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

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| In the Matter of the Accusation Against: | ) | |
| YUKI KASHIWABARA, M.D. | ) | Case No. 800-2014-006284 |
| Physician's and Surgeon's Certificate No. A79688 | ) | |
| Respondent | ) | |

## DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 2, 2018.

IT IS SO ORDERED: January 4, 2018.

MEDICAL BOARD OF CALIFORNIA

Ronald Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
REBECCA L. SMITH
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*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against:<br><br>YUKI KASHIWABARA, M.D.<br><br>14626 Newport Avenue, Suite 320<br>Tustin, California 92780<br><br>Physician's and Surgeon's Certificate<br>No. A 79688,<br><br>Respondent. | Case No. 800-2014-006284<br><br>OAH No. 2017060581<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Respondent Yuki Kashiwabara, M.D. ("Respondent") is represented in this proceeding by attorney Raymond J. McMahon, whose address is 5440 Trabuco Road Irvine, California 92620.

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3. On July 1, 2002, the Board issued Physician's and Surgeon's Certificate number A-79688 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-006284, and will expire on July 31, 2018, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-006284 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 30, 2017. Respondent filed a timely Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-006284 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-006284. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2014-006284 and that she has thereby subjected her license to disciplinary action.

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10. Respondent agrees that if she ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2014-006284 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format ("PDF") and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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## DISCIPLINARY ORDER

**IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. A 79688 issued to Respondent Yuki Kashiwabara, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than forty (40) hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the program or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within sixty (60) days after Respondent has successfully completed the clinical competence assessment program, Respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within fifteen (15) calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than ten (10) calendar days after the end of the preceding quarter.

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9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the dates of departure and return.

10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than thirty (30) calendar days and within fifteen (15) calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least forty (40) hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than one-hundred twenty (120) calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within fifteen (15) calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/14/17.

YUKI KASHIWABARA, M.D.
*Respondent*

I have read and fully discussed with Respondent Yuki Kashiwabara, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: November 14, 2017

RAYMOND J. McMAHON
*Attorney for Respondent*

## ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: November 16, 2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 800-2014-006284**

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*Attorneys for Complainant*



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

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|---|---|
| In the Matter of the Accusation Against:<br><br>YUKI KASHIWABARA, M.D.<br><br>14642 Newport Avenue, Suite 320<br>Tustin, California 92780-6059<br><br>Physician's and Surgeon's Certificate No. A79688,<br><br>Respondent. | Case No. 800-2014-006284<br><br>**ACCUSATION** |

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 ("Board").

2. On July 1, 2002, the Board issued Physician's and Surgeon's Certificate Number A79688 to Yuki Kashiwabara, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2018, unless renewed.

**JURISDICTION**

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

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.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education

activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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.

"..."

## FACTUAL ALLEGATIONS

7. Patient K.T. was a 36-year-old female, gravida 4, para 0 when she sought prenatal care with Respondent on January 13, 2011, at 9-10 weeks gestation.[1] By way of history, the patient had been Respondent's patient since approximately June 2010. Her medical records from

[1] Initials are used for privacy purposes.

Respondent's office reflect that she was 5'4" tall. Her pre-pregnancy weight was 103 pounds on October 5, 2010, and she weighed 105.5 pounds at the time of her initial prenatal visit on January 13, 2011. The patient had approximately 15 prenatal visits with Respondent's from January 13, 2011 to July 14, 2011.

8. At the time of the patient's first prenatal visit on January 13, 2011, Respondent calculated the patient's estimated due date (EDD).[2] The patient reported that her last menstrual period (LMP) began November 7, 2010. An ultrasound was performed at that visit and Respondent noted that the Crown Rump Length (CRL)[3] of the fetus was consistent with a gestational age of 8 weeks, 3 days.[4] Respondent calculated Patient K.T.'s estimated due date (EDD) to be August 14, 2011.[5] On the patient's prenatal flow sheet, Respondent noted the fundal height to be 8 centimeters.[6] The patient's blood pressure was noted to be 113/84. The patient was instructed to return in two weeks.

9. The patient's next prenatal visit with Respondent was on January 27, 2011 at which time Respondent estimated that the patient was at 11 weeks, 4 days gestation. An ultrasound was performed and Respondent noted that the CRL was consistent with 10 weeks, 4 days gestation.

