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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Yashwant S. Chaudhri, M.D.** **4537 College Avenue** **San Diego, CA 92115** **Physician's and Surgeon's Certificate No. A 67679,** Respondent.	Case No. 800-2016-021067 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about March 5, 1999, the Medical Board issued Physician's and Surgeon's Certificate No. A 67679 to Yashwant S. Chaudhri, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . ."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

". . ."

6. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . ."

7. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

8. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 67679 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A, as more particularly alleged hereinafter:[1]

10. On or about June 22, 2013, Patient A went to Respondent's office in Santee, California to commence outpatient psychiatric treatment. Patient A was seen by Respondent's Nurse Practitioner, D.G.

11. According to the notes prepared by Nurse Practitioner D.G. for the June 22, 2013, visit, Patient A had a history of depression and the purpose for the visit was medication management. The notes also indicated that Patient A's primary care provider had prescribed a six-month supply of psychiatric medications to Patient A, but he ran out of the medications 10 days earlier. Patient A's psychiatric medications included Risperdal (risperidone) 2 mg twice daily,[2] Depakote (depakote divalproex sodium)1500 mg once daily,[3] and Paxil (paroxetine) 80 mg once daily.[4] Patient A was noted as having a history of a psychiatric hospitalization three years earlier, neurosyphilis, encephalitis, and use of cannabis since age 17, with the last use being on or about June 21, 2013. Patient A was also noted as having a medical marijuana card. A mental status examination was performed and the following psychiatric diagnoses were noted: Axis I (Bipolar Disorder); Axis II (none); Axis III (history of encephalitis and neurosyphilis); and Axis IV (psychosocial environmental stressors secondary to chronic mental illness). No Axis V assessment was provided.

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[1] References to "Patient A" herein are used to protect patient privacy.

[2] Risperdal is an atypical antipsychotic medication that is used to treat certain mental/mood disorders, such as schizophrenia and bipolar disorder.

[3] Depakote is an anticonvulsant medication that is used to treat the manic symptoms of bipolar disorder.

[4] Paxil is a medication that is used to treat depression, panic attacks, and anxiety disorders.

12. The treatment plan for the June 22, 2013, visit, was to continue with Patient A's current medication regimen as follows: Risperdal 2 mg twice daily, Depakote 1500 mg once daily, and Paxil 40 mg once daily. The notes did not include any explanation for reducing the daily dosage of Paxil from 80 mg to 40 mg, nor did they document any discussion of this change with Patient A. On or about June 23, 2013, Respondent signed Nurse Practitioner D.G.'s notes for this visit and, next to his signature, Respondent handwrote the following statement: "Reviewed assessment and agreed with the treatment plan."

13. On or about July 8, 2013, and August 5, 2013, respectively, Patient A had a follow-up visit with Nurse Practitioner D.G. at Respondent's office. According to the notes prepared by Nurse Practitioner D.G. for these visits, Patient A reported compliance with the medication regimen with no side effects and improved sleeping and eating. A mental status examination was performed and the same prior psychiatric diagnoses were noted. The treatment plan was to continue with Patient A's current medication regimen, including Risperdal, Depakote, and Paxil, along with psychoeducation on psychotropic medicines. Patient A was to return in four weeks. On or about July 8, 2013, and August 5, 2013, respectively, both Nurse Practitioner D.G. and Respondent signed the notes for these visits.

14. On or about September 4, 2013, Respondent saw Patient A at Respondent's office. According to Respondent's notes, Patient A reported compliance with the medication regimen with no side effects and improved sleeping and eating. In addition, Patient A expressed his desire to continue with the same medications. A mental status examination was performed and the same prior psychiatric diagnoses were noted, along with an Axis V Global Assessment of Functioning (GAF) score of 54. The treatment plan was to continue with Patient A's current medication regimen, however, only Risperdal and Paxil were listed. Depakote was not included on the list of medications. Respondent did not note the reasons for stopping Depakote, nor did he document any discussion of this change with Patient A.

