

Oregon Medical Board
BOARD ACTION REPORT
November 15, 2012

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between October 16, 2012 and November 15, 2012.

Scanned copies of Interim Stipulated Orders, Orders of Emergency Suspension, Stipulated Orders, Final Orders, Termination Orders, Modification Orders and Voluntary Limitations are included at the end of this report in the order that they appear in the report. These orders are marked with an * asterisk. **Scanned copies of Corrective Action Agreements and Consent Agreement are not posted, as they are not disciplinary action and impose no practice limitations.** Complaint and Notices of Proposed Disciplinary Action are not listed in this report, as they are not final actions by the Board. Both Orders, however, are public and are available upon request.

Printed copies of the Board Orders not provided with this report are available to the public. To obtain a printed copy of a Board Order not provided in this report, please complete a Service Request Form (<http://egov.oregon.gov/BME/PDFforms/VerDispMalFillin.pdf>) found under the Licensee Information Request Form link on the Board's web site, submit it with the \$10.00 fee *per licensee* and mail to:

**Oregon Medical Board
1500 SW 1st Ave, Ste 620
Portland, OR 97201**

Copies of the Orders listed below are mailed to Oregon hospitals where the Licensee had self-reported that he/she has privileges.

***Mann, Thomas Weimar, MD; MD06385; Eugene, OR**

On October 29, 2012, the Board issued an Order Terminating Order of License Suspension. This Order terminates Licensee's July 31, 2012, Order of License Suspension.

***Yankee, Joseph Earl, DO; DO19458; Milwaukie, OR**

On October 25, 2012, the Board issued a Default Final Order for unprofessional or dishonorable conduct; gross or repeated acts of negligence; willfully violating any rule adopted by the Board or any Board order or any Board request; and prescribing controlled substances without a legitimate medical purpose, or prescribing without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order revokes Licensee's license to practice medicine in Oregon, assesses a civil penalty of \$10,000, and assesses the costs of the contested case hearing.

If you have any questions regarding this service, please call the Board at (971) 673-2700 or toll-free within Oregon at (877) 254-6263.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
THOMAS WEIMAR MANN, MD)
LICENSE NO. MD06385) ORDER TERMINATING ORDER
OF LICENSE SUSPENSION)

1.

On July 31, 2012, the Oregon Medical Board (Board) issued an Order of License Suspension regarding Thomas Weimar Mann, MD (Licensee). This Order suspended Licensee's license to practice medicine and was issued pursuant to ORS 677.205 for violating the Medical Practice Act, to wit: ORS 677.190(17) willfully violating a Board rule, specifically OAR 847-008-0070, continuing medical competency (education). On August 21, 2012, the Board received documentation that Licensee has completed the required 60 hours of continuing medical education for the 2010-2011 biennium.

2.

The Board does hereby terminate the July 31, 2012 Order of License Suspension and orders that Licensee's license be returned to active status effective October 29, 2012.

IT IS SO ORDERED this 27th day of September, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
JOSEPH EARL YANKEE, DO) DEFAULT FINAL ORDER
LICENSE NO. DO19458)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including osteopathic physicians, in the state of Oregon. Joseph Earl Yankee, DO (Licensee) holds a suspended license to practice osteopathic medicine in the state of Oregon.

2.

2.1 The Board issued an Order for Emergency Suspension on December 2, 2011, and a Complaint and Notice of Proposed Disciplinary Action on January 11, 2012. The Board directed that the two proceedings be consolidated for purposes of a contested case hearing. Licensee submitted a timely request for hearing. A contested case hearing was scheduled for June 18 – 21, 2012. The Board issued an Amended Complaint and Notice of Proposed Disciplinary Action on May 17, 2012, in which the Board proposed taking disciplinary action pursuant to ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and (b); ORS 677.190(13) gross or repeated acts of negligence; ORS 677.190(17) willfully violating any rule adopted by the Board or any Board order or any Board request; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

