Oregon Medical Board

BOARD ACTION REPORT

September 15, 2017

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between August 16, 2017, and September 15, 2017.

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 Consent Agreements 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 the License Verification and Malpractice Report Request (http://www.oregon.gov/OMB/ombforms1/request-licensee-info-verification.pdf) found under the Forms 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.

***Carlson, Bruce Donald, MD; MD07786; Pendleton, OR**
On September 1, 2017, Licensee entered into an Interim Stipulated Order to voluntarily cease initiating or begin tapering opioids for chronic pain patients; limit prescribing for acute pain; taper concurrent benzodiazepines; and cease prescribing carisoprodol (Soma) concurrently with opioids pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

King, Douglas Hoff, MD; MD14477; Portland, OR
On September 7, 2017, Licensee entered into a Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to practice under the supervision of a Board-approved mentor for three months.

***Margaliot, Zvi, MD; MD183826; Beaverton, OR**
On September 7, 2017, Applicant entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order requires that Applicant provide a chaperone to patients aged 18 years and older; maintain a relationship with a Board-approved healthcare provider; and undergo semi-annual testing.

Ochs, Chelsea Richelle, LAc; AC178843; Newberg, OR
On August 17, 2017, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's February 1, 2017, Consent Agreement.

***Popowich, Yale Sands, MD; MD26661; Portland, OR**
On September 14, 2017, Licensee entered into an Interim Stipulated Order in which he agreed to conduct all examinations of or procedures on female patients, aged 18 or older, in the presence of a medically trained chaperone, and to avoid social media contact with patients pending the completion of the Board's investigation.

***Roberts, Brenda Diane, MD; MD21507; Troutdale, OR**
On September 5, 2017, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place her license in Inactive status pending the completion of the Board's investigation into her ability to safely and competently practice medicine.

***Rose, Mark Craig, MD; MD14469; Lebanon, OR**
On September 6, 2017, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

***Siepert, Kash K, DPM; DP00273; Roseburg, OR**
On September 7, 2017, Licensee entered into a Voluntary Limitation to limit his practice of podiatric medicine. Licensee will not perform hospital based surgery.

***Yankee, Joseph Earl, DO; DO19458; Milwaukie, OR**
On August 23, 2017, the Board issued a Final Order on Default 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.

***Yankee, Joseph Earl, DO; DO19458; Milwaukie, OR**
On August 23, 2017, the Board issued a Final Order on Remand. This Order denies the motion of Licensee to reschedule the August 13, 2012, 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.

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of BRUCE DONALD CARLSON, MD LICENSE NO. MD07786	)))))	INTERIM STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Bruce Donald Carlson, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to certain terms until the investigation is completed.

3.

In order to address the Board's concerns, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and will remain in effect while this matter remains under investigation, and provides that Licensee shall comply with the following conditions:

3.1 Licensee must not begin treatment for chronic pain with opioids for any new or existing patient. For the purposes of this Order, chronic pain is defined as pain that persists or progresses over a period of time greater than 30 days.

3.2 Licensee must immediately begin to taper opioid medications for any chronic pain patient with an MED over 90 by at least 10% per month until patient's MED is 90 or less.

Alternatively, Licensee may transfer the care of any patient with an MED over 90 to another physician. Licensee may continue to prescribe greater than 90 MED for chronic pain for patients who are currently enrolled in hospice or who are currently receiving treatment for a diagnosis of cancer. Licensee must certify on the written prescription that the patient is a hospice or cancer patient.

3.3 Licensee must limit his prescribing for acute pain to less than 30 days per year, and with a maximum morphine equivalent dose (MED) of 50.

3.4 For patients taking benzodiazepines and opioids, who have an MED of 90 or less or who have been first tapered to an MED of 90 or less, Licensee must begin to taper benzodiazepines. Licensee must taper by at least 10% per month until the patient is weaned off benzodiazepines. Alternatively, Licensee may transfer the care of any patient for whom he is prescribing benzodiazepines and opioids to another physician. Licensee may continue to prescribe benzodiazepines to patients who are currently enrolled in hospice or have a life expectancy of less than six months. Licensee must certify on the written prescription that the patient is a hospice or cancer patient.

3.5 For current patients who are prescribed opioids with benzodiazepines, tapering will occur as outlined in terms 3.2 and 3.4, and subsequent to tapering, Licensee must not concomitantly prescribe opioids with benzodiazepines.

3.6 Licensee must not concomitantly prescribe opioids with carisoprodol (Soma).

3.7 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

3.8 Licensee understands this Order becomes effective the date he signs it.

4.

At the conclusion of the Board's investigation, the Board will decide whether to close the case or to proceed to some form of disciplinary action. If the Board determines, following that review, not to lift the requirements of this Order, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.410, which grants the Board the authority to attach conditions to the license of Licensee to practice medicine. These conditions will remain in effect while the Board conducts a complete investigation in order to fully inform itself with respect to the conduct of Licensee. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document and is reportable to the National Databank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 1st day of September, 2017.

[redacted]

BRUCE DONALD CARLSON, MD

IT IS SO ORDERED THIS 12th day of September, 2017.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

JOSEPH J. THALER, MD
Medical Director

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of ZVI MARGALIOT, MD APPLICANT	)))))	STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Zvi Margaliot, MD (Applicant) has submitted an application for an unlimited medical license in the State of Oregon.

2.

Applicant is a non-Board certified plastic surgeon who submitted an application for an Oregon medical license on April 27, 2017. Applicant received a Doctor of Medicine degree from the Schulich School of Medicine University of Western Ontario on June 2, 1995. Upon completion of medical school, Applicant entered into a plastic and reconstructive surgery residency at the University of Toronto and completed the seven-year program in June 2002. On his application, Applicant disclosed that a disciplinary action was taken by the College of Physicians and Surgeons of Ontario in 2016, due to a consensual, romantic affair with a patient. Applicant was issued a fine and his license was revoked. Applicant underwent a multidisciplinary evaluation as directed by the College of Physicians and Surgeons of British Columbia. It was reported during this evaluation that Applicant has been compliant with the recommendations of his healthcare providers.

3.

Applicant understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes, and fully and finally

waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Applicant stipulates that he engaged in the conduct described in paragraph 2 and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a). Applicant also understands that this Order is a public record and is a disciplinary action that is reportable to the DataBank and the Federation of State Medical Boards.

4.

Applicant and the Board desire to settle this matter by the entry of this Stipulated Order, which becomes effective on the date it is signed by the Board Chair. Applicant and the Board agree that the Board will close this matter and grant Applicant an active license to practice medicine in the State of Oregon, subject to the following terms and conditions:

4.1 Applicant will not see any female patient 18 years of age or older without a medically trained chaperone being present throughout the course of the examination or procedure. The presence of the chaperone will be immediately documented in the patient chart. The chaperone must not be related to Applicant or the patient.

4.2 Applicant must maintain an on-going relationship with a healthcare provider who will provide quarterly written reports to the Board. The healthcare provider must be pre-approved by the Board's Medical Director and Applicant must sign all necessary releases to allow direct communication between the provider and the Board. Revocation of these releases shall constitute a violation of this Order.

4.3 At his own expense, Applicant must undergo testing on a semi-annual basis by a person that is pre-approved by the Board's Medical Director and coordinated through the Board's compliance officer. Applicant must sign releases to allow full communication and exchange of documents and reports between the Board and the testing entity. Revocation of these releases shall constitute a violation of this Order.

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4.4 Applicant may request to modify or terminate this Order after one year of successful compliance with all terms of this Order.

4.5 Applicant must obey all federal, state and local laws, and all rules governing the practice of medicine in the state of Oregon, or any other jurisdiction.