15. On or about December 19, 2013, Patient A was seen at Respondent's office. According to the notes for this visit, Patient A reported compliance with the medication regimen with no side effects and improved sleeping and eating. However, Patient A reported that while he

continued to take Risperdal and Paxil, he discontinued Depakote on his own. The notes did not document when Patient A stopped taking Depakote, the reasons for doing so, the risks of stopping Depakote, or the need to change the treatment plan. The treatment plan was to continue with Patient A's current medication regimen with respect to Risperdal and Paxil only. Due to Patient A's extended trip to New Orleans, Patient A was to return in six months. The notes for this visit were signed by Respondent on or about December 19, 2013.

16. On or about June 20, 2014, Patient A was again seen at Respondent's office. According to the notes for this visit, Patient A reported compliance with the medication regimen and improved sleeping and eating. The treatment plan was to continue with Patient A's current medication regimen, which, in addition to Risperdal and Paxil, now included Depakote 1000 mg daily. The notes did not document any discussion with Patient A regarding restarting Depakote, nor did they document the clinical rationale for stopping and restarting the medication and changing the dosage. Patient A was to return in two weeks. The notes for this visit were signed by Respondent on or about June 20, 2014.

17. On or about July 9, 2014, Patient A had a follow-up visit at Respondent's office and was seen by Respondent's Nurse Practitioner, B.J. According to the notes prepared by Nurse Practitioner B.J. for this visit, Patient A's current medication regimen included Risperdal, Paxil, and Depakote. The current medication regimen was discussed and the treatment plan was to decrease the Risperdal dosage to 1 mg twice daily and continue Paxil and Depakote. In addition, a laboratory test for Depakote levels was ordered for July 21, 2014. Patient A was to return on July 23, 2014. The notes for this visit were signed by Nurse Practitioner B.J. and Respondent on or about July 9, 2014.

18. On or about August 26, 2014, a request for refill of Patient A's Paxil medication was faxed to Respondent's office. The request was not approved and included the following notation: "Needs to see Doctor." The medical records, however, did not include any attempts by Respondent's office to contact Patient A regarding the Paxil refills, to set up an appointment with Patient A so that the medication could be refilled, or to otherwise advise Patient A that a follow-up visit was necessary to continue the medication treatment.

19. On or about September 15, 2014, Patient A had a follow-up visit with Nurse Practitioner D.G. at Respondent's office. According to the notes prepared by Nurse Practitioner D.G. for this visit, Patient A reported that he discontinued Depakote on his own and had to stop taking Paxil for the past two weeks because he ran out of refills and the pharmacy's refill request was declined. The treatment plan was to continue Paxil, but increase Risperdal to 2 mg twice daily and add Neurontin (gabapentin)[5] and Cogentin (benztropine)[6] to the medication regimen. The notes did not document any discussion with Patient A regarding increasing the Risperdal dosage or adding Neurontin and Cogentin, nor did they document the clinical rationale for these medication changes. In addition, the notes did not document when Patient A stopped taking Depakote, the reasons for doing so, the risks of stopping Depakote, or the need to change the treatment plan. The notes for this visit were signed by Respondent on or about September 15, 2014. Respondent also added the following notation: "Patient referred to IOP, API."

20. On or about September 25, 2014, Patient A was admitted to the Alvarado Parkway Institute Intensive Outpatient Program (IOP). Upon admission, Patient A reported a history of substance abuse with marijuana, including daily use since age 17. Patient A also reported that the marijuana was medically prescribed. On or about the same day, Respondent issued a telephone order for Risperdal 1 mg twice daily and Depakote 1000 mg once daily, in addition to antibiotic treatment. The telephone order was signed by Respondent on or about September 29, 2014. The notes for this visit made no reference to Paxil, Neurontin, and Cogentin, which were previously prescribed to Patient A on or about September 15, 2014, and they did not reflect any discussions with Patient A regarding these medication changes.

21. On or about September 26, 2014, Patient A underwent a history and physical examination performed by an IOP physician, Dr. F.J. Patient A was noted to be "off his psychotropic medications[,]" with admitted alcohol drinking and daily use of marijuana.

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[5] Neurontin is an anticonvulsant medication that is used with other medications to prevent and control seizures and relieve postherpetic neuralgia.

[6] Cogentin is a medication that is used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs.