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[2] EDD is the date that spontaneous onset of labor is expected to occur. The due date may be estimated by adding 280 days (9 months and 7 days) to the first day of the last menstrual period (LMP). The accuracy of the EDD based on LMP depends on accurate recall by the patient, assumes regular 28 day cycles, and that ovulation and conception occurs on day 14 of the cycle. EDD is also estimated by ultrasound which uses the size of the fetus to determine the gestational age. Ultrasound measurements of the embryo or fetus in the first trimester is the most accurate method to establish or confirm gestational age.

[3] CRL is the length of the embryo or fetus from the top of its head to bottom of its torso and is one of the ultrasound methods to estimate fetal age.

[4] Next to the ultrasound image in the patient's chart, Respondent wrote "8+3" which denotes 8 weeks, 3 days. On the patient's prenatal flowsheet, Respondent noted that the ultrasound reflected that the patient was "8+4." At the time of her interview with the Board, Respondent acknowledged that the "8+4" in the prenatal chart was a transcribing error and should have been "8+3."

[5] The ultrasound on January 13, 2011 was consistent with 8 weeks 3 days gestation. As such, the EDD as of January 13, 2011 should have been adjusted to August 22, 2011.

[6] Fundal height is a diagnostic tool wherein measurement is taken from the top of the pubic bone to the top of the uterus that should increase as the pregnancy continues towards the EDD.

The patient's blood pressure was noted to be 127/93. The patient was instructed to return in two weeks.

10. The patient's next prenatal visit with Respondent was on February 10, 2011 at which time Respondent estimated that the patient was at 13 weeks, 4 days gestation. An ultrasound for genetic screening was performed and interpreted by radiologist, Dr. P.H. who noted a CRL of 60.6 millimeters, consistent with 12 weeks, 5 days gestation. The patient's blood pressure was noted to be 110/79. Blood was collected for first trimester prenatal screening, which was ultimately reported as negative. The patient was instructed to return in four weeks.

11. The patient returned the following day, February 11, 2011, with complaints of vaginal bleeding. Respondent performed a speculum examination and found old blood in the vaginal vault with no active bleeding. Respondent recommended nothing in the vagina for two weeks. At the time of the visit, Respondent estimated that the patient was at 13 weeks, 5 days gestation. An ultrasound was performed but no notation regarding CRL and gestation was made. The patient's blood pressure was noted to be 105/74 and a urine protein dipstick measurement was positive for trace protein.[7] The patient was instructed to return in four weeks.

12. The patient's next prenatal visit with Respondent was on March 10, 2011 at which time Respondent estimated that the patient was at 17 weeks, 4 days gestation. An ultrasound was performed and interpreted by radiologist, Dr. P.H. whose impression was that the gestation was 16 weeks, 4 days. The patient's blood pressure was noted to be 127/95. Respondent noted that the patient complained of hemorrhoids, which had good relief with Preparation H. Blood was collected for second trimester prenatal screening. The patient was instructed to return in four weeks.

13. The patient presented to Respondent's office on March 17, 2011 following notice that her screening tests revealed an elevated risk of Down Syndrome. At the time of the visit, the

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[7] A urine protein dipstick measurement is a screening test. A small amount of protein in urine during pregnancy is common but can also be indicative of conditions such as a urinary tract infection, kidney dysfunction or preeclampsia, all of which require further evaluation.

patient's blood pressure was noted to be 110/83. The patient was referred to maternal fetal medicine specialist, Dr. M.K. to undergo further testing.

14. On March 18, 2011, the patient was seen by Dr. M.K. in consultation for evaluation of the fetus due to advanced maternal age and a positive trisomy 21 (Down Syndrome) risk. An ultrasound was performed. In his report faxed to Respondent's office that same day, Dr. M.K. noted the estimated gestational age based upon fetal measurements to be 17 weeks, 4 days. Dr. M.K. further noted that the ultrasound identified symmetrically small fetal measurements and recommended a growth ultrasound to rule out growth abnormalities in 4 to 6 weeks.

15. The patient next presented to Respondent's office on April 7, 2011 at which time Respondent estimated that the patient was at 21 weeks, 4 days gestation. Fundal height was noted to be 18 centimeters. The patient's blood pressure was noted to be 133/94. The patient was instructed to return in three weeks.

16. The patient returned to Respondent's office on April 28, 2011 at which time Respondent estimated that the patient was at 24 weeks, 4 days gestation. Fundal height was again noted to be 18 centimeters. The patient's blood pressure was noted to be 133/82. The patient expressed concern about hemorrhoids and Respondent noted that only a skin tag was visible on examination. The patient was instructed to return in two weeks.