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1 2.2 The Board's Amended Complaint and Notice of Proposed Disciplinary Action
2 designated the Board's file on this matter as the record for purposes of a default order and
3 granted Licensee an opportunity for a hearing, if requested in writing within 21 days of the
4 mailing of the Notice. Licensee was deemed to have already provided the Board with a timely
5 request for hearing. The parties participated in a pre-hearing conference call on May 21, 2012,
6 in which a new hearing date was set for August 13-16, 2012, at the request of Licensee's
7 counsel. On June 18, 2012, Licensee's counsel submitted a letter withdrawing from the case. A
8 pre-hearing status conference call was set by Administrative Law Judge (ALJ) Alison Webster
9 on July 9, 2012, but Licensee failed to appear. On August 6, 2012, the Office of Administrative
10 Hearing received a request from Licensee to postpone the hearing scheduled to begin on August
11 13, 2012, "asking for a 60-day postponement so there is appropriate council (sic) and I can get a
12 fare (sic) hearing." The Board opposed the request for set over. On August 8, 2012, ALJ
13 Webster issued a ruling denying Licensee's motion to postpone hearing. On August 13, 2012,
14 the Board, represented by Senior Assistant Attorney General Warren Foote, and ALJ Webster
15 were present at the scheduled time and place for the contested case hearing. Licensee failed to
16 appear at 9:00 a.m., the time scheduled for the hearing to begin. At 09:18 a.m., ALJ Webster
17 opened the proceedings, noted for the record that Licensee had failed to appear, found Licensee
18 to be in default and closed the proceedings.

19 2.3 On October 10, 2012, Licensee submitted a motion to reschedule the hearing and to
20 prohibit issuance of a final order by default. Licensee does not deny that he received notice that
21 the contested case hearing was scheduled for August 13, 2012 through August 16, 2012, with a
22 hearing time of 9:00 am. In the Board's Amended Complaint and Notice of Proposed
23 Disciplinary Action, dated May 17, 2012, Licensee was informed at paragraph 6 of the
24 following:

25 Failure by Licensee to request a hearing or failure to appear at any hearing
26 scheduled by the Board will constitute waiver of the right to a contested case
27 hearing and will result in a default order by the Board, including the revocation of
28 his medical license and assessment of such penalty and costs as the Board deems

1 appropriate under ORS 677.205. If a default order is issued, the record of
2 proceeding to date, including Licensee's file with the Board and any information
3 on the subject of the contested case automatically becomes a part of the contested
4 case record for the purpose of proving a prima facie case per ORS 183.417(4).

5 Licensee states in his motion that he called the Board at approximately 10:00 am on August 13,
6 2012, "to confirm that location of the room where the hearing would be held as he had evidence
7 and witnesses to present in his defense." He was informed by Board Investigator Terry Lewis
8 that the hearing "was 'over' because I had not shown up at 9:00 am." In his declaration
9 (appended to his motion), Licensee states that "I planned to come to the hearing mid-morning to
10 listen to the Board's evidence and participate as best I could, without counsel, during the course
11 of the four-day hearing."

12 2.5 OAR 137-003-0075(2) provides that: "If the party failed to appear at the hearing
13 and, before issuing a final order by default, the agency finds that the failure of the party to appear
14 was caused by circumstances beyond the party's reasonable control, the agency may not issue a
15 final order by default under section (1)(c) of this rule but shall schedule a new hearing." In this
16 case, the facts are not in dispute, so there is no need to schedule a hearing on the reasons for
17 Licensee's failure to appear, *see* OAR 137-003-0670(2). The issue is whether Licensee has
18 articulated "good cause" to explain his decision not to attend the hearing, which began at 9:00
19 am on August 13, 2012. Licensee asserts that he did not understand that he was required to be
20 present at 9:00 am on August 13, 2012, or he would lose by default. Licensee acknowledges that
21 he was able to rehire his legal counsel, as he "was able to secure financing for my counsel but his
22 calendar no longer permitted him to defend me at the August 13 – 16, 2012, scheduled hearing."
23 "Good cause" is defined by OAR 137-003-0501(7) to exist "when an action, delay, or failure to
24 act arises from an excusable mistake, surprise, excusable neglect, reasonable reliance on the
25 statement of a party or agency relating to procedural requirements, or from fraud,
26 misrepresentation, or other misconduct of a party or agency participating in the proceeding."
27 The Board does not find that Licensee's failure to appear is attributable to good cause or to
28 circumstances that were beyond Licensee's reasonable control. When Licensee submitted his

1 request to postpone the hearing on August 6, 2012, he represented that he now had funds to
2 rehire his attorney, but the attorney was no longer available for the August 13 – 16 scheduled
3 hearing. The Board concludes that Licensee had the ability to confer with his legal counsel, and
4 suffered under no misunderstanding when the hearing was to begin. Neither did he encounter
5 any unexpected circumstances that prevented his appearance at the hearing on August 13, 2012,
6 at 9:00 am. He had notice, and made the decision not to appear at the time and place specified in
7 the notice of hearing. And he had been informed on May 17, 2012, that his failure to appear at
8 any hearing scheduled by the Board “will constitute waiver of the right to a contested case
9 hearing and will result in a default order.”