22. On or about September 29, 2014, Respondent made a handwritten note stating that a psychiatric evaluation was done. Respondent noted the following psychiatric diagnoses: Axis I (bipolar I disorder, mixed, severe with no psychosis; cannabis dependence); Axis II (deferred); Axis III (hyperlipidemia, neurosyphilis, GERD); Axis IV (blank); and Axis 5 (highest GAF in past year: 52, current GAF: 30). Respondent did not include any information regarding symptoms, impairments, medications, or treatment objectives for Patient A.

23. On or about September 30, 2014, an IOP Interdisciplinary Master Treatment Plan was prepared by IOP physician, Dr. C.B. The Plan identified "Symptom Management" as the first problem and a history of medication and treatment non-compliance by Patient A, including attempts to adjust medications without psychiatrist consultation. The diagnoses were noted as follows: Axis I (bipolar I disorder, most recent episode depressed); Axis II (deferred); Axis III (neurosyphilis, hyperlipidemia, hypertriglyceridemia, GERD); Axis IV (severe, primary support and social environment); Axis V (GAF: current 30).

24. On or about October 16, 2014, Patient A was seen by IOP physician, Dr. C.B. The treatment plan was to continue Depakote and Risperdal as prescribed and refer Patient A back to Respondent for any further interventions.

25. On or about October 28, 2014, Respondent dictated his Psychiatric Admission Evaluation for Patient A. The note was not signed until on or about November 17, 2014. Respondent summarized Patient A's clinical history and reason for admission. The psychiatric diagnoses were noted as follows: Axis I (bipolar I disorder, mixed, severe without psychotic features; cannabis abuse); Axis II (deferred); Axis III (neurosyphilis, hyperlipidemia, gastroesophageal reflux disease); Axis IV (psychosocial and environmental stress secondary to chronic mental illness); Axis 5 (GAF: on admission 28).

26. On or about October 29, 2014, the IOP Interdisciplinary Treatment Plan was updated by IOP physician, Dr. B.S. The update noted that Patient A continued to use marijuana on a daily basis and was sent home one day as a result of coming to the program under the influence of marijuana.

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27. On or about November 17, 2014, Patient A was seen by Respondent. Patient A reported medication compliance with no side effects, except for Depakote. The note stated that Depakote would be discontinued. On or about the same day, Respondent ordered that Patient A's Depakote be discontinued, however, he also issued a telephone order for three-month refills of Risperdal 1 mg twice daily and Depakote 1000 mg once daily. The telephone order was signed by Respondent on or about November 17, 2014. The note for this visit did not address the October 29, 2014, updated treatment plan and its assessments regarding Patient A's daily marijuana use, including his attendance at the program while under the influence of marijuana.

28. Between on or about September 25, 2014, and November 19, 2014, Patient A was prescribed Risperdal 1 mg twice daily. Between on or about September 25, 2014, and November 17, 2014, Patient A was prescribed Depakote 1000 mg once daily. Beginning on or about November 19, 2014, Patient A was prescribed Risperdal 2 mg twice daily, along with gabapentin, paroxetine, and benztropine. Respondent did not document any discussion with Patient A regarding increasing the Risperdal dosage or starting gabapentin, paroxetine, and benztropine, nor did Respondent document the clinical rationale for these medication changes.

29. On or about November 25, 2014, the IOP Interdisciplinary Treatment Plan was updated by Respondent. The update noted that Patient A was not compliant with his Depakote medication, but was compliant with all other medications. Respondent adjusted Patient A's medications by discontinuing Depakote. Patient A reported that he continued to use marijuana, but was cutting back. The update was signed by Respondent on or about January 9, 2015.

30. On or about December 8, 2014, Patient A reported in group therapy that he had stopped taking his medication for depression two weeks earlier and did not inform IOP staff.

31. On or about December 10, 2014, a laboratory test for blood Depakote levels was ordered. According to a note dated on or about December 9, 2014, however, Patient A reported that he was not taking Depakote.

32. On or about December 15, 2014, Patient A was seen by Respondent. Respondent noted that Patient A was compliant with his medications and wished to continue with his medication regimen, but requested an increase of his Risperdal dosage. Respondent changed

Patient A's medications by increasing his Risperdal dosage to 2 mg twice daily. On or about the same day, Respondent made an order reflecting this change. On or about the same day, Respondent also issued a telephone order for three-month refills of benztropine, gabapentin, and paroxetine. The telephone order was signed by Respondent on or about January 9, 2015.