17. The patient next presented to Respondent's office on May 12, 2011 at which time Respondent estimated that the patient was at 26 weeks, 4 days gestation. Fundal height was noted to be 19 centimeters. The patient's blood pressure was noted to be 131/91. The patient was instructed to return in two weeks.

18. The patient returned to Respondent's office on May 26, 2011 at which time Respondent estimated that the patient was at 28 weeks, 4 days gestation. Fundal height was noted to be 22 centimeters. The patient's blood pressure was noted to be 131/87. The patient was instructed to return in two weeks.

19. The patient next presented to Respondent's office on June 9, 2011 at which time Respondent estimated that the patient was at 30 weeks, 4 days gestation. Fundal height was noted

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to be 25 centimeters. The patient's blood pressure was noted to be 127/89. The patient was instructed to return in two weeks.

20. The patient returned to Respondent's office on June 23, 2011 at which time Respondent estimated that the patient was at 32 weeks, 4 days gestation. Fundal height was noted to be 27 centimeters. The patient's blood pressure was noted to be 141/97. A second blood pressure reading was noted to be 143/102 with a heart rate of 72. Respondent noted that the patient reported no headaches and that preeclampsia precautions (to report headache, vision changes, epigastric pain and anything out of the ordinary) were given.[8] The patient was instructed to return in two weeks.

21. The patient next presented to Respondent's office on June 28, 2011 at which time Respondent estimated that the patient was at 33 weeks, 2 days gestation. Fundal height was noted to again be 27 centimeters. The patient's blood pressure was noted to be 160/106. A second blood pressure reading was noted to be 157/97 with a heart rate of 71. Respondent noted that the patient had borderline hypertension but that she had no complaints of headache or vision changes. The patient was instructed to return in one week.

22. The patient returned to Respondent's office on July 7, 2011 at which time Respondent estimated that the patient was at 34 weeks, 2 days gestation. Fundal height was again noted to be 27 centimeters. The patient's blood pressure was noted to be 173/114. Trace protein was noted on the urine dipstick. Respondent noted that she discussed the possibility of hypertension and preeclampsia with the patient. Respondent ordered laboratory studies, including a 24-hour urine collection. The patient was instructed to stop working or decrease her work hours. She was instructed to return in one week.

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[8] Preeclampsia is a condition that can occur when a woman has persistent high blood pressure (140/90 or greater) that develops during pregnancy or during the postpartum period that is associated with protein in the urine or the new development of decreased blood platelets, trouble with the kidney or liver, fluid in the lungs, or signs of brain trouble such as seizures and/or visual disturbances. Severe preeclampsia is associated with blood pressure greater than 160/110.

23. The laboratory testing results were reported on July 7, 2011. The copy in the patient's chart from Respondent's office reflects that it was printed on July 8, 2011 and has Respondent's initials on the report reflecting that it was reviewed by her.

24. On July 11, 2011, the 24-hour urine collection laboratory results were reported and reflected high protein in the urine at 1004 milligrams (with the reference range/normal limits being 0-150 mg.) On July 12, 2011, Respondent initialed and dated a 24-hour urine collection laboratory results but took no action at that time.

25. The patient next presented to Respondent's office on July 14, 2011 at which time Respondent estimated that the patient was at 35 weeks, 2 days gestation. The "Final EDD" line on the Prenatal Care Flowsheet remained blank, which Respondent indicated at the time her subject interview with the Medical Board on April 13, 2017, meant that the initial EDD was correct. Fundal height was noted to be 29 centimeters. The patient's blood pressure was noted to be 163/105. Trace protein in urine was noted. Respondent noted that she discussed the need for delivery with the patient secondary to severe preeclampsia. She noted that the patient's cervix was favorable for delivery. She ordered that the patient be admitted to the hospital for labor induction with magnesium sulfate and Pitocin augmentation.

26. The patient was admitted to the hospital at approximately 5:40 p.m. that same day. Her admitted laboratory studies revealed a low platelet count and elevated liver function studies. Her blood pressure continued to be elevated. Magnesium sulfate was administered to prevent seizures, prophylactic antibiotics were administered to prevent infection and oxytocin was administered to augment labor. At approximately 7:00 p.m., the nursing staff notified Respondent of the patient's status. The patient's membranes were ruptured at approximately 8:00 p.m. by the in-hospital laborist, Dr. M.W.