4.6 Applicant stipulates and agrees that any violation of the terms of this Order shall be grounds for disciplinary action under ORS 677.190(18).

5.

This order becomes effective the date it is signed by the Board Chair.

IT IS SO STIPULATED this 17th day of August, 2017.

[redacted]

ZVI MARGALIOT, MD

IT IS SO ORDERED this 7th day of September 2017.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

MICHAEL J. MASTRANGELO, JR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
YALE SANDS POPOWICH, MD	)	INTERIM STIPULATED ORDER
LICENSE NO. MD26661	)	
	)	

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Yale Sands Popowich, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to certain terms until the investigation is completed.

3.

In order to address the Board's concerns, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and will remain in effect while this matter remains under investigation, and provides that Licensee shall comply with the following conditions:

3.1 Licensee must not conduct any examination or medical procedure on a female patient 18 years of age or older without a medically trained chaperone being present throughout the course of the entire patient encounter. The presence of the chaperone will be immediately documented in the patient chart. The chaperone shall be medically trained and not a friend or relative of the patient or physician.

3.2 Licensee must avoid all social media contacts (including but not limited to Facebook, Instagram, and Twitter) with his patients, prospective patients, and former patients (within six months of their last clinical visit).

3.3 Licensee understands that violating any term of this Order may be grounds for disciplinary action under ORS 677.190(17), willfully violating Board order.

3.4 Licensee understands this Order becomes effective the date he signs it.

4.

At the conclusion of the Board's investigation, the limitation placed on Licensee will be reviewed in an expeditious manner. If the Board determines, following that review, that these limitations shall not be lifted, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.265 while the Board conducts its investigation for the purpose of fully informing itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document, and is reportable to the National Databank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 14 day of SEPTEMBER, 2017.

[redacted]

YALE SANDS POPOWICH, MD

IT IS SO ORDERED THIS 18th day of September, 2017.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

JOSEPH J. THALER, MD
MEDICAL DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of BRENDA DIANE ROBERTS, MD LICENSE NO. MD21507	))))))	INTERIM STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Brenda Diane Roberts, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to certain terms until the investigation is completed.

3.

In order to address the Board's concerns, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and will remain in effect while this matter remains under investigation, and provides that Licensee shall comply with the following conditions:

3.1 Licensee may only practice medicine, to include the prescribing of medication, in a clinical setting that is pre-approved by the Board's Medical Director. Licensee must not provide treatment or write prescriptions in a residential setting.

3.2 Licensee must chart every patient encounter.

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3.3 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

3.4 Licensee understands this Order becomes effective the date she signs it.

4.

At the conclusion of the Board's investigation, the Board will decide whether to close the case or to proceed to some form of disciplinary action. If the Board determines, following that review, not to lift the requirements of this Order, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.410, which grants the Board the authority to attach conditions to the license of Licensee to practice medicine. These conditions will remain in effect while the Board conducts a complete investigation in order to fully inform itself with respect to the conduct of Licensee. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document and is reportable to the National Databank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 10th day of July, 2017.

[redacted]

BRENDA DIANE ROBERTS, MD

IT IS SO ORDERED THIS 11th day of July, 2017.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

JOSEPH J. THALER, MD
MEDICAL DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of MARK CRAIG ROSE, MD LICENSE NO. MD14469	)))))	INTERIM STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the State of Oregon. Mark Craig Rose, MD (Licensee) is a licensed physician in the State of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to cease the practice of medicine until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

3.1 Licensee voluntarily withdraws from the practice of medicine and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

3.2 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

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4.

At the conclusion of the Board's investigation, Licensee's status will be reviewed in an expeditious manner. Following that review, if the Board determines that Licensee shall not be permitted to return to the practice of medicine, Licensee may request a hearing to contest that decision.

5.

This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose of protecting the public, and making a complete investigation in order to fully inform itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure. However, as a stipulation this Order is a public document and is reportable to the national Data Bank and the Federation of State Medical Boards.

6.

This Order becomes effective the date it is signed by the Licensee.

IT IS SO STIPULATED THIS 6th day of September, 2017.

[redacted]

MARK CRAIG ROSE, MD

IT IS SO ORDERED THIS 6th day of September, 2017.

State of Oregon
OREGON MEDICAL BOARD

[redacted]

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the matter of, KASH K SIEPERT, DPM LICENSE NO. DP00273	VOLUNTARY LIMITATION

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including podiatric physicians, in the state of Oregon. Kash K Siepert, DPM (Licensee) is a licensed podiatric physician in the state of Oregon.

2.

Licensee has elected to voluntarily limit the scope of his practice of podiatric medicine. Effective the date this Order is signed by the Board Chair, Licensee agrees to abide by the terms and conditions of voluntary limitation, pursuant to ORS 677.410 as follows:

2.1 Licensee will not perform hospital based surgery.

2.2 Licensee stipulates and agrees that any violation of the terms of this Order shall be grounds for disciplinary action under ORS 677.190(17).

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3.

Licensee understands that this is a final order under Oregon law and therefore is a public record. This order is not a disciplinary action, but is a limitation on Licensee's medical practice and is therefore reportable to the Federation of State Medical Boards and the DataBank.

IT IS SO STIPULATED this 31 day of August, 2017.

[redacted]

KASH K SIEPERT, DPM

IT IS SO ORDERED this 7th day of September, 2017.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

MICHAEL J. MASTRANGELO, JR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

IN THE MATTER OF:	)	
	)	
JOSEPH EARL YANKEE, D.O.	)	**FINAL ORDER ON DEFAULT**
LICENSE NO. DO19458	)	

1.

HISTORY OF THE CASE

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) held a suspended license to practice osteopathic medicine in the state of Oregon.

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.

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

On October 10, 2012, Licensee submitted a motion to reschedule the hearing to the Board, asserting reasons for his failure to appear at the hearing. On February 4, 2013, the Board issued a Default Final Order based upon Licensee's failure to appear at the August 13, 2012, hearing. In the Default Final Order, the Board found that Licensee's failure to appear for the hearing was not attributable to good cause or to circumstances beyond his reasonable control. In the Default Final Order, the Board revoked Licensee's medical license and assessed him a civil penalty and the costs of the hearing.

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Licensee sought judicial review of the Default Final Order by the Oregon Court of Appeals, but did not request a stay enforcement of the Board's Order. On October 4, 2016, the Court of Appeals issued its ruling, reversing the Board's decision and remanding the matter to the Board, finding that Licensee "was entitled to have a hearing before a neutral ALJ on the reasons for his not appearing" at the August 2012 hearing.[1]

On October 12, 2016, the Board referred the matter to the Office of Administrative Hearings (OAH) for a hearing on Licensee's reschedule request. On October 21, 2016, ALJ Webster convened a prehearing conference. Senior AAG Foote appeared on behalf of the Board. Mr. McDermott appeared on behalf of Licensee. ALJ Webster scheduled the hearing and set deadlines for submission of witness lists and exhibits.

On November 4, 2016, the OAH reassigned the matter to ALJ Samantha Fair. On January 18, 2017, ALJ Fair convened an in-person hearing in Portland, Oregon. Licensee appeared, testified and was represented by Ms. Costanzo. The Board appeared and was represented by Senior AAG Foote. The evidentiary record closed on January 18, 2017, at the conclusion of the hearing. The record closed on February 6, 2017, after receipt of the transcript of the hearing.

On April 5, 2017, ALJ Fair issued a Proposed Final Order that Licensee did not have good cause for failing to appear at a previously scheduled hearing and recommended that the Board deny Licensee's motion to reschedule the August 13, 2012 hearing. The Oregon Medical Board adopted those findings and recommendations in the Board's Final Order on Remand.