33. On or about December 23, 2014, the IOP Interdisciplinary Treatment Plan was updated by Respondent. According to the update, the following medications were added: resveratrol 500 mg, vitamin B12, huperzine A, milk thistle, chromium picolinate, raw probiotics, and aspirin. The update also noted Patient A's continued use of marijuana on a daily basis. The update was signed by Respondent on or about January 9, 2015.

34. On or about January 9, 2015, Patient A was seen by Respondent. Respondent noted that Patient A was compliant with his medications with no side effects, sleeping and eating better, and wished to continue with his medication regimen. He also noted that Patient A complained of memory problems.

35. On or about January 12, 2015, Respondent also issued a telephone order to refer Patient A to a neurologist for evaluation of memory and cognitive decline and appropriate treatment. Respondent signed the telephone order on or about March 2, 2015.

36. On or about January 20, 2015, the IOP Interdisciplinary Treatment Plan was updated by Respondent. The update noted no medication adjustments and continuing complaints of memory problems by Patient A. The update also referenced Respondent's referral of Patient A to a neurologist. The update was signed by Respondent on or about March 2, 2015.

37. On or about January 27, 2015, Respondent issued a telephone order for three-month refills of Risperdal 2 mg twice daily as well as benztropine, gabapentin, and paroxetine. The telephone order was signed by Respondent on March 2, 2015.

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38. On or about February 5, 2015, the IOP Interdisciplinary Treatment Plan was updated by Respondent. The update reported that Patient A was discharged as of his last date of attendance on or about February 5, 2015, due to family reunification activities out of state. The update was signed by Respondent on or about March 2, 2015. Likewise, on or about February 5, 2015, Respondent issued a telephone order discharging Patient A from the IOP. The telephone order was signed by Respondent on or about March 2, 2015.

39. According to the discharge summary dated on or about February 5, 2015, the discharge diagnoses for Patient A were as follows: Axis I (bipolar I disorder, most recent episode depressed); Axis II (deferred); Axis III: (neurosyphilis, hyperlipidemia, GERD); Axis IV (severe, primary support and social environment); Axis V (GAF: 30). In addition, discharge psychiatric medications included Risperdal 2 mg twice daily, as well as gabapentin, paroxetine, and benztropine.

40. On or about February 25, 2015, Patient A was readmitted to the Alvarado Parkway Institute IOP. On or about the same day, Respondent issued a telephone order for the following psychiatric medications: Risperdal 2 mg twice daily, as well as paroxetine, benztropine, and gabapentin. The telephone order was signed by Respondent on or about March 2, 2015.

41. On or about March 2, 2015, Respondent made a handwritten note stating that a psychiatric evaluation was done. Respondent noted the following diagnoses: Axis I (bipolar I disorder, mixed, severe with no psychosis); Axis II (deferred); Axis III (neurosyphilis, hyperlipidemia); Axis IV (psychosocial stress secondary to mental illness); and Axis 5 (highest GAF in past year: 52, current GAF: 28). Respondent did not include any information regarding symptoms, impairments, medications, or treatment objectives for Patient A.

42. On or about March 4, 2015, an IOP Interdisciplinary Master Treatment Plan was prepared for Patient A. In the "Specific Causes of Functional Impairment" section, Patient A was noted to exhibit impaired cognitive functioning with memory loss, chronic cannabis abuse, and history of medication non-compliance, including present non-compliance. The treatment plan was signed by Respondent on or about May 24, 2015.

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43. On or about March 18, 2015, Patient A was seen by IPO physician, Dr. S.E. Changes in Patient A's mental status were noted, with intermittent episodes of confusion and poor concentration, as well as continued abuse of cannabis. Medication changes were made, including decreasing Paxil and decreasing Cogentin. Patient A was to follow up regarding the neurology consult results. On or about March 19, 2015, Patient A was also seen by IPO physician, Dr. J.C., for a new decrease in memory.