10 2.6 Licensee also argues that Licensee’s failure to participate in a pre-hearing
11 conference call set for July 9, 2012 “led directly to the ALJ denying his reasonable request for a
12 60-day postponement.” Licensee points out that the Office of Administrative Hearing sent notice
13 of the Notice of Prehearing Conference to the wrong address, and that he never received the
14 notice, and so, did not participate in the pre-hearing conference on July 9, 2012. In her ruling
15 denying Licensee’s motion to postpone hearing, the ALJ based her decision to deny Licensee’s
16 motion on a number of factors, to include his failure to request postponement when he knew his
17 counsel had withdrawn on June 18, 2012, his failure to contact the Board or the Office of
18 Administrative Hearings for at least 6 weeks to advise of his efforts to secure new legal
19 representation, his failure to call in for the status conference, and that Licensee waited until
20 August 6, 2012, seven days prior to the scheduled hearing, to request a postponement. The ALJ
21 determined that: “[a]lthough Licensee has explained the reason for counsel’s withdrawal and the
22 basis for his request to continue the hearing, he had not established good cause under the
23 standard set forth above.” Licensee’s contention that the ALJ based her ruling on his failure to
24 call in for the July 9, 2012 status conference call lacks merit.

25 2.7 Licensee also argues that the Order of Emergency Suspension did not contain
26 language that his failure to appear at a hearing would result in a default order. But the Amended
27 Complaint and Notice of Proposed Disciplinary Action stated that the event the Licensee
28 requested a hearing, that “the hearing shall be combined and consolidated into a single

1 proceeding with any hearing held in regard to the Order of Emergency Suspension.” Licensee
2 was on notice that his failure to the hearing would result in a default order, and that the Board
3 had combined the disciplinary action and the emergency suspension into a single proceeding.
4 Licensee received adequate notice. Furthermore, the Board notes that Licensee’s suspension
5 terminates once his license revocation goes into effect.

6 2.8 As a result, Licensee has waived his right to participate in a contested case hearing
7 and now stands in default. Licensee had failed to state good cause to support his decision not to
8 appear for his hearing on August 13, 2012. He stands in default. The Board elects in this case to
9 designate the record of proceeding to date, which consists of Licensee’s file with the Board, as the
10 record for purposes of proving a prima facie case, pursuant to ORS 183.417(4)

11 3.

12 NOW THEREFORE, after considering the Board’s file relating to this matter, the Board
13 enters the following Order.

14 FINDINGS OF FACT

15 Licensee engaged in acts and conduct that violated the Medical Practice Act, as follows:

16 3.1 On October 12, 2009, Licensee and the Board entered into a Stipulated Order in
17 which Licensee was reprimanded and stipulated to certain terms and conditions, to include
18 paragraph 4.4, which states: “Licensee will not store or dispense any Schedule II, III, or IV
19 controlled substances (to include samples) in his clinic or any office where he provides medical
20 services.”

21 3.2 During the course of 2010, Licensee prescribed and dispensed Suboxone
22 (Schedule III, Buprenorphine and Nalaxone) to Patient G at his clinic in Milwaukie, Oregon, in
23 violation of the 2009 Stipulated Order. Licensee ordered and received at his clinic five monthly
24 shipments of 90 Suboxone tablets in 2010, for a total of 450 Suboxone tablets, as part of a drug
25 manufacturer’s patient assistance program. Upon receiving each shipment, either Licensee or a
26 clinic employee would take the shipment of Suboxone (received via FedEx in a sealed package)
27 to the adjoining clinic of another physician (who is in a separate practice), where the medication
28 would be stored in a locked receptacle. Licensee failed to maintain an accurate log to document

1 the receipt and dispensing of Suboxone received at his clinic. When Patient G appeared at the
2 clinic to receive the medications, either Licensee or a clinic employee would retrieve the package
3 of Suboxone and deliver the package to Patient G. This arrangement violated the terms of
4 paragraph 4.4 of the 2009 Stipulated Order. Licensee failed to note each release of the
5 medication to Patient G in the medical chart. Patient G was interviewed and stated that only
6 three of the five shipments were received. A review of the medical chart and interview with
7 Patient G determined that the Licensee saw Patient G for only one visit for Suboxone induction
8 and yet continued to provide Suboxone for Patient G for several months without any follow-up.