2.

NOW THEREFORE, after considering the Board's file relating to this matter and the Board's Final Order on Remand, the Board now enters the following Order, with the following findings of fact and conclusions of law.

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[1] Yankee v. Oregon Medical Board, 280 Or App 1 (2016).

FINDINGS OF FACT

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

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

During the course of 2010, Licensee prescribed and dispensed Suboxone (Schedule III, Buprenorphine and Nalaxone) to Patient G at his clinic in Milwaukie, Oregon, in violation of the 2009 Stipulated Order. Licensee ordered and received at his clinic five monthly shipments of 90 Suboxone tablets in 2010, for a total of 450 Suboxone tablets, as part of a drug manufacturer's patient assistance program. Upon receiving each shipment, either Licensee or a clinic employee would take the shipment of Suboxone (received via FedEx in a sealed package) to the adjoining clinic of another physician (who is in a separate practice), where the medication would be stored in a locked receptacle. Licensee failed to maintain an accurate log to document the receipt and dispensing of Suboxone received at his clinic. When Patient G appeared at the clinic to receive the medications, either Licensee or a clinic employee would retrieve the package of Suboxone and deliver the package to Patient G. This arrangement violated the terms of paragraph 4.4 of the 2009 Stipulated Order. Licensee failed to note each release of the medication to Patient G in the medical chart. Patient G was interviewed and stated that only three of the five shipments were received. A review of the medical chart and interview with Patient G determined that the Licensee saw Patient G for only one visit for Suboxone induction and yet continued to provide Suboxone for Patient G for several months without any follow-up.

Licensee treats many patients suffering from narcotics addiction with Suboxone. The Board's review of charts for Patients A – G reveals a pattern of practice that does not conform to the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Licensee's chart notes are sparse, and do not include an adequate assessment (to include patient

history, physical examination with objective findings, and appropriate laboratory testing) to support a diagnosis and treatment plan. For chronic pain patients, Licensee's charts often do not include a material risk notice, contain either no pain contract or an incomplete pain contract, do not include any record of drug screening tests, lack any reference to pill counts, and reflect that Licensee will authorize early refills without stating his reasoning in the chart. The deficiencies in Licensee's chart notes reflect a manner of practice that does not conform to the standard of care and subjects his patients to the risk of harm.

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

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

a. Patient A, a 55 year old male, had a history of three prior back surgeries. Patient A participated in the study even though the exclusion criteria for the study stated

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that any patient that "has had more than 2 surgeries for low back pain" must not be enrolled.

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

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

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

e. The history of Patient E, a 41 year old male patient, included chronic low back pain which Licensee treated with Suboxone. Patient E presented to Licensee in acute distress on January 19, 2009. Licensee charted that Patient E was in opiate withdrawal, and treated this condition by "titrating Suboxone." Despite a history that included treatment for opiate dependence, Patient E participated in the study.

The Board's review of charts for Patients A – G also raises serious questions in regard to the manner of the Licensee's overall clinical practice. This review revealed a pattern of failing to comply with Federal opioid treatment standards and poor clinical practice in regard to his management of patient care, to include the following: (1) Licensee's handwritten chart notes

(which are sparse and lacking in detail) failed to document an adequate physical examination and his chart notes lack objective findings to support his stated diagnoses; (2) Licensee failed to document how he determined to treat complaints of chronic pain with controlled substances or to initiate treatment with Suboxone; (3) Licensee failed to address the efficacy of the treatment provided and failed to adequately manage patient progress in follow up clinical visits; (4) Licensee failed to require his patients to undergo an initial or periodic urine screening tests, or pill counts; (5) Licensee's charts failed to note assessments of comorbid medical and psychosocial conditions or address the interaction between Suboxone and patient concomitant use of alcohol or controlled substances, to include benzodiazepines or marijuana; (6) Licensee failed to describe an induction procedure for Suboxone or a titration procedure when patients complained of withdrawal symptoms; and (7) Licensee failed to set forth clinical findings to support a diagnosis and treatment of hypogonadism or hypothyroidism. Specific examples of substandard care include the following:

a. In August of 2003, Licensee's assessment of Patient A included a diagnosis of hypogonadism and hypothyroidism, and ordered an intramuscular injection of testosterone. The only stated clinical finding to support this diagnosis was a statement recorded on September 11, 2003 that the patient "will start on thyroid if fatigue is not resolved." On October 14, 2003, Licensee initiated a trial of testosterone (Androgel, Schedule III) and levothyroxine (Synthroid), with a chart note that states: "testosterone shots...still having some fatigue – and + energy no side effects from the test...has [increased] sex drive." A lab report for August 12, 2003 reflects a TSH (thyroid stimulating hormone) of 7.41 (slightly elevated) and a free T4 level of 0.94 (normal). Licensee does not chart a comprehensive physical examination, clinical findings, consultation with an endocrinologist, or repeated laboratory tests to establish a diagnosis of either hypothyroidism or hypogonadism. On November 17, 2003, Licensee increased the dosage of Synthroid to 100 mcgs qd (every day) with a comment in the chart that the

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

b. Patient B was hospitalized in January 2009 with a seizure most likely associated with alcohol dependence or abuse. Although Patient B reported drinking 4 -5

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

prescribing Morphine for Patient B after expressing concerns about his alcohol use and recent hospitalizations for alcohol abuse.

c. In March of 2005, Licensee diagnosed Patient C as suffering from gout in his toe, and in subsequent years, continued to diagnose gout and provided treatment with joint injections of triamcinolone (Kenalog) and prescriptions of hydrocodone & acetaminophen (Norco, Schedule III) without a diagnosis that is established in the chart. The chart notes reflect that Licensee failed to conduct any testing for uric acid levels or joint fluid for uric acid crystals from 2004 through 2010. Licensee's chart notes lack clinical findings, to include laboratory reports, to support the diagnosis or treatment of gout. On January 26, 2011, there is a chart note stating that since Patient C started taking Uloric, he had suffered no further gout attacks. Patient C indicated that he wanted to try Embeda in September 2010. Licensee also administered Kenalog (a steroid) on October 13, 2010, while Patient C participated in the Embeda study, in violation of the study protocol, and failed to document his rationale and patient response to a rapid titration of Embeda from 160 mg per day to 320 mg per day, resulting in complaints of constipation and withdrawal from the study.

d. Patient F, a 18 year old male patient, presented to Licensee for treatment of pain associated with a T6 and T8 compression fracture he suffered during a motocross event on or about October 17, 2010 and a history that included treatment by another provider with Oxycodone HCL, 5 mg on 10/19/2010. On 11/11/2010, Licensee prescribed Oxycodone HCL, 5 mg, #60 (Schedule II), with instructions to take 1 tablet every 4 to 6 hours as needed. Licensee issued this same prescription (with instructions to take 1 - 2 tablets every 4 to 6 hours as needed for pain) on 12/6/2010, 12/30/2010, 1/19/2011, 3/24/2011, 4/25/2011, and 6/3/2011. Licensee prescribed a trial of Hydrocodone / Acetaminophen 5/325 #60 on 1/17/2011, without seeing the patient or documenting the reason for the change in medication. As noted above, two days later