44. On or about April 1, 2015, the IOP Interdisciplinary Treatment Plan was updated. The update noted that Patient A met with a psychiatrist on March 13, 2015, to discuss medications and symptoms and that four medication changes were made: "remove Paroxetine HCL for depression, Benztropine for EPS and add Paxie [sic] for depression, Cogentin for EPS." The update also noted Patient A's March 19, 2015, visit with Dr. J.C. due to his continuing struggles with memory issues, confusion, and disorganization and that he was referred to an outside medical doctor. The update was signed by Respondent on or about April 17, 2015.

45. On or about April 6, 2015, Respondent dictated his Psychiatric Admission Evaluation for Patient A. The note was not signed until on or about April 17, 2015. Respondent summarized Patient A's clinical history and reason for admission. The psychiatric diagnoses were noted as follows: Axis I (bipolar I disorder, mixed, severe without psychotic features; cannabis abuse); Axis II (deferred); Axis III (neurosyphilis, hyperlipidemia, gastroesophageal reflux disease); Axis IV: (psychosocial and environmental stress secondary to chronic mental illness); Axis 5 (GAF: 28). The note made no mention of Patient A's reported changes in mental status and medications.

46. On or about April 7, 2015, Patient A presented to the nursing station stating that he did not feel well and that his primary physician recommended that he stop all of his medications, including the psychotropic medications, which Patient A agreed to do.

47. On or about April 17, 2015, Patient A was seen by Respondent. Respondent noted that Patient A was compliant with his medication with no side effects, was sleeping and eating better, and wished to continue with the same medications. The note indicated no medication changes. The note made no mention of Patient A's new memory problems, confusion, disorganization, medication changes, or prior reports of medication non-compliance.

48. On or about April 21, 2015, Patient A was seen by IPO physician, Dr. J.C. One of the reasons for the visit was Patient A's memory deficits.

49. On or about April 29, 2015, the IOP Interdisciplinary Treatment Plan was updated. The update reported no medication changes for the recording period. The update referenced Patient A's prior medication non-compliance as reported on or about April 7, 2015, and stated that Patient A became medication compliant a few days later and his mood improved. The update was signed by Respondent on or about May 4, 2015.

50. On or about May 4, 2015, Patient A was seen by Respondent. Respondent noted that Patient A was compliant with his medication with no side effects and was sleeping and eating better. The note indicated no medication changes. Respondent made no mention of Patient A's prior medication non-compliance or any discussions with Patient A regarding the adverse effects of stopping his medications.

51. On or about May 7, 2015, Patient A was suspended from the program for two days due to behavioral issues, including threatening behavior towards program peers.

52. On or about May 20, 2015, Patient A was discharged from the IOP due to his refusal to return to the program. His last date of attendance was on or about May 18, 2015. Patient A's psychiatric medications at discharge included Risperdal 2 mg twice daily, along with gabapentin, Paxil, and Cogentin. Respondent was listed as Patient A's provider on the discharge summary. The discharge summary was signed by Respondent on or about May 24, 2015.

53. On or about May 20, 2015, Respondent issued a telephone order discharging Patient A as of May 18, 2015. The telephone order was signed by Respondent on or about May 24, 2015. The telephone order did not include Patient A's discharge psychiatric medications.

54. On or about May 20, 2015, the IOP Interdisciplinary Treatment Plan was updated to reflect Patient A's discharge from the IOP. The update was signed by Respondent on or about May 24, 2015.

55. During Patient A's entire admission at the Alvarado Parkway Institute IOP, Respondent did not provide a plan to address Patient A's chronic cannabis use, nor did he evaluate its effects or give a rationale for not addressing it.

56. During the timeframe that Patient A was receiving treatment at Respondent's office and during Patient A's entire admission at the Alvarado Parkway Institute IOP, Respondent's treatment records did not contain any informed consent for psychiatric medication treatment, nor did they include any documentation of any discussion with Patient A regarding treatment objectives, potential side effects, alternatives, risks, dosage, or need for monitoring.

57. During the timeframe that Patient A was receiving treatment at Respondent's office and during Patient A's entire admission at the Alvarado Parkway Institute IOP, Respondent's treatment records did not contain any laboratory reports for blood levels pertaining to Depakote, orders for such testing, documentation that Patient A refused testing, or documentation that attempts were made to obtain baseline laboratory results from Patient A's prior providers or laboratory.