27. At 9:00 p.m., the patient's cervix was dilated to 4 cm, and completely effaced. An anesthesiologist administered an epidural anesthetic shortly thereafter. A deceleration in fetal heart rate was noted at 9:15 p.m. and a direct fetal scalp electrode was placed at 9:19 p.m. Respondent was called for delivery at 9:20 p.m. with Dr. M.W. on standby pending Respondent's arrival. By 9:30 p.m., the fetal heart rate tracing revealed fetal distress with minimal variability,

absent accelerations, and several decelerations. Dr. M.W. performed an outlet vacuum-assisted delivery. A male infant was born at 9:35 p.m. He weighed 1695 grams (3 pounds, 12 ounces) and had APGAR scores of 4 and 9 at one and five minutes, respectively.[9].

28. The placenta delivered at 9:36 p.m. and postpartum hemorrhage ensued. Medication was administered to mitigate the postpartum hemorrhaging. Dr. M.W. explored the lower uterine segment, at which time he identified a right sulcus tear, a right-pelvic sidewall tear, and several other lacerations. He was repairing the lacerations when Respondent arrived at the patient's bedside at approximately 9:50 p.m. Respondent took over the laceration repairs, with Dr. M.W. assisting. At approximately 10:40 p.m., Respondent and Dr. M.W. took the patient from Labor and Delivery to the operating room for further management with the surgical assistance of urogynecologist, Dr. M.H. At 10:45 p.m., Respondent called a Code OB to facilitate rapid blood product transfusion. The hemorrhaging could not be controlled and the decision to perform an abdominal hysterectomy was made. During the performance of the hysterectomy, a cervical laceration and broad ligament hematoma were noted. Upon completing the hysterectomy, vaginal bleeding had been effectively resolved. The patient had significant blood loss (estimated at 4000 cc). Following surgery at approximately 2:19 a.m. on July 15, 2011, the patient was transferred to the intensive care unit for further care and treatment. By 7:44 a.m., her pupils were unequal, fixed and dilated. She was pronounced dead at 9:53 a.m. Cardiac arrest, cervical-uterine laceration and severe preeclampsia were noted to be the cause of death.

## STANDARD OF CARE

29. The standard of medical practice in California requires that a practitioner treating pregnant patients accurately assess the most likely due date of pregnancy.

A. An accurately assigned EDD is necessary for optimizing clinical outcomes, making obstetric decision, timing obstetric care, scheduling and interpreting certain antepartum

[9] APGAR is a quick, overall assessment of newborn wellbeing used immediately following the delivery of a baby measuring the baby's color, heart rate, reflexes, muscle tone and respiratory effort. Each category is scored with 0, 1, or 2, depending on the observed condition. The APGAR score is based on a total score of 1 to 10. The higher the score, the better the baby is doing after birth. A score of 7, 8, or 9 is normal and is a sign that the newborn is in good health. Any score lower than 7 is a sign that the baby needs medical attention.

tests, determining the appropriateness of fetal growth, and planning interventions to prevent preterm births, post-term births and related morbidities.

30. As soon as data from the LMP, the first accurate ultrasound examination, or both are obtained, the standard of medical practice in California requires that the gestational age and estimated due date be determined, discussed with the patient, and documented clearly in the medical record.

31. In the event that the ultrasound dating before 14 weeks of gestation differs by more than 7 days from LMP dating, the standard of medical practice in California requires that a practitioner treating pregnant patients investigate the discrepancy, by reviewing, reconsidering, and recalculating of the original estimate of gestational age. Any adjustments and recalculations in EDD are to be discussed with the patient and documented clearly in the medical record.

32. The standard of medical practice in California requires that a practitioner treating pregnant patients assess fundal height at each prenatal visit, after 20 weeks gestation for appropriate serial and interval grown.

A. There is a symmetric correlation between the gestational age in weeks and the fundal height in centimeters between 20-34 weeks. Variables such as obesity, uterine fibroids and multiple gestations may distort the correlation but growth trends can still be followed.

B. Fundal height assessment allows for the detection of a potentially small for gestational age (SGA) or growth-restricted fetus.

33. When a discrepancy of greater than 2 centimeters from the gestational age, not otherwise explained, the standard of medical practice in California requires that a practitioner further evaluate the patient, including reconsideration and reevaluation of the fetus' gestational age.

34. The standard of medical practice in California requires that a practitioner evaluate and manage patients for the existence, manifestations or development of any hypertensive disorder during pregnancy.

A. Gestational hypertension is a clinical diagnosis defined by the new onset of hypertension (a blood pressure of greater than 140 systolic or greater than 90 diastolic, measured

on two separate occasions at least four hours apart) after 20 weeks of gestation in the absence of proteinuria or new signs of end-organ dysfunction.