9 3.3 Licensee treats many patients suffering from narcotics addiction with Suboxone.
10 The Board's review of charts for Patients A -- G reveals a pattern of practice that does not
11 conform to the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid
12 Addiction. Licensee's chart notes are sparse, and do not include an adequate assessment (to
13 include patient history, physical examination with objective findings, and appropriate laboratory
14 testing) to support a diagnosis and treatment plan. For chronic pain patients, Licensee's charts
15 often do not include a material risk notice, contain either no pain contract or an incomplete pain
16 contract, do not include any record of drug screening tests, lack any reference to pill counts, and
17 reflect that Licensee will authorize early refills without stating his reasoning in the chart. The
18 deficiencies in Licensee's chart notes reflect a manner of practice that does not conform to the
19 standard of care and subjects his patients to the risk of harm.

20 3.4 Licensee applied in 2010 to participate as an investigator in a clinical drug study,
21 for Embeda (Schedule II), which is a combination of morphine sulfate and naltrexone
22 hydrochloride and is FDA approved for the treatment of moderate to severe chronic pain. In his
23 application to participate in the drug study, Licensee answered "no" to the following question:
24 "Ever been disciplined by a public or private organization or licensing agency?" This answer
25 was not accurate. Licensee accurately answered "yes" to the next question: "Ever been
26 sanctioned or restricted by a professional board?" In his explanation for this response, Licensee
27 provided misleading information regarding the 2009 Stipulated Order by failing to disclose the
28 Board Order and that he had prescribed and diverted controlled substances for his personal use.

1 3.5 Licensee selected chronic pain patients from his practice to participate in this
2 study, some of whom were not suitable candidates for the study. In so doing, Licensee
3 compromised the integrity of the study and subjected these participating patients to the
4 unnecessary risk of harm. The Embeda study contained written protocols for the study, which
5 listed specific exclusion criteria under the express warning that: "A patient who meets ANY of
6 the following exclusion criteria must not be enrolled." Nevertheless, Licensee enrolled the
7 following patients into the Embeda study, even though they were not suitable candidates for the
8 study:

9 a. Patient A, a 55 year old male, had a history of three prior back surgeries. Patient
10 A participated in the study even though the exclusion criteria for the study stated that any patient
11 that "has had more than 2 surgeries for low back pain" must not be enrolled.

12 b. The health history for Patient B, a 57 year old male, included chronic obstructive
13 pulmonary disease, acute respiratory failure, and alcohol dependence or abuse. Patient B
14 participated in the study even though the exclusion criteria listed the following as exclusion
15 criteria: "1. Patient is currently diagnosed and/or exhibiting signs or symptoms of opioid and /
16 or alcohol abuse..." and "4. Patient has ... chronic obstructive pulmonary disease." Patient B's
17 history included prior admissions to the emergency room for seizures associated with alcohol
18 dependence and intoxication. Nevertheless, Patient B participated in the study.

19 c. Patient C, a 41 year old male patient, met the inclusion criteria to participate in
20 the study, but Licensee violated the terms of the protocol by administering injectable steroids
21 into Patient C while he participated in the study.

22 d. Patient D, a 44 year old male patient, met the inclusion criteria to participate in
23 the study, but Licensee violated the terms of the study protocol by administering injectable
24 steroids into Patient D's affected joint while he participated in the study

25 e. The history of Patient E, a 41 year old male patient, included chronic low back
26 pain which Licensee treated with Suboxone. Patient E presented to Licensee in acute distress on
27 January 19, 2009. Licensee charted that Patient E was in opiate withdrawal, and treated this

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1 condition by "titrating Suboxone." Despite a history that included treatment for opiate
2 dependence, Patient E participated in the study.

3 3.6 The Board's review of charts for Patients A – G also raises serious questions in
4 regard to the manner of the Licensee's overall clinical practice. This review revealed a pattern of
5 failing to comply with Federal opioid treatment standards and poor clinical practice in regard to
6 his management of patient care, to include the following: (1) Licensee's handwritten chart notes
7 (which are sparse and lacking in detail) failed to document an adequate physical examination and
8 his chart notes lack objective findings to support his stated diagnoses; (2) Licensee failed to
9 document how he determined to treat complaints of chronic pain with controlled substances or to
10 initiate treatment with Suboxone; (3) Licensee failed to address the efficacy of the treatment
11 provided and failed to adequately manage patient progress in follow up clinical visits; (4)
12 Licensee failed to require his patients to undergo an initial or periodic urine screening tests, or
13 pill counts; (5) Licensee's charts failed to note assessments of comorbid medical and
14 psychosocial conditions or address the interaction between Suboxone and patient concomitant
15 use of alcohol or controlled substances, to include benzodiazepines or marijuana; (6) Licensee
16 failed to describe an induction procedure for Suboxone or a titration procedure when patients
17 complained of withdrawal symptoms; and (7) Licensee failed to set forth clinical findings to
18 support a diagnosis and treatment of hypogonadism or hypothyroidism. Specific examples of
19 substandard care include the following:

20 a. In August of 2003, Licensee's assessment of Patient A included a diagnosis of
21 hypogonadism and hypothyroidism, and ordered an intramuscular injection of testosterone. The
22 only stated clinical finding to support this diagnosis was a statement recorded on September 11,
23 2003 that the patient "will start on thyroid if fatigue is not resolved." On October 14, 2003,
24 Licensee initiated a trial of testosterone (Androgel, Schedule III) and levothyroxine (Synthroid),
25 with a chart note that states: "testosterone shots...still having some fatigue – and + energy no
26 side effects from the test...has [increased] sex drive." A lab report for August 12, 2003 reflects a
27 TSH (thyroid stimulating hormone) of 7.41 (slightly elevated) and a free T4 level of 0.94
28 (normal). Licensee does not chart a comprehensive physical examination, clinical findings,

1 consultation with an endocrinologist, or repeated laboratory tests to establish a diagnosis of
2 either hypothyroidism or hypogonadism. On November 17, 2003, Licensee increased the dosage
3 of Synthroid to 100 mcgs qd (every day) with a comment in the chart that the patient still
4 complained of "fatigue." On October 12, 2005, a lab test revealed Patient A's testosterone level
5 was 1210 (elevated) and his free T4 was 0.91 and his TSH level was 1.97—levels in the normal
6 range. In the chart note on October 17, 2005, Licensee describes these thyroid test results as
7 low and documents a plan to increase the dosage of Synthroid without explanation, and to
8 decrease his testosterone. Licensee continued to treat Patient A over the successive years with
9 varying doses of Synthroid for hypothyroidism and 300 mg injections of Testosterone for
10 hypogonadism without medical justification or supporting clinical findings. On January 2, 2008,
11 Licensee discontinued the treatment of chronic pain with Methadone (Schedule II), and on
12 January 4, 2008, Licensee initiated treatment with Suboxone, but without stating any clinical
13 findings or rationale in the chart. In 2010, the chart reflects that Licensee prescribed successive
14 doses of Methadone, 5 mg, #120, and Alprazolam, 0.5 mg, #90 (Xanax, Schedule IV), but
15 without any chart note to address drug interactions or informed consent. Although the chart
16 reflects that Patient A had a medical marijuana card, Licensee did not address the issue of drug
17 interaction with Patient A, or address any risk factors for abuse or impairment. On October 4,
18 2010, during the first Embeda drug study visit, Licensee prescribed Embeda 160 mg, bid and
19 Morphine IR (Schedule II) for breakthrough pain. The chart note for this date reflects that
20 Patient A was suffering "withdrawals from methadone." On October 12, 2011, the chart note
21 states that "patient feels fatigue, but physically his body feels better, feels like arthritis pain is
22 under control better than ever." Licensee prescribed at this time Embeda, 100 mg, #30 tablets, 2
23 tablets bid (twice a day) and MSIR (Morphine, Schedule II) 15 mg, every 4 – 6 hours for
24 breakthrough pain. On January 13, 2011, the chart reflects that Patient A had completed the
25 Embeda study and wanted to transfer back to Methadone.

26 b. Patient B was hospitalized in January 2009 with a seizure most likely associated
27 with alcohol dependence or abuse. Although Patient B reported drinking 4 -5 hard lemonades a
28 day, Licensee did not address the issue of possible alcohol dependence or abuse with the patient,