58. During the timeframe that Patient A was receiving treatment at Respondent's office and during Patient A's entire admission at the Alvarado Parkway Institute IOP, Respondent's treatment records did not reflect any discussion or decision that Respondent's treatment of Patient A had been terminated, that Respondent had notified Patient A of any such termination, whether in writing or verbally, or that Respondent provided any treatment referrals to Patient A for another provider. Respondent's treatment records also did not reflect any records of refills of Patient A's psychiatric medications following his May 20, 2015, discharge from the Alvarado Parkway Institute IOP, any treatment referrals, or any attempts to notify Patient A of the reasons for not authorizing refill requests.

59. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to the following:

(a) Respondent purportedly terminated his treatment of Patient A without discussion or notification to Patient A and, following Patient A's discharge from the Alvarado Parkway Institute IOP on or about May 20, 2015, Respondent failed to refill Patient A's medications without discussion or notification to Patient A of the reasons for not authorizing refill requests and without providing Patient A with treatment referrals to another provider.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

60. Respondent has subjected his Physician's and Surgeon's Certificate No. A 67679 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged in paragraphs 10 through 59, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

61. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but was not limited to the following:

(a) Respondent failed to obtain sufficient clinical information during Patient A's initial visit on or about June 22, 2013, to formulate an accurate psychiatric diagnosis necessary for developing an appropriate treatment plan;

(b) Respondent failed to obtain Patient A's informed consent for psychiatric medication treatment with Paxil, Risperdal, Depakote, Neurontin, and Cogentin during the timeframe that Patient A was receiving treatment at Respondent's office and during Patient A's entire admission at the Alvarado Parkway Institute IOP;

(c) Respondent failed to adequately document the rationale for changes in Patient A's treatment with psychiatric medications or that the treatment changes were discussed with Patient A during the timeframe that Patient A was receiving treatment at Respondent's office and during Patient A's entire admission at the Alvarado Parkway Institute IOP;

(d) Respondent failed to obtain adequate baseline laboratory studies and provide laboratory monitoring during Patient A's treatment with Depakote during the timeframe that Patient A was receiving treatment at Respondent's office and during Patient A's entire admission at the Alvarado Parkway Institute IOP;

(e) Respondent failed to maintain a comprehensive record of all aspects of treatment, including billing records; identifying patient information such as address, phone number, emergency contact, and power of attorney; logs or records of patient

phone contacts; pharmacy faxes; laboratory reports; requests for records or contact with other treating clinicians, whether attempted or made; HIPAA privacy notices; HIPAA-compliant authorizations; and informed consent for psychiatric medication treatment during the timeframe that Patient A was receiving treatment at Respondent's office;

(f) Respondent denied Patient A's request for refill of his Paxil on or about August 26, 2014, thereby exposing Patient A to the risk of withdrawal symptoms and decompensation in Patient A's psychiatric condition;

(g) Respondent failed to dictate his Psychiatric Admission Evaluation until on or about October 28, 2014, several weeks after Patient A was first admitted to the Alvarado Parkway Institute IOP;

(h) Respondent failed to review Patient A's treatment records, including treatment plans and updates by the treatment team, in a timely manner during Patient A's entire admission at the Alvarado Parkway Institute IOP;

(i) Respondent failed to dictate the Psychiatric Admission Evaluation until on or about April 6, 2015, several weeks after Patient A was readmitted to the Alvarado Parkway Institute IOP; and

(j) Respondent failed to recognize, acknowledge, and clinically respond to changes in Patient A's condition that were documented in the records during Patient A's readmission at the Alvarado Parkway Institute IOP.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

62. Respondent has subjected his Physician's and Surgeon's Certificate No. A 67679 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 10 through 61, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

63. Respondent has subjected his Physician's and Surgeon's Certificate No. A 67679 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 10 through 62, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 67679, issued to Respondent Yashwant S. Chaudhri, M.D.;

2. Revoking, suspending or denying approval of Respondent Yashwant S. Chaudhri, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Yashwant S. Chaudhri, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: February 22, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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