(1/19/2011) Licensee resumed the existing prescription of Oxycodone. Licensee prescribed 10 mg of Oxycodone HCL (1 tablet every 4 – 6 hours for pain) on the following dates: 2/7/2011, 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 chart notes reflect that Patient F was seen at Licensee's clinic on 11/11/2010, 12/30/2010, 1/19/2011, 3/7/2011, 8/15/2011, and 8/30/2011. On August 15, 2011, Licensee charted "Pt here for induction" and "opiate dependence—suboxone induction." Patient F received Suboxone from Licensee or his designee at his clinic on that date. Licensee's chart notes fail to document any urine drug screening test, no documented medical reasoning regarding the risk and benefit of continued opiate therapy, and no stated rationale or treatment plan for initiating Suboxone therapy. In addition, Licensee allowed more than five months to pass without patient follow up, only to conclude 8/15/2011 that Patient F was opiate dependent.

e. Patient G, a 31 year old female, initially presented to Licensee as a patient in July 2006 seeking an allergy shot. She returned to his clinic on March 29, 2010, complaining of withdrawal symptoms associated with using high doses ("15 – 20 qd") of Vicodin (Schedule III), Oxycodone (Schedule II), OxyContin (Schedule II) and Percocet (Schedule II) that she acquired "off the street." Licensee's stated diagnosis was "opiate withdrawal" based upon her report and determined that she was a candidate for Suboxone. Licensee charted that she complained of "headache, stomach ache – diarrhea – fatigue." Licensee's chart note reflects that he did not examine her, to include failing to check for the presence of infectious disease, and made no clinical findings to support the diagnosis of opiate withdrawal. In addition, Licensee did not ask her to undergo a urine screening test to confirm the recent use of drugs or to detect the presence of unreported substances, did not conduct a mental status examination and did not conduct a pregnancy screening test. Licensee dispensed to her ½ tablet of Suboxone at 1033, at 1052, Licensee's chart notes: "25% of symptoms gone – no stomach ache." At 1053, Licensee

dispensed another ½ tablet of Suboxone to Patient G. At 1113, Licensee's chart notes: "75% of symptoms gone – headache gone – feels much better." At 1114, Licensee dispensed another ½ tablet of Suboxone to Patient G (total dose of 12 mgs). Licensee provided 90 tablets of Suboxone to Patient G during that clinical visit, with no plans for follow up or written instructions provided to the patient. Licensee had no chart notes pertaining to the induction of Suboxone for this patient other than what has been referenced, and no note pertaining to stabilization and maintenance of Suboxone. Patient G was never re-examined or followed by Licensee, although she continued to receive packages containing 90 tablets of Subxone (12 mg) in April and May 2010. Licensee did not refer Patient G for drug treatment or counseling.

On November 16, 2011, the Board issued an Order for Evaluation, directing Licensee to undergo an evaluation at the Center for Personalized Education for Physicians (CPEP). Licensee underwent the ordered evaluation, and CPEP subsequently issued an Assessment Report, dated March 26, 2012. The report noted deficiencies in Licensee's charting, to include inadequate documentation of prescriptions, failing to document refills, failing to sign informed consent forms, and a lack of written informed consent agreements in regard to Suboxone therapy. The report concluded that while Licensee's knowledge about Suboxone was "adequate, overall" and that his clinical judgment and reasoning was "mostly adequate" there were "a few important lapses regarding application of knowledge, primarily in the area of chronic pain management." The report also noted that while Licensee "understood the disease concept of addiction, his knowledge of the principles of screening, diagnosis, and treatment of substance abuse was incomplete." This report's findings in regard to Licensee's lapses in medical knowledge and clinical judgment and reasoning reflect deficiencies that are consistent with the shortcomings identified by the Board's review of Licensee's charts.

The CPEP Assessment Report also identified "discrepancies" in four patient charts that Licensee submitted to CPEP as part of the assessment process. These charts, pertaining to

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

Additionally, the Licensee submitted incomplete and misleading information as part of his intake to CPEP in regards to his 2009 Board Order by failing to disclose that he had prescribed a schedule II controlled substance for a staff member and then diverted this medication for his personal use. Licensee's curriculum vitae that was submitted to CPEP incorrectly listed the identity of his osteopathic medical school as Western Michigan University. By submitting incomplete and misleading information and altered medical records to CPEP, Licensee failed to comply with the Board's order to undergo the evaluation at CPEP, and compromised the assessment process.

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

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

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

3.

CONCLUSIONS OF LAW

Licensee's conduct, as described above, breached well recognized standards of practice and ethics of the medical profession. Licensee engaged in multiple acts that place his patients at serious risk of harm. He also engaged in multiple acts of unethical conduct, to include submitting falsified records to the Board as well as CPEP, providing false and misleading information to the proponent of the Embeda clinical drug study, seeing patients while his license was suspended, and dispensing controlled substances at his clinic in 2010 and 2011 that violated the terms of the Board's Stipulated Order of 2009 as well as the Board's Order for Emergency Suspension and the Order for Evaluation. Licensee's medical practice, in regard to his management of patient complaints of chronic pain, his selection of patients to participate in the

clinical drug study, his failure to comply with study protocols, and the delivery of care to patients with other health care issues, to include the diagnosis and treatment of gout, hypogonadism and hypothyroidism, can only be described as grossly negligent. The Board concludes that Licensee's conduct violated 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.

Based upon its examination of the record in this case, the Board finds that each alleged violation of the Medical Practice Act is supported by reliable, probative and substantial evidence. Licensee is unethical and grossly incompetent. The Board also notes that throughout the course of the investigation, Licensee has not taken responsibility for his own conduct. Instead, he has blamed his clinic employees while asserting that he provided good patient care. It is therefore necessary to revoke his license to practice medicine.

4.

ORDER

IT IS HEREBY ORDERED THAT the license of Joseph Earl Yankee, D.O., to practice medicine is revoked. The violations of the Medical Practice Act alleged in the Board's Amended Complaint and Notice of Proposed Disciplinary Action, issued on May 17, 2012, are affirmed. The Board's Order of Emergency Suspension, dated December 2, 2011 is also affirmed. In addition, Licensee is assessed a civil penalty of $10,000 and is assessed the costs of the

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disciplinary proceedings, to include the hearing on remand that was held on January 18, 2017. The Order of Emergency Suspension terminates when this Order becomes final by operation of law.

DATED this 23rd day of August, 2017.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

MICHAEL MASTRANGELO, JR., 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.

CERTIFICATE OF MAILING

On August 31, 2017, I mailed the foregoing Final Order on Default regarding Joseph Earl Yankee, DO, to the following parties:

By: First Class Certified/Return Receipt U.S. Mail
Certified Mail Receipt # 7016 0340 0000 0470 0604

Joseph Earl Yankee, DO
16800 S. Beckman Road
Oregon City, OR 97045

By: First Class Certified/Return Receipt U.S. Mail
Certified Mail Receipt # 7016 0340 0000 0470 1571

Tara M. Costanzo
Lindsay, Hart, LLP
1300 SW 5th Avenue, Suite 3400
Portland, OR 97201

By: Regular Mail

Warren Foote
Department of Justice
1162 Court St NE
Salem OR 97301

Beverly Loder
Beverly Loder
Investigations Secretary
Oregon Medical Board

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

IN THE MATTER OF:	)	
	)	**FINAL ORDER ON REMAND**
JOSEPH EARL YANKEE, DO	)	
LICENSE NO. DO19458	)	

HISTORY OF THE CASE

On December 2, 2011, the Oregon Medical Board (Board) issued an Order of Emergency Suspension to Joseph E. Yankee, DO, immediately suspending his medical license. On January 11, 2012, the Board issued a Complaint and Notice of Proposed Disciplinary Action to Dr. Yankee, proposing to take disciplinary action against him.

On February 3, 2012, Dr. Yankee, through his attorney Thomas McDermott, requested a hearing on the Notice and the Order of Emergency Suspension. The Board referred the matters to the Office of Administrative Hearings (OAH) on February 10, 2012. The OAH assigned Administrative Law Judge Alison Webster to preside over the matters. During a February 28, 2012 telephone conference, the two matters were consolidated for hearing and the hearing was scheduled for June 18 through 21, 2012.