1 or document that he considered the interaction of alcohol with the narcotic medications he was
2 prescribing, or that Licensee provided appropriate medical advice or referral for Patient B. The
3 chart reflects that throughout 2009 and 2010, Licensee prescribed varying quantities of MS
4 Contin (Schedule II) 100 mg, Oxycodone (Schedule II) 5 mg, oxycodone & acetaminophen
5 (Percocet, Schedule II), 5/325, and Xanax (Schedule IV) 0.5 mg, for Patient B. Licensee did
6 obtain a pain treatment consultation in August 2009. Beginning on October 5, 2010, Patient B
7 participated in the Embeda study with an initial dose of Embeda of 400 mgs per day, which was
8 increased the following week to 500 mgs per day, without explanation in the chart. On October
9 14, 2010, the chart note stated that the patient was not any better taking Embeda and was having
10 to take more breakthrough medication, but that "when he takes the breakthgh [sic] med – its
11 because he feels like he is going into withdrawal?" Licensee failed to further investigate this
12 patient complaint and reduced the Embeda dosage to 200 mgs per day without explanation in the
13 chart. On December 2, 2010, Patient B stated that he wanted to stop taking Embeda, stating that
14 "he feels like he is going into withdrawal." Patient went off the study on December 7, 2010.
15 Patient B was hospitalized on January 25, 2011 due to a motor vehicle accident, and was re-
16 hospitalized a week later with an apparent alcohol withdrawal seizure. On February 10, 2011,
17 Licensee's chart note reflects that Patient B was non-compliant with his medications (without
18 further explanation) and was encouraged to "stop smoking and no ETOH [drinking alcohol]."
19 Patient B was readmitted in May 2011 for alcohol intoxication. Licensee's chart note for June 1,
20 2011 indicates that Licensee discussed Patient B's continued use of alcohol with him, but did not
21 assess his continued use of alcohol, the interaction with his prescribed medications, and did not
22 further address or refer Patient B for evaluation or treatment of possible alcohol dependence.
23 Licensee continued prescribing Morphine for Patient B after expressing concerns about his
24 alcohol use and recent hospitalizations for alcohol abuse.

25 c. In March of 2005, Licensee diagnosed Patient C as suffering from gout in his toe,
26 and in subsequent years, continued to diagnose gout and provided treatment with joint injections
27 of triamcinolone (Kenalog) and prescriptions of hydrocodone & acetaminophen (Norco,
28 Schedule III) without a diagnosis that is established in the chart. The chart notes reflect that

1 Licensee failed to conduct any testing for uric acid levels or joint fluid for uric acid crystals from
2 2004 through 2010. Licensee's chart notes lack clinical findings, to include laboratory reports,
3 to support the diagnosis or treatment of gout. On January 26, 2011, there is a chart note stating
4 that since Patient C started taking Uloric, he had suffered no further gout attacks. Patient C
5 indicated that he wanted to try Embeda in September 2010. Licensee also administered Kenalog
6 (a steroid) on October 13, 2010, while Patient C participated in the Embeda study, in violation of
7 the study protocol, and failed to document his rationale and patient response to a rapid titration
8 of Embeda from 160 mg per day to 320 mg per day, resulting in complaints of constipation and
9 withdrawal from the study

10 d. Patient F, a 18 year old male patient, presented to Licensee for treatment of pain
11 associated with a T6 and T8 compression fracture he suffered during a motocross event on or
12 about October 17, 2010 and a history that included treatment by another provider with
13 Oxycodone HCL, 5 mg on 10/19/2010. On 11/11/2010, Licensee prescribed Oxycodone HCL, 5
14 mg, #60 (Schedule II), with instructions to take 1 tablet every 4 to 6 hours as needed. Licensee
15 issued this same prescription (with instructions to take 1 - 2 tablets every 4 to 6 hours as needed
16 for pain) on 12/6/2010, 12/30/2010, 1/19/2011, 3/24/2011, 4/25/2011, and 6/3/2011. Licensee
17 prescribed a trial of Hydrocodone / Acetaminophen 5/325 #60 on 1/17/2011, without seeing the
18 patient or documenting the reason for the change in medication. As noted above, two days later
19 (1/19/2011) Licensee resumed the existing prescription of Oxycodone. Licensee prescribed 10
20 mg of Oxycodone HCL (1 tablet every 4 - 6 hours for pain) on the following dates: 2/7/2011,
21 3/7/2011, 4/4/2011, 5/5/2011, 5/16/2011, 6/13/2011, 7/6/2011, 7/28/2011 and 8/11/2011. The
22 chart notes reflect that Patient F was seen at Licensee's clinic on 11/11/2010, 12/30/2010,
23 1/19/2011, 3/7/2011, 8/15/2011, and 8/30/2011. On August 15, 2011, Licensee charted "Pt here
24 for induction" and "opiate dependence—suboxone induction." Patient F received Suboxone
25 from Licensee or his designee at his clinic on that date. Licensee's chart notes fail to document
26 any urine drug screening test, no documented medical reasoning regarding the risk and benefit of
27 continued opiate therapy, and no stated rationale or treatment plan for initiating Suboxone

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1 therapy. In addition, Licensee allowed more than five months to pass without patient follow up,
2 only to conclude 8/15/2011 that Patient F was opiate dependent.

