 4, 2018, MY presented for the planned procedures at a Hospital where Respondent had privileges; however, the scheduling request from Respondent failed to disclose the planned re-implantation. The Hospital refused to allow the re-implantation of the ovarian tissue procedure to be done due to concerns regarding sterility, infection control, verification of the specimen and a potential of re-implantation of cancerous cells as well as it being an experimental procedure. The procedures were cancelled and MY was discharged from the Hospital without being seen by Respondent.

7. Subsequently, MY met Respondent at his office to discuss the cancellation. Respondent promised to investigate the reason for the cancellation. Respondent did not follow up with MY, despite MY's attempts to contact him.

8. The standard of care requires a physician to disclose all planned surgical procedures to the surgical facility when scheduling. Respondent deviated from this standard of care by failing to inform the Hospital of the planned experimental procedure of re-implantation of ovarian tissue.

9. The standard of care requires a physician to adequately communicate the reasoning or issues surrounding the cancellation of a planned procedure within a timely manner. Respondent deviated from the standard of care by failing to communicate the reasons for the cancelled procedure to MY and not providing a response to her follow-up inquiries.
10. There was the potential for patient harm in that the concerns raised by the Hospital regarding sterility and infection may have been an issue in the event that Respondent had performed the procedure.

11. On December 28, 2018, Respondent underwent an evaluation by a Board-approved provider. Based on the findings of the evaluation, the evaluator opined that Respondent should engage in psychotherapy weekly for one month, then every other week for four months. On January 7, 2019, Respondent reported that he had initiated treatment and completed the initial four sessions of treatment.

12. During a Formal Interview on this matter, Respondent expressed regret that his actions caused confusion for the operating room staff. Respondent recognized that his reaction to staff compounded the problem. Respondent testified that he had gained insight into his actions and improved his oral and written communications in order to prevent future similar occurrences. Respondent agreed that he should have returned the patient's calls in order to reassure her and address her concerns regarding the cancellation of the procedure. Respondent stated that he has not performed the same procedure at the Hospital for any other patients as the procedure performed on MY was very rare. Respondent recognized that the Hospital considered the procedure to be experimental.

13. During that same Formal Interview, Board members recognized that Respondent had complied with recommendations from the evaluator and completed an intensive, in-person course in medical recordkeeping. Board members also commented regarding the emotional harm done to the patient when Respondent ceased communicating with her. Board members ultimately agreed that discipline was warranted.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.
2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described 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 issued a Letter of Reprimand.

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 14th day of June, 2019.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director
EXECUTED COPY of the foregoing mailed this 4th day of June, 2019 to:

Paul Giancola, Esq.
Snell & Wilmer L.L.P.
One Arizona Center
400 E. Van Buren Street
Phoenix, Arizona 85004-2202
Attorney for Respondent

ORIGINAL of the foregoing filed this 4th day of June, 2019 with:

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

[Signature]
Board staff