On May 17, 2012, the Board issued an Amended Complaint and Notice of Proposed Disciplinary Action (Amended Notice) to Dr. Yankee, proposing to revoke his medical license and assess a civil penalty and the costs of the disciplinary proceeding. During a May 21, 2012 status conference, the hearing was rescheduled to August 13 through 16, 2012, to allow Dr. Yankee's counsel additional time to review the Amended Notice.

On June 18, 2012, Dr. Yankee's counsel withdrew from representation of Dr. Yankee. On the Board's request, on July 2, 2012, the OAH scheduled a telephone status conference for July 9, 2012. Dr. Yankee did not participate in the July 9, 2012 telephone conference.[1]

On August 6, 2012, Dr. Yankee submitted a request to postpone the hearing. On August 7, 2012, ALJ Webster denied the request.

On August 13, 2012, ALJ Webster convened an in-person hearing in Portland, Oregon. The Board appeared, represented by Senior Assistant Attorney General (AAG) Warren Foote. After 18 minutes without appearance by Dr. Yankee, ALJ Webster found Dr. Yankee in default.

On October 10, 2012, Dr. Yankee submitted a motion to reschedule the hearing to the Board, asserting reasons for his failure to appear at the hearing. On February 4, 2013, the Board issued a Default Final Order based upon Dr. Yankee's failure to appear at the August 13, 2012,

[1] The OAH's notice for the conference was sent to Dr. Yankee at an incorrect address.

hearing. In the Default Final Order, the Board found that Dr. Yankee's failure to appear for the hearing was not attributable to good cause or to circumstances beyond his reasonable control. In the Default Final Oder, the Board revoked Dr. Yankee's medical license and assessed him a civil penalty and the costs of the hearing.

Dr. Yankee sought judicial review of the Default Final Order by the Oregon Court of Appeals. On October 4, 2016, the Court of Appeals issued its ruling, reversing the Board's decision and remanding the matter to the Board, finding that Dr. Yankee "was entitled to have a hearing before a neutral ALJ on the reasons for his not appearing" at the August 2012 hearing.[2]

On October 12, 2016, the Board referred the matter to the OAH for a hearing on Dr. Yankee's reschedule request. On October 21, 2016, ALJ Webster convened a prehearing conference. Senior AAG Foote appeared on behalf of the Board. Mr. McDermott appeared on behalf of Dr. Yankee. ALJ Webster scheduled the hearing for December 8, 2016, and set deadlines for submission of witness lists and exhibits.

On November 4, 2016, the OAH reassigned the matter to ALJ Samantha Fair. On December 8, 2016, the Department of Administrative Services closed state buildings in the Portland metropolitan area, which included the Board's location where the hearing was scheduled, because of hazardous weather and road conditions. Therefore, the hearing had to be postponed.

On December 14, 2016, ALJ Fair convened a telephone prehearing conference. Senior AAG Foote appeared on behalf of the Board as well as Eric Brown. Attorney Tara Costanzo appeared on behalf of Dr. Yankee. Ms. Costanzo confirmed that she would be the attorney representing Dr. Yankee at the hearing. ALJ Fair scheduled the hearing for January 18, 2017, at 9 a.m. On January 17, 2017, the parties agreed to delay the commencement of the hearing until 1 p.m. in consideration of potentially hazardous weather and road conditions.

On January 18, 2017, ALJ Fair convened an in-person hearing in Portland, Oregon. Dr. Yankee appeared, testified[3] and was represented by Ms. Costanzo. The Board appeared and was represented by Senior AAG Foote. Also testifying on behalf of the Board was Terry Lewis, a retired Board investigator and compliance officer. The evidentiary record closed on January 18, 2017, at the conclusion of the hearing.[4] The record closed on February 6, 2017, after receipt of the transcript of the hearing.

ISSUE

Whether Dr. Yankee had good cause for failing to appear at a previously scheduled hearing. OAR 137-003-0670(2).

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[2] Yankee v. Oregon Medical Board, 280 Or App 1 (2016).

[3] Dr. Yankee was called as a witness by both parties.

[4] The record remained open for the receipt of the transcript of the hearing from the court reporter.

EVIDENTIARY RULINGS

Exhibits A1 through A6, offered by the Board, were admitted into the record without objection. Exhibits R1 through R14, offered by Dr. Yankee, were admitted into the record without objection.

FINDINGS OF FACT

1. The Board issued Dr. Yankee a medical license more than 20 years ago. (Tr. at 48.)

2. On December 2, 2011, the Board issued Dr. Yankee an Order of Emergency Suspension, immediately suspending his medical license. (Ex. R1 at 1, 10.) The Order of Emergency Suspension stated that Dr. Yankee was entitled to a contested case hearing on the suspension if the Board received a request for hearing within 90 days. The Order of Emergency Suspension further stated that the Board would notify Dr. Yankee of the time and place for the hearing if he requested one. (*Id.* at 9.) The Order of Emergency Suspension provided no other information regarding any potential hearing. (Ex. R1.) Dr. Yankee received this Order of Emergency Suspension. (Tr. at 28.)

3. On January 11, 2012, the Board issued Dr. Yankee a Complaint and Notice of Proposed Disciplinary Action. (Ex. R4 at 1.)

4. Attorney Thomas McDermott represented Dr. Yankee regarding the Board's allegations and continued to represent him until June 18, 2012. (Ex. R3 at 1-2.) Dr. Yankee, through Mr. McDermott, timely requested a hearing on the Order of Emergency Suspension and the Complaint and Notice of Proposed Disciplinary Action. (Ex. R4 at 1; Tr. at 46.) Dr. Yankee understood that only by prevailing at a hearing would he be able to get his medical license reinstated. (Tr. at 48.)

5. On February 27, 2012, the OAH issued a Notice of Prehearing Conference, scheduling a telephone prehearing conference for February 28, 2012, at 9 a.m. The notice advised the parties that "If you fail to call within **five (5) minutes** after the time set for the prehearing conference, the prehearing conference may proceed without you." (Ex. R11 at 1, 6; emphasis in original.) Subsequent notices of prehearing conference sent in this contested case proceeding included this same language. (Exs. R8 and R12.)

6. On May 17, 2012, the Board issued Dr. Yankee the Amended Complaint and Notice of Proposed Disciplinary Action, proposing to revoke his medical license and assess him a civil penalty and the costs of the proceeding. (Ex. R2 at 1, 11, 13.) The Amended Notice provided:

> Failure by Licensee to request a hearing or failure to appear at any hearing scheduled by the Board will constitute waiver of the right to a contested case hearing and will result in a default order by the Board, including the revocation of his medical license and assessment of such penalty and costs as the Board deems appropriate under ORS 677.205. If a default order is issued, the record of proceeding to date, including

> Licensee's file with the Board and any information on the subject of the contested case automatically becomes a part of the contested case record for the purpose of providing a prima facie case per ORS 183.417(4).

(*Id.* at 11.) Dr. Yankee received the Amended Notice. (Tr. at 30.) Dr. Yankee understood from the Amended Notice that if he did not appear for the hearing, that the Board "could put me in default and revoke my license." (*Id.* at 32.)