3 e. Patient G, a 31 year old female, initially presented to Licensee as a patient in July
4 2006 seeking an allergy shot. She returned to his clinic on March 29, 2010, complaining of
5 withdrawal symptoms associated with using high doses ("15 – 20 qd") of Vicodin (Schedule III),
6 Oxycodone (Schedule II), OxyContin (Schedule II) and Percocet (Schedule II) that she acquired
7 "off the street." Licensee's stated diagnosis was "opiate withdrawal" based upon her report and
8 determined that she was a candidate for Suboxone. Licensee charted that she complained of
9 "headache, stomach ache – diarrhea – fatigue." Licensee's chart note reflects that he did not
10 examine her, to include failing to check for the presence of infectious disease, and made no
11 clinical findings to support the diagnosis of opiate withdrawal. In addition, Licensee did not ask
12 her to undergo a urine screening test to confirm the recent use of drugs or to detect the presence
13 of unreported substances, did not conduct a mental status examination and did not conduct a
14 pregnancy screening test. Licensee dispensed to her ½ tablet of Suboxone at 1033, at 1052,
15 Licensee's chart notes: "25% of symptoms gone – no stomach ache." At 1053, Licensee
16 dispensed another ½ tablet of Suboxone to Patient G. At 1113, Licensee's chart notes: "75% of
17 symptoms gone – headache gone – feels much better." At 1114, Licensee dispensed another ½
18 tablet of Suboxone to Patient G (total dose of 12 mgs). Licensee provided 90 tablets of
19 Suboxone to Patient G during that clinical visit, with no plans for follow up or written
20 instructions provided to the patient. Licensee had no chart notes pertaining to the induction of
21 Suboxone for this patient other than what has been referenced, and no note pertaining to
22 stabilization and maintenance of Suboxone. Patient G was never re-examined or followed by
23 Licensee, although she continued to receive packages containing 90 tablets of Subxone (12 mg)
24 in April and May 2010. Licensee did not refer Patient G for drug treatment or counseling.

25 3.6 On November 16, 2011, the Board issued an Order for Evaluation, directing
26 Licensee to undergo an evaluation at the Center for Personalized Education for Physicians
27 (CPEP). Licensee underwent the ordered evaluation, and CPEP subsequently issued an
28 Assessment Report, dated March 26, 2012. The report noted deficiencies in Licensee's charting,

1 to include inadequate documentation of prescriptions, failing to document refills, failing to sign
2 informed consent forms, and a lack of written informed consent agreements in regard to
3 Suboxone therapy. The report concluded that while Licensee's knowledge about Suboxone was
4 "adequate, overall" and that his clinical judgment and reasoning was "mostly adequate" there
5 were "a few important lapses regarding application of knowledge, primarily in the area of
6 chronic pain management." The report also noted that while Licensee "understood the disease
7 concept of addiction, his knowledge of the principles of screening, diagnosis, and treatment of
8 substance abuse was incomplete." This report's findings in regard to Licensee's lapses in
9 medical knowledge and clinical judgment and reasoning reflect deficiencies that are consistent
10 with the shortcomings identified by the Board's review of Licensee's charts.

11 3.7 The CPEP Assessment Report also identified "discrepancies" in four patient
12 charts that Licensee submitted to CPEP as part of the assessment process. These charts,
13 pertaining to Patients H, I, J, and K contained a form entitled "Long Term Management of
14 Intractable Non-Malignant Pain." This form presents separate lines for the patient to print and
15 sign their name, and to date the form, as well as a line for Licensee to sign and date. This form,
16 found in each of the four patient charts submitted to CPEP, has a footer that states:
17 "Physician/Patient Medication Contract/Agreement Revised 11/2011." Each of the four forms
18 contains a hand printed name and signature of the patient that does not appear to match the
19 signature of each the patients found in other documents within the charts. In addition, each of
20 the four forms are dated and signed by both the patient and Licensee in either 2010, or in months
21 preceding November 2011. Additionally, Patients H, J and K were contacted regarding these
22 apparent discrepancies and have all stated that they did not sign the questioned documents. This
23 discrepancy in dates and patient signatures casts the integrity of Licensee's chart notes into
24 serious question. The Licensee's submission of altered medical records impacts the validity of
25 the CPEP assessment as the review of these records was a significant component of the
26 assessment process.