B. Gestational hypertension is severe when there is a blood pressure of greater than 160 systolic or greater than 110 diastolic, measured on two separate occasions at least four hours apart.

C. Gestational hypertension is a temporary diagnosis for hypertensive pregnant patients who do not yet meet the diagnostic criteria for preeclampsia or chronic hypertension.

D. Preeclampsia is defined as gestational hypertension (a blood pressure of greater than 140 systolic or greater than 90 diastolic, measured on two separate occasions at least four hours apart) along with proteinuria of greater than or equal to 300 milligrams in a 24-hour urine specimen, a protein (mg/dL)/creatinine (mg/dL) ratio of 0.3 or higher, or a urine dipstick protein of 1+ or new signs of end-organ dysfunction.

E. Preeclampsia with severe features is defined as the presence of one of the following symptoms or signs in the presence of preeclampsia:

i. Blood pressure of greater than 160 systolic or greater than 110 diastolic, measured on two separate occasions at least four hours apart while the patient is on bed rest (unless antihypertensive therapy has previously been initiated upon the first severely elevated reading).

ii. Impaired hepatic function as indicated by abnormally elevated blood concentrators of liver enzymes (to double the normal concentration), severe persistent upper quadrant or epigastric pain that does not respond to pharmacotherapy and is not accounted for by alternative diagnoses, or both.

iii. Progressive renal insufficiencies (serum creatinine concentration greater than 1.1 milligrams per deciliter or a doubling of the serum creatinine concentration in the absence of other renal disease).

iv. New onset of cerebral or visual disturbances (manifested by symptoms like headaches, scotomata, etc.).

v. Pulmonary edema.

vi. Thrombocytopenia (a platelet count less that 100,000 per microliter).

35. When a pregnant patient has chronic hypertension, the standard of medical practice in California requires that the practitioner perform further investigation, such as home blood pressure determinations, basic serum chemistries to assess hepatic and renal function and a baseline 24-hour urine collection for protein and creatinine clearance, and possibly a spot protein/creatinine ratio.

36. The standard of medical practice in California requires that the practitioner perform close fetal monitoring, up to and including hospitalization and/or delivery, in a pregnant patient with chronic hypertension, preeclampsia or pregnancy-induced hypertension.

37. For maternal safety, the standard of medical practice in California requires that the practitioner perform immediate acute blood pressure lowering with antihypertensive agents for any single episode of a severely elevated blood pressure reading, as defined by a systolic blood pressure greater than 160 or a diastolic blood pressure greater than 110.

38. The standard of medical practice in California requires that the practitioner perform immediate further evaluation and control of blood pressure in patients with preeclampsia with severe features, or with severe gestational hypertension, including serial blood pressure measurements, fetal monitoring, consultation with a maternal fetal medicine specialist and immediate acute blood pressure lowering with antihypertensive agents for any single episode of a severely elevated blood pressure reading, as defined by a systolic blood pressure greater than 160 or a diastolic blood pressure greater than 110.

**FIRST CAUSE FOR DISCIPLINE**

(Gross Negligence – Failure to Accurately Assess Gestational Age and Due Date during Prenatal Care)

39. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she engaged in gross negligence by failing to accurately assess the gestational age and due date during Patient K.T.'s prenatal care. Complainant refers to and, by this reference, incorporates herein, paragraphs 7 through 31, above, as though fully set forth herein. The circumstances are as follows:

A. At the time of the patient's first prenatal visit on January 13, 2011, she reported that her LMP began on November 7, 2010 at which time Respondent calculated an EDD of August 14, 2011 and gestational age of 9 weeks, 4 days.

B. The ultrasound measurements of the CRL performed on January 13, 2011 was consistent with a gestational age of 8 weeks, 3 days, suggesting an EDD of August 22, 2011, 8 days later.

C. The 8-day discrepancy should have caused Respondent to re-date the pregnancy.

D. Subsequent ultrasounds were performed, including but not limited to January 27, 2011 (consistent with 10 weeks, 4 days gestation), February 10, 2011 (consistent with 12 weeks, 5 days gestation), and March 10, 2011 (consistent with 16 weeks, 4 days).