7. On May 23, 2012, the OAH issued a Notice of Rescheduled In-Person Hearing. (Ex. R9 at 1, 6.) The notice provided the following information regarding the date, time and location of the in-person hearing:

> **Hearing Date: August 13, 2012 through August 16, 2012**
>
> **Hearing Time: 9:00 a.m.**
>
> **Location:** **Oregon Medical Board**
> **1500 SW First Ave Ste 620**
> **Portland OR 97201**

(*Id.* at 1; emphasis in original.) The notice included a Notice of Contested Case Rights and Procedures for Board Licensees (emphasis in original) (Contested Case Notice). The Contested Case Notice included the following procedural information:

> **8. Order of evidence.**
> A hearing is similar to a court proceeding but is less formal. Its general purpose is to determine the facts and whether the Board's proposed action is appropriate. The order of presentation of evidence is normally as follows:
> a. Testimony of witnesses and other evidence of Board in support of its proposed action.
> b. Testimony of your witnesses and your other evidence.
> c. Rebuttal evidence by the Board and by you.
>
> **9. Burden of presenting evidence.**
> * * * All witnesses are subject to cross-examination and also to questioning by the ALJ.
>
> * * * * *
>
> **11. Objections to evidence.**
> Objections to the admissibility of evidence must be made at the time the evidence is offered[.]

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(*Id.* at 3-4; emphasis in original.) Neither notice provided any information on the procedures that occur when a party fails to appear for the hearing.[5] (Ex. R9.) Dr. Yankee received the Notice of Rescheduled In-Person Hearing prior to August 13, 2012. (Tr. at 22, 33, 47.)

8. On June 18, 2012, Dr. Yankee's attorneys, Mr. McDermott and Mr. Michael Estok, gave written notice to all parties, including Dr. Yankee, that they no longer represented him. In the written notice, the attorneys notified the parties of Dr. Yankee's mailing address. (Ex. R7 at 1-2.) Dr. Yankee's attorneys withdrew from his representation because Dr. Yankee could no longer pay them. (Tr. at 38.)

9. At the Board's request, on July 2, 2012, the OAH issued a Notice of Prehearing Conference to the parties, scheduling a telephone prehearing conference for July 9, 2012. The OAH failed to mail the notice to Dr. Yankee at the address provided by Dr. Yankee's former attorneys. (Exs. A2 at 1; R8 at 1, 3; test. of Yankee, Tr. at 40-41.) Dr. Yankee never received this notice and was unaware of any such prehearing conference. (Ex. R4 at 2; Tr. at 41.) Dr. Yankee did not appear for the July 9, 2012, prehearing conference. (Tr. at 41-42.)

10. On July 13, 2012, the Board mailed a copy of its exhibits to the ALJ and Dr. Yankee. In the cover letter, the Board identified its witnesses as: Joseph E. Yankee, DO, Terry Lewis, Deborah Waltz, Jill Stransky, Cassie Stalheim, Anthony Edwards and Sanford Fox. (Ex. A6 at 3.) On July 25, 2012, Dr. Yankee received the mailing. (*Id.* at 1; Tr. at 51-52.)

11. On July 31, 2012, the Board mailed a letter to the ALJ and Dr. Yankee, in which it supplemented its witness list by two additional witnesses, Dr. Joseph Thaler and Dr. Andrew Mendenhall. (Ex. R5 at 1.)

12. Dr. Yankee secured a loan to rehire Mr. McDermott, who now had a scheduling conflict with the August hearing dates. (R4 at 1; Tr. at 39.) Mr. McDermott indicated he would resume representing Dr. Yankee if the hearing dates were changed. (Tr. at 39.) On August 6, 2012, Dr. Yankee submitted a written request for "a postponement of my hearing on Aug 13, 2012" so that Mr. McDermott could represent him. (Ex. A1 at 1; Tr. at 39.)

13. On August 7, 2012, the OAH issued to the parties ALJ Webster's Ruling Denying Licensee's Motion to Postpone Hearing. (Ex. A2 at 1-3.) In the ruling, ALJ Webster found:

> In this case, in May 2012, the hearing was rescheduled from June to mid-August. Licensee knew by June 18, 2012 that his counsel had withdrawn. He did not request a postponement of the hearing at that time. In the intervening six weeks since his attorney withdrew, Licensee did not contact the Board or the OAH to advise of his efforts to secure new representation. Licensee also did not call in for the July 9, 2012 status conference. Licensee waited until August 6, 2012, seven days prior to the scheduled hearing to request a postponement. Although Licensee has explained the reason for counsel's withdrawal and the basis

[5] A Notice of In-Person Hearing, scheduling the hearing for June 18, 2012 through June 21, 2012, contained this same language. (Ex. R13.)

> for his request to continue the hearing, he has not established good cause under the standard set forth above. For this reason, Licensee's request to postpone the hearing is denied.

(*Id.* at 2.) Dr. Yankee received the ruling on August 10, 2012. (Exs. A5 at 3; R4 at 2; Tr. at 23.)

14. On August 13, 2012, ALJ Webster convened the in-person hearing. The Board was present, represented by AAG Foote. Also present on behalf of the Board were Mr. Lewis and Dr. Andrew Mendenhall. Dr. Yankee was not present. At 9:20 a.m., ALJ Webster declared Dr. Yankee in default. (Ex. A3 at 3-4.) Prior to declaring Dr. Yankee in default, a Board employee had called Dr. Yankee at the phone number for Dr. Yankee listed on his postponement request and received no response. (*Id.* at 5-6; A4 at 1.) The hearing was adjourned at 9:23 a.m. (Ex. A3 at 7.)

15. When the hearing convened at 9 a.m. on August 13, 2012, Dr. Yankee was at his house in Oregon City. He was aware that the hearing was scheduled to begin at 9 a.m. (Tr. at 25, 27.) Dr. Yankee never appeared at the Board's office for the hearing on August 13, 2012. (*Id.* at 62.) Dr. Yankee knew that the hearing would take place at the Board's office. (*Id.* at 21-22.) Dr. Yankee was not ill on August 13, 2012. (*Id.* at 26.)

16. On August 13, 2012, Dr. Yankee received a call from his prior office manager Jill Stransky, one of the Board's witnesses. Ms. Stransky called and yelled at him, wanting to know why he had not been at the hearing. Dr. Yankee then called Mr. McDermott and subsequently called the Board. (Tr. at 42-43.)

17. On August 13, 2012, at 1:45 p.m., Dr. Yankee called the Board and spoke with Mr. Lewis. Mr. Lewis advised Dr. Yankee that "the Board had prevailed in the hearing by default as he had failed to appear." (Ex. A4 at 1; Tr. at 63.) Dr. Yankee told Mr. Lewis he thought the hearing started on Tuesday, August 14, 2012. He also told Mr. Lewis that he thought the first day of the hearing would be for the Board's witnesses and that his case would be presented on the second day of the hearing. (Ex. A4 at 1, 3; Tr. at 44, 65-66.)

18. On October 3, 2012, Dr. Yankee signed a Declaration of Joseph Yankee, declaring the statements contained therein to be true. (Ex. R4 at 1, 3.) In the declaration, Dr. Yankee stated:

> 7. * * *. I intended to appear and defend myself and to question any witnesses called by the Board. * * *. Consequently, I planned to come to the hearing mid-morning to listen to the Board's evidence and participate as best I could, without counsel, during the course of the four-day hearing.
>
> 8. Sometime around 10:00 am on August 13, 2012, I called the Board to confirm the location of the room where the hearing would be held and spoke with Terry Lewis. He informed me that the hearing was "over" because I had not shown up at 9:00 am[.]

(*Id.* at 2.) On January 18, 2017, Dr. Yankee maintained that the declaration's contents were correct and truthful. (Tr. at 53.)

19. On October 21, 2016, the OAH issued a Notice of In-Person Hearing, scheduling an in-person hearing for December 8, 2016. This notice included the following additional language that had not appeared in the 2012 notice:

> **Important note**: If you fail to appear within 15 minutes of the time set for your hearing, your request for hearing may be dismissed or the hearing may proceed without you.

