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

In the Matter of the First Amended Accusation Against: **Joon Won Rhee, M.D.** **Physician's and Surgeon's Certificate No. A 77852** **Respondent.**	**MBC File # 800-2018-042932**

ORDER CORRECTING NUNC PRO TUNC
CLERICAL ERROR IN "CASE NUMBER" PORTION OF DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the "case number" shown on page 4, line 26 of the Stipulated Settlement and Disciplinary Order in the above-entitled matter, and that such clerical error should be corrected so that the case number will conform to the Board's case number.

IT IS HEREBY ORDERED that the case number contained within the Decision of the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "800-2018-042932."

October 5, 2021

Richard E. Thorp, M.D.,
Chair
Panel B

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

In the Matter of the First Amended Accusation Against: Joon Won Rhee, M.D. Physician's & Surgeon's Certificate No A 77852 Respondent	Case No. 800-2018-042932

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 September 30, 2021.

IT IS SO ORDERED August 31, 2021.

MEDICAL BOARD OF CALIFORNIA

Alejandra Campoverdi, Vice Chair
Panel B

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **JOON WON RHEE, M.D.** **1895 Orange Tree Lane #201** **Redlands, California 92374-0113** Physician's and Surgeon's Certificate A 77852, Respondent.	Case No. 800-2018-042932 OAH No. 2021030035 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Chris Leong, Deputy Attorney General.

2. Respondent Joon Won Rhee, M.D. (Respondent) is represented in this proceeding by attorney Steven H. Zeigen, 10815 Rancho Bernardo Road, Suite 310, San Diego, California 92127-2189.

3. On February 1, 2002, the Board issued Physician's and Surgeon's Certificate No. A 77852 to Respondent. That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-042932, and will expire on October 31, 2021, unless renewed.

4. In a disciplinary action entitled *In the Matter of the Accusation Against Joon Won Rhee, M.D.*, Case No. 18-2013-232643, the Board issued a decision, effective November 2, 2016, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed, and Respondent's Physician's and Surgeon's Certificate was placed on probation for thirty-five months with specific terms and conditions.

5. On July 18, 2019, in a disciplinary action entitled *In the Matter of the Accusation/Petition to Revoke Probation Against Joon Won Rhee, M.D.*, Case No. 800-2019-053094, a pleading was filed. This filing extended the probation until the matter was resolved. The Board issued a decision, effective April 10, 2020, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed, and the probation period from Respondent's prior disciplinary action was extended by one year from the effective date of the Decision, with specific terms and conditions.

JURISDICTION

6. On February 18, 2021, Accusation No. 800-2018-042932 was filed before the Board against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the Accusation. This filing extended the probation until the present matter is resolved.

7. On April 8, 2021, First Amended Accusation No. 800-2018-042932 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent. A copy of the First Amended Accusation No. 800-2018-042932 is attached as Exhibit A and incorporated herein by reference.

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ADVISEMENT AND WAIVERS

8. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2018-042932. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

9. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his 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.

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

CULPABILITY

11. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2018-042932, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

12. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

13. Respondent does not contest that, at an administrative hearing, the Complainant could establish a prima facie case with respect to the charges and allegations in First Amended Accusation No. 800-2018-042932, a copy of which is attached, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 77852 to disciplinary action.

14. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

15. Respondent agrees that if the Board ever takes action pursuant to the Order below, all of the charges and allegations contained in First Amended Accusation No. 800-2018-042932, shall be deemed true, and correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

16. 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 his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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.

17. 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.

18. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED THAT Joon Won Rhee, M.D. is publicly reprimanded pursuant to Business and Professions Code section 2227. This public reprimand is issued in connection with Respondent's actions as set forth in the First Amended Accusation No. 800-2016-021838, related to the lack of a transfer agreement at the time of the procedure.

IT IS FURTHER ORDERED THAT Respondent comply with the following:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this

decision, Respondent shall enroll in an educational program(s) or course(s) approved in advance by the Board or its designee. Respondent shall successfully complete the program(s) or course(s) not later than one (1) year after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge in the area of liposuction procedure and practice 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 65 hours of CME of which 40 hours were in satisfaction of this condition.