E. Respondent failed to re-evaluate the patient's dating criteria and accurately re-date the pregnancy.

40. Respondent's acts and/or omissions as set forth in paragraphs 7 through 31, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

**SECOND CAUSE FOR DISCIPLINE**

(Gross Negligence – Failure to Appropriately Assess Fetal Growth in Response to Lagging Fundal Height and Progress during Prenatal Care)

41. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she engaged in gross negligence by failing to appropriately assess fetal growth in response to lagging fundal height and progress during Patient K.T.'s prenatal care. Complainant refers to and, by this reference, incorporates herein, paragraphs 7 through 33, above, as though fully set forth herein. The circumstances are as follows:

A. Respondent measured and documented fundal height on 9 occasions after 20 weeks gestation: April 7, 2011 (fundal height was measured at 18 centimeters); April 28, 2011 (fundal height was measured at 18 centimeters); May 12, 2011 (fundal height was measured at 19 centimeters); May 26, 2011 (fundal height was measured at 22 centimeters); June 9, 2011 (fundal

height was measured at 25 centimeters); June 23, 2011 (fundal height was measured at 27 centimeters); June 28, 2011 (fundal height was measured at 27 centimeters); July 7, 2011 (fundal height was measured at 27 centimeters); and July 14, 2011 (fundal height was measured at 29 centimeters).

B. Respondent failed to address the size-less-than-dates discrepancies and the widening gap in the size-less-than-dates discrepancies as the pregnancy progressed.

C. Respondent failed to obtain a growth ultrasound to rule out growth restriction and/or other developmental abnormalities in 4-6 weeks, as recommended by maternal fetal medicine consultant, Dr. M.K. on March 18, 2011. Respondent further failed to obtain a growth ultrasound to rule out growth restriction and/or other developmental abnormalities, as indicated by the size-less-than-dates discrepancies and the widening gap in the size-less-than dates discrepancies as the pregnancy progressed.

D. Respondent failed to reconsider, recalculate or reassess the patient's dating criteria in light of the size-less-than-dates discrepancies.

42. Respondent's acts and/or omissions as set forth in paragraphs 7 through 33, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

**THIRD CAUSE FOR DISCIPLINE**

(Gross Negligence – Failure to Properly Evaluate and Manage Hypertensive Disorder of Pregnancy during Prenatal Care)

43. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she engaged in gross negligence in failing to properly evaluate and manage Patient K.T.'s hypertensive disorder of pregnancy during her prenatal care. Complainant refers to and, by this reference, incorporates herein, paragraphs 7 through 28 and 34 through 38, above, as though fully set forth herein. The circumstances are as follows:

A. By March 10, 2011, Respondent failed to diagnose the patient's chronic hypertension which manifested on January 27, 2011 with a blood pressure reading of 127/93 and on March 10, 2011 with a subsequent blood pressure reading of 127/95.

B. Following the first two elevated blood pressures during the patient's prenatal care, Respondent failed to perform further investigation and treatment to address the elevated blood pressures.

C. On June 28, 2011, Respondent failed to diagnose and treat the patient's elevated blood pressure readings of 160/106 and 157/97, the first of which meets criteria for a severe elevation in blood pressure.

D. On July 7, 2011, Respondent failed to diagnose and treat the patient's severely elevated blood pressure reading of 173/114.

E. While Respondent ordered blood tests and a 24-hour urine collection following the patient's July 7, 2011 prenatal visit, she failed to timely follow up regarding the results.

F. Respondent failed to diagnose, evaluate, surveil and manage the patient's hypertensive disorder during the patient's prenatal course.

44. Respondent's acts and/or omissions as set forth in paragraphs 7 through 28 and 34 through 38, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

**FOURTH CAUSE FOR DISCIPLINE**

(Repeated Acts of Negligence)

45. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that she engaged in repeated acts of negligence in the prenatal care and treatment of Patient K.T. Complainant refers to and, by this reference, incorporates herein, paragraphs 7 through 44, above, as though fully set forth herein. The circumstances are as follows:

A. Respondent failed to accurately assess the gestational age and due date during the patient's prenatal care.

B. Respondent failed to appropriately assess fetal growth by fundal height during the patient's prenatal course of treatment.

C. Respondent failed to properly evaluate and manage the patient's hypertensive disorder of pregnancy during her prenatal course of treatment.

46. Respondent's acts and/or omissions as set forth in paragraphs 7 through 44, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

## 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 Number A79688, issued to Yuki Kashiwabara, M.D.;

2. Revoking, suspending or denying approval of her authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. If placed on probation, ordering her to pay the Board the costs of probation monitoring; and

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

DATED: May 30, 2017

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

*Complainant*

LA2017505613