(Ex. R10 at 1, 3; emphasis in original.)[6] This additional language did not appear in any of the notices of hearing that Dr. Yankee received prior to August 13, 2012. (Exs. R8, R9, R11 and R12; Tr. at 37.)

20. Neither the Board nor the OAH ever told, or put in writing, to Dr. Yankee that he would be found in default if he failed to appear for the hearing by 9:20 a.m. on August 13, 2012. (Exs. R4 at 3; R1, R2, R9, R11 – R13.)

21. Dr. Yankee had been a practicing physician since the initial granting of his medical license until the Board suspended his license in December 2011. The reinstatement and retention of his medical license is necessary for his livelihood. (Tr. at 48-49.)

CONCLUSION OF LAW

The Board adopts ALJ Fair's conclusion of law and her supporting opinion that Dr. Yankee did not have good cause for failing to appear at a previously scheduled hearing.

OPINION

Dr. Yankee asserts that he had good cause for failing to appear at the hearing scheduled to begin at 9 a.m. on August 13, 2012. As the proponent of the allegation, he has the burden to establish, by a preponderance of the evidence, good cause for his failure to appear. ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Comp. of Harris v. SAIF*, 292 Or 683, 690, 642 P.2d 1147 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor, Inc. v. Tandy Corp.*, 303 Or 390, 402, 737 P.2d 595 (1987).

OAR 137-003-0670(2) provides:

> If the party failed to appear at the hearing and, before issuing a final order by default, the agency or administrative law judge finds that the

[6] A Notice of In-Person Hearing, scheduling the hearing for January 18, 2017, contained this same language. (Ex. R14.)

> party had good cause for not appearing, the agency or administrative law judge may not issue a final order by default under section (1)(c) of this rule. In this case, the administrative law judge shall schedule a new hearing. If the reasons for the party's failure to appear are in dispute, the administrative law judge shall schedule a hearing on the reasons for the party's failure to appear.

OAR 137-003-0501(7) defines "good cause." It provides:

> For purposes of OAR 137-003-0501 to 137-003-0700, "good cause" exists when an action, delay, or failure to act arises from an excusable mistake, surprise, excusable neglect, reasonable reliance on the statement of a party or agency relating to procedural requirements, or from fraud, misrepresentation, or other misconduct of a party or agency participating in the proceeding.

There was no evidence and no assertion that Dr. Yankee failed to appear at the prior hearing because of fraud, misrepresentation or other misconduct by the Board or the OAH. Dr. Yankee received the Notice of Rescheduled In-Person Hearing that clearly stated that the hearing began at 9 a.m. on August 13, 2012. Therefore, there was no evidence of any surprise regarding the date, time or location for the commencement of the hearing. Finally, there was no evidence that the Board or the OAH ever informed Dr. Yankee that he did not need to appear at the commencement of the scheduled hearing. There was no evidence to support a finding that Dr. Yankee reasonably relied on any statement from the Board or the OAH for his failure to appear at the prior hearing. Pursuant to OAR 137-003-0501(7), for Dr. Yankee to establish "good cause," his failure to appear must be due to excusable mistake or excusable neglect.

Dr. Yankee's reason for his failure to appear must be known in order to determine if it qualifies as excusable mistake or excusable neglect. Dr. Yankee's credibility is essential to determining why he failed to appear for the August 2012 hearing. To reconcile any conflicts in the record and determine which evidence is more likely than not true, it is necessary in this case to assess the credibility and reliability of the following: Dr. Yankee's prior statement to the Board's investigator; his subsequent sworn declaration; and his testimony at hearing.

ORS 44.370 provides, in part:

> A witness is presumed to speak the truth. This presumption, however, may be overcome by the manner in which the witness testifies, by the character of the testimony of the witness, or by evidence affecting the character or motives of the witness, or by contradictory evidence.

A determination of witness credibility can be based on a number of factors, other than the manner of testifying. These factors include the inherent probability of the evidence, whether the evidence is corroborated, whether the evidence is contradicted by other testimony or evidence, whether there are internal inconsistencies, and "whether human experience demonstrates that the evidence is logically incredible." *Tew v. DMV*, 179 Or App 443, 449, 40 P.3d 551, 555 (2002),

citing Lewis and Clark College v. Bureau of Labor, 43 Or App 245, 256 (1979) *rev den* 288 Or 667 (1980) (Richardson, J., concurring in part, dissenting in part). A review of the record establishes that Dr. Yankee's testimony and statements regarding his reason for his failure to appear lack credibility.

On the afternoon of August 13, 2012, Dr. Yankee informed the Board's investigator that he believed the hearing started on Tuesday, August 14, 2012, not Monday, August 13, 2012. Although he further indicated to Mr. Lewis that he believed his case would be presented on the second day of the scheduled hearing, this statement did not contradict his initial statement of his belief that the hearing started on Tuesday, not Monday. However, at the January 18, 2017, hearing, Dr. Yankee asserted that he knew the hearing began at 9 a.m. on August 13, 2012. His current testimony is inconsistent with his statement to Mr. Lewis, which was made contemporaneously to the August 13, 2012 hearing date.

On October 3, 2012, Dr. Yankee completed a sworn declaration, which he currently maintains to be accurate and truthful. In the declaration, he indicated that he called the Board on August 13, 2012 "to confirm the location of the room where the hearing would be held." However, his testimony at hearing directly contradicts this sworn statement. Although he did call the Board, he did not call to confirm the location of the hearing. Instead, he called because a Board witness, his former office manager, had called him to find out why he had failed to appear at the hearing. Once again, Dr. Yankee's current testimony contradicts a prior, and in this case, sworn statement made almost contemporaneously to the August 13, 2012 hearing date.

In the October 2012 declaration, Dr. Yankee stated that "I intended to appear and defend myself and to question any witnesses called by the Board. * * *. Consequently, I planned to come to the hearing mid-morning to listen to the Board's evidence * * *." ALJ Fair found these two statements contradictory and the second statement improbable. ALJ Fair found it quite persuasive that Dr. Yankee would want to "appear and defend myself and to question any witnesses called by the Board." Dr. Yankee's livelihood depends upon successfully defending himself at the hearing in order to have his medical license reinstated. To do so, he would need to listen to *all* of the Board's evidence so that he could challenge it through cross-examination of witnesses and be prepared to present his own evidence in contradiction to the Board's evidence. Thus, choosing to arrive at some indeterminate point later in the day would fail to achieve the objective of mounting the most effective defense to secure the reinstatement of his license.

Additionally, ALJ Fair observed that human experience demonstrates that Dr. Yankee's testimony is logically incredible. When one's livelihood is on the line, a person would err on the side of caution to take any and all reasonable steps to defend his license. It is not credible that Dr. Yankee would decide, based upon no evidence, that he did not need to appear at the time his hearing was scheduled to begin.[7] It is not credible that Dr. Yankee would believe, based upon no evidence, that an evidentiary hearing, which he requested, would continue in his absence.