Determination as to whether Respondent successfully completed the educational program(s) or course(s) is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the educational program(s) or course(s) 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. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the education course have been completed. If the Respondent does not successfully complete the educational program(s) or course(s), the Respondent shall not resume the practice of medicine until a final decision has been rendered on a subsequently filed accusation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Steven H. Zeigen. 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.

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DATED: 6/16/2021

JOON WON RHEE, M.D.
Respondent

I have read and fully discussed with Respondent Joon Won Rhee, 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: 6/17/21

DAVID ROSEN GELLER FOR

STEVEN H. ZEIGEN
Attorney for Respondent

ENDORSEMENT

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

DATED: June 17, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

Chris Leong

CHRIS LEONG
Deputy Attorney General
Attorneys for Complainant

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With Board Edits Stipulated Settlement and Disc Order.docx

Exhibit A

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Acting Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: JOON WON RHEE, M.D. 1895 Orange Tree Lane #201 Redlands, California 92374-0113 **Physician's and Surgeon's Certificate No. A 77852,** Respondent.	Case No. 800-2018-042932 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On February 1, 2002, the Board issued Physician's and Surgeon's Certificate Number A 77852 to Joon Won Rhee, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2021, unless renewed.

3. In a disciplinary action entitled *In the Matter of the Accusation Against Joon Won Rhee, M.D.*, Case No. 18-2013-232643, the Board issued a Decision, effective November 2, 2016,

in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed, and Respondent's Physician's and Surgeon's Certificate was placed on probation for thirty-five months with specific terms and conditions.

4. In a disciplinary action entitled *In the Matter of the Accusation/Petition to Revoke Probation Against Joon Won Rhee, M.D.*, Case No. 800-2019-053094, the Board issued a Decision, effective April 10, 2020, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed, and the probation period from Respondent's prior disciplinary action was extended by one year from the effective date of the Decision, with specific terms and conditions.

JURISDICTION

5. This First Amended 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.

6. 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."

7. 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.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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.

CALIFORNIA CODE OF REGULATIONS

9. Title 16, California Code of Regulations, section 1356.6, provides that:

Liposuction Extraction and Postoperative Care Standards.

(a) A liposuction procedure that is performed under general anesthesia or intravenous sedation or that 'results in the extraction of 5,000 or more cubic centimeters of total aspirate shall be performed in a general acute-care hospital or in a setting specified in Health and Safety Code Section 1248.1.

(b) The following standards apply to any liposuction procedure not required by subsection (a) to be performed in a general acute-care hospital or a setting specified in Health and Safety Code Section 1248.1:

(1) Intravenous Access and Emergency Plan. Intravenous access shall be available for procedures that result in the extraction of less than 2,000 cubic centimeters of total aspirate and shall be required for procedures that result in the extraction of 2,000 or more cubic centimeters of total aspirate. There shall be a written detailed plan for handling medical emergencies and all staff shall be informed of that plan. The physician shall ensure that trained personnel, together with adequate and appropriate equipment, oxygen, and medication, are onsite and available to handle the procedure being performed and any medical emergency that may arise in connection with that procedure. The physician shall either have admitting privileges at a local general acute-care hospital or have a written transfer agreement with such a hospital or with a licensed physician who has admitting privileges at such a hospital.

(2) Anesthesia. Anesthesia shall be provided by a qualified licensed practitioner. The physician who is performing the procedure shall not also administer or maintain the anesthesia or sedation unless a licensed person certified in advanced cardiac life support is present and is monitoring the patient.

(3) Monitoring. The following monitoring shall be available for volumes greater than 150 and less than 2,000 cubic centimeters of total aspirate and shall be required for volumes between 2,000 and 5,000 cubic centimeters of total aspirate:

(A) Pulse oximeter

(B) Blood pressure (by manual or automatic means)

(C) Fluid loss and replacement monitoring and recording

(D) Electrocardiogram

(4) Records. Records shall be maintained in the manner necessary to meet the standard of practice and shall include sufficient information to determine the quantities of drugs and fluids infused and the volume of fat, fluid, and supernatant extracted and the nature and duration of any other surgical procedures performed during the same session as the liposuction procedure.

(5) Discharge and Postoperative-care Standards.