27 3.8 Additionally, the Licensee submitted incomplete and misleading information as
28 part of his intake to CPEP in regards to his 2009 Board Order by failing to disclose that he had

1 prescribed a schedule II controlled substance for a staff member and then diverted this
2 medication for his personal use. Licensee's curriculum vitae that was submitted to CPEP
3 incorrectly listed the identity of his osteopathic medical school as Western Michigan University.
4 By submitting incomplete and misleading information and altered medical records to CPEP,
5 Licensee failed to comply with the Board's order to undergo the evaluation at CPEP, and
6 compromised the assessment process.

7 3.9 On December 2, 2011, the Board issued an Order of Emergency Suspension, in
8 which the Board suspended Licensee's medical license to practice medicine. Licensee has
9 violated the terms of this Order by subsequently engaging in conduct that constitutes the practice
10 of medicine, as described below:

11 a. On January 9, 2012, Patient H, an adult male and an established patient of
12 Licensee presented at Licensee's clinic for a scheduled blood test. Licensee entered the
13 examination room and drew Patient H's blood. Licensee caused the blood specimen to be
14 submitted to a clinical laboratory service for analysis. Licensee told Patient H that the clinic
15 would let him know the lab results. The Licensee's clinic staff contacted Patient H's employer
16 and disclosed confidential medical information without the patient's knowledge or authorization.
17 Licensee's conduct constituted the practice of medicine, violating the terms of the Order of
18 Emergency Suspension.

19 b. On January 9, 2012, Patient L, an adult male and an established patient of
20 Licensee presented at Licensee's clinic for a scheduled injection for a painful wrist. Patient L
21 was placed in an examination room. Licensee subsequently entered the room and told Patient L
22 that he would not be receiving the injection. Licensee informed Patient L that Licensee would
23 order an x-ray of his hand and provide a referral to an orthopedic surgeon. Licensee's conduct
24 constituted the practice of medicine, violating the terms of the Order of Emergency Suspension.

25 4.

26 CONCLUSIONS OF LAW

27 4.1 Licensee's conduct, as described above, breached well recognized standards of
28 practice and ethics of the medical profession. Licensee engaged in multiple acts that place his

1 patients at serious risk of harm. He also engaged in multiple acts of unethical conduct, to include
2 submitting falsified records to the Board as well as CPEP, providing false and misleading
3 information to the proponent of the Embeda clinical drug study, seeing patients while his license
4 was suspended, and dispensing controlled substances at his clinic in 2010 and 2011 that violated
5 the terms of the Board's Stipulated Order of 2009 as well as the Board's Order for Emergency
6 Suspension and the Order for Evaluation. Licensee's medical practice, in regard to his
7 management of patient complaints of chronic pain, his selection of patients to participate in the
8 clinical drug study, his failure to comply with study protocols, and the delivery of care to patients
9 with other health care issues, to include the diagnosis and treatment of gout, hypogonadism and
10 hypothyroidism, can only be described as grossly negligent. The Board concludes that
11 Licensee's conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as
12 defined in ORS 677.188(4)(a) and (b); ORS 677.190(13) gross or repeated acts of negligence;
13 ORS 677.190(17) willfully violating any rule adopted by the Board or any Board order or any
14 Board request; and ORS 677.190(24) prescribing controlled substances without a legitimate
15 medical purpose, or prescribing without following accepted procedures for examination of
16 patients, or prescribing controlled substances without following accepted procedures for record
17 keeping.

18 4.2 Based upon its examination of the record in this case, the Board finds that each
19 alleged violation of the Medical Practice Act is supported by reliable, probative and substantial
20 evidence.

21 5.

22 **ORDER**

23 Licensee is unethical and grossly incompetent. The Board also notes that throughout the
24 course of the investigation, Licensee has not taken responsibility for his own conduct. Instead,
25 he has blamed his clinic employees while asserting that he provided good patient care. His
26 license must be revoked.

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IT IS HEREBY ORDERED THAT the license of Joseph Earl Yankee, D.O., to practice medicine is revoked and the Order of Emergency Suspension is affirmed. In addition, Licensee is assessed a civil penalty of \$10,000 and is assessed the costs of the hearing.

DATED this 25th day of October, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
BOARD CHAIR

APPEAL

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after this default final order is served upon you. See ORS 183.480 et seq.