[7] Dr. Yankee argued that the Contested Case Notice led him to believe that the Board would present its case the first day and he would present his case the second day based upon paragraph 8 of the notice. However, the notice does not state that. Paragraph 8 of the Contested Case Notice stated that normally the Board presents its evidence first, followed by the other party's evidence, and followed by rebuttal evidence. There was no mention of how long each party's case would take. Despite the lack of such language, Dr. Yankee asserted that the Board would take one day to present its evidence, and he would take one day to present his, and then the third or fourth day would be if the

Dr. Yankee's lack of credibility is further supported by his inconsistent testimony during the 2017 hearing. During the hearing, he asserted that he did not believe he needed to be at the hearing when the Board presented its evidence. (Tr. at 28.) He also asserted that he did not intend to appear until the second day of the hearing, at which time he would present his evidence. (*Id.* at 36.) However, he continued to assert that he intended to question the Board's witnesses. (*Id.* at 54-55.) When this inconsistency was pointed out to him, Dr. Yankee contended that the Board's witnesses would be present and available for him to cross-examine on the second day of the hearing. This directly contradicted his earlier contention that the second day of hearing was reserved for him, and not the Board, to present evidence. (*Id.* at 54.) Subsequently, Dr. Yankee testified that he intended on appearing at some point on the first day of the hearing, contradicting his earlier testimony that he did not intend to appear for the first day of the hearing. (*Id.* at 28, 56.) Dr. Yankee testified that trials are held over a period of a few days and "you show up when it's your turn." (*Id.* at 33.) But he then denied any basis for such knowledge when he testified that he had never been in a courtroom for a lawsuit. (*Id.* at 50.) Additionally, he testified that his actual prior legal experience was limited to providing declarations and being deposed as a witness, confirming that he always appeared at the specified date and time for depositions. (*Id.* at 50-51.)

Based on ALJ Fair's assessment of Dr. Yankee's credibility, the Board adopts ALJ Fair's finding that that his testimony regarding his reason for not appearing at the beginning of his scheduled August 2012 hearing was implausible, contradictory to his earlier statements to the Board's investigator and in his declaration, and uncorroborated by other evidence. As a result, ALJ Fair found that Dr. Yankee's testimony, in which he asserted that he believed he did not have to appear for the first scheduled day of the hearing and could wait to appear to present his case on the second day, lacked credibility.

Dr. Yankee made some additional arguments in support of his failure to appear at the August 2012 hearing. First, he asserted that he never received any notification from the OAH or the Board that, if he failed to appear by 9:20 a.m. on August 13, 2012, he would be in default. However, this argument is not persuasive. Although he did not receive any such specific warning, he also never received any notification that he could not attend the first scheduled hearing day and not be considered in default. In fact, the one notification that he received that directly discussed what would happen if a party failed to appear for a hearing was the Amended Notice. The Amended Notice contained an explanation that a failure to appear "at any hearing * * * will constitute waiver of the right to a contested case hearing and will result in a default order * * *." Therefore, the Amended Notice made clear that Dr. Yankee's failure to appear would be a waiver of his right to a hearing, *i.e.*, no hearing would occur.

Dr. Yankee also argued that his failure to appear on August 13, 2012, was related to his failure to attend the July 9, 2012, prehearing conference. Dr. Yankee asserted that, if he had attended the July 9, 2012, prehearing conference, he may have been told that he had to appear no later than 9:20 a.m. on August 13, 2012, or be found in default. Dr. Yankee is correct that the

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Board's or his evidence took longer. His testified "belief" that his case would not be presented until the second day, and therefore he would not need to be present until the second day, was not supported by the language of the Contested Case Notice.

OAH failed to issue the notice for this prehearing conference to his correct mailing address; therefore, his failure to attend the prehearing conference was due to the OAH's error. However, the prehearing conference did not result in any changes to the scheduled hearing, and it is merely speculation whether Dr. Yankee would have learned anything during the course of the prehearing conference about his required attendance at the hearing. Whether Dr. Yankee had good cause for his failure to appear on August 13, 2012, must be based on his actual reasons and knowledge, not speculative reasons and knowledge.[8] For this same reason, any new language from the 2017 notices of hearing are irrelevant to a determination of whether Dr. Yankee had good cause to fail to appear for the 2012 hearing.

Dr. Yankee received the Amended Notice that advised him that he would be in default and waive his right to a hearing if he failed to appear for the contested case hearing. Dr. Yankee received the Notice of Rescheduled In-Person Hearing, which scheduled the contested case hearing to begin at 9 a.m. on August 13, 2012. Dr. Yankee knew of the date, time and location of the hearing he had requested but failed to appear for the hearing. There was no evidence that his failure to appear was due to surprise, reasonable reliance on the statement of a party or agency relating to procedural requirements, or from fraud, misrepresentation, or other misconduct of a party or agency participating in the proceeding. Dr. Yankee testified that his failure to appear was due to excusable neglect or excusable mistake based upon a mistaken belief that his presence was unnecessary at the hearing until such time as he needed to present his own evidence. However, as explained above, his testimony regarding this reason for his failure to appear lacked credibility. Dr. Yankee provided no other explanation for his failure to appear. Therefore, the evidence failed to establish that excusable neglect or excusable mistake caused his failure to appear for the August 13, 2012, hearing. Dr. Yankee did not have good cause for his failure to appear at the hearing, which was scheduled to commence at 9 a.m. on August 13, 2012. ALJ Fair concluded that the Board is entitled to take a final order by default against Dr. Yankee.

ORDER

On April 5, 2017, ALJ Fair issued a Proposed Final Order with a recommendation that the Oregon Medical Board issue an order that Joseph Earl Yankee, DO, did not have good cause for failing to appear at a previously scheduled hearing and that Dr. Yankee's motion to reschedule the August 13, 2012, hearing for the December 2, 2011, Order of Emergency Suspension and May 17, 2012 Amended Complaint and Notice of Proposed Disciplinary Action be denied. In addition, that the Board may issue Final Orders by Default on the December 2, 2011 Order of Emergency Suspension and May 17, 2012, Amended Complaint and Notice of Proposed Disciplinary Action.

The Board notes that Dr. Yankee did not file any exceptions to ALJ Fair's Proposed Final Order.

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[8] Dr. Yankee also dwelt on the denial of his request for postponement, which he and his attorney asserted was because he failed to appear for the July 9, 2012 prehearing conference. As noted in her ruling, ALJ Webster did *not* deny Dr. Yankee's request for postponement because he failed to appear for the prehearing conference. She denied his request because he failed to establish good cause for the requested postponement. The prehearing conference would have simply been an opportunity for Dr. Yankee to broach a request for postponement to secure an attorney prior to the week before the scheduled hearing, when he actually did request the postponement.

ORDER

After considering the matter on remand, the Oregon Medical Board adopts the findings of fact and conclusions of law in the Proposed Order by ALJ Fair, as reflected in this document, and issues the following order:

Joseph Earl Yankee, DO, did not have good cause for failing to appear at the contested case hearing on August 13, 2012. The motion of Joseph Earl Yankee, DO, to reschedule the August 13, 2012, hearing for the December 2, 2011, Order of Emergency Suspension and May 17, 2012, Amended Complaint and Notice of Proposed Disciplinary Action is denied.

DATED this 23 day of August, 2017.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

MICHAEL MASTRANGELO, JR., 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 the final order is served upon you. *See* ORS 183.480 *et seq.*

CERTIFICATE OF MAILING

On August 31, 2017, I mailed the foregoing Final Order on Remand regarding Joseph Earl Yankee, DO, to the following parties:

By: First Class Certified/Return Receipt U.S. Mail
Certified Mail Receipt # 7015 3010 0000 1785 1618

Joseph Earl Yankee, DO
16800 S. Beckman Road
Oregon City, OR 97045

By: First Class Certified/Return Receipt U.S. Mail
Certified Mail Receipt # 7016 0340 0000 0470 0598

Tara M. Costanzo
Lindsay, Hart, LLP
1300 SW 5th Avenue, Suite 3400
Portland, OR 97201

By: Regular Mail

Warren Foote
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1162 Court St NE
Salem OR 97301

Beverly Loder
Beverly Loder
Investigations Secretary
Oregon Medical Board