(A) A patient who undergoes any liposuction procedure, regardless of the amount of total aspirate extracted, shall not be discharged from professionally supervised care unless the patient meets the discharge criteria described in either the Aldrete Scale or the White Scale. Until the patient is discharged, at least one staff person who holds a current certification in advanced cardiac life support shall be present in the facility.

(B) The patient shall only be discharged to a responsible adult capable of understanding postoperative instructions.

FACTUAL ALLEGATIONS

10. JWR Wellness Clinics (the "Clinic") is an outpatient preventive medicine facility located in Redlands, California, owned by the Respondent, an internist. At the Clinic, patient evaluation includes bone density X-rays and body fat composition analysis X-rays using equipment owned and maintained by the Respondent.

11. The patient[1] in this case was a 48-year-old morbidly obese (BMI 43) female, a chronic one-pack-per-day smoker, taking medications for blood pressure, depression and asthma. She desired improvement in her abdominal contour. A physician had previously recommended a gastric sleeve procedure for treatment of her obesity which she had declined.

12. On May 11, 2015, three days pre-operatively, the patient was started on antibiotics and was advised to discontinue smoking peri-operatively.

13. On May 14, 2015, Respondent performed an abdominal liposuction surgery on the patient at his JWR Wellness Clinic. This facility was not an accredited outpatient surgical facility. Respondent did not have admitting or surgical privileges at any hospital. He had no written transfer agreement with an accredited hospital at the time of this procedure. It was only on June 16, 2015, a month after this procedure, that Respondent has documentation of a transfer agreement with Redlands Community Hospital.

14. The surgery on the patient was performed in a "procedure room." Review of the relevant photographs of the "procedure room" document an examination type table, not an operating room table. There was no overhead lighting or other form of adequate surgical lighting. Other photographs demonstrate a small capacity autoclave, no segregation of cleaning and processing "clean" and "dirty" instruments, no designated scrub sink other than standard counter-top sink, and no photographic documentation of a "crash" cart or emergency defibrillator. The drug cabinet had a limited stock of drugs. There was no designated cabinet for the storage of sterile supplies. The patient alleged that Respondent left the room several times during the procedure and was not sterile upon returning to the operating room.

[1] Patient's name is being withheld to protect their identity.

15. Respondent calculated her safe dose of lidocaine to be 45 mg/kg x 115 kg, or 5,216 mg (the correct safe dose is 35 mg/kg x 115 kg, or 4,025 mg). She had 3,400 cc tumescent fluid infiltrated (containing 3,400 mg Lidocaine), and 4,550 cc fat aspirated. Following completion of the surgery, the patient was discharged home. She was scheduled to return for follow-up the next day but was not seen by Respondent until May 19, 2015, five days after the surgery. The patient did not stop smoking perioperatively, and in fact, was noted by Respondent's staff as smoking a cigarette immediately after her surgical procedure.

16. For the procedure, the patient was given oral premedication consisting of 1 mg Ativan, 1 tablet of Vicodin (5/300), and Zofran (which was not documented). She had also been started on prophylactic oral keflex 500 mg, beginning three days before the procedure.

17. On May 19, 2015, postoperative day #5, Respondent saw the patient for the first time after surgery. Respondent noted that "on the lower hypogastric area there is purpura, bruising, edema and seroma. There is swelling, and there is some tenderness to touch. Minimal drainage." No temperature or other vital signs were documented. Respondent diagnosed that the observed physical findings were due to poor circulation and referred the patient for lymphatic massage.

18. On May 21, 2015, postoperative day #7, the patient's ten-day course of Keflex was completed.

19. On May 26, 2015, postoperative day #12, Respondent noted "minimal redness, moderate edema, purpura, soreness, significant seroma/edema. No temperature or vital signs were documented. The patient was told to return in 1-2 days or go to the E.R. if her condition worsened.

20. On May 28, 2015, postoperative day #14, the patient was seen by her primary M.D., who felt she had cellulitis and immediately sent her to the Emergency Room at San Gorgonio Hospital in Banning, California. At the hospital, she did not have a fever or elevated white blood cell count. She had CT scans performed on her abdomen, which the radiologist read as "Probable abdominal wall cellulitis" and she was given Clindamycin and antibiotics were continued on an outpatient basis.

21. On June 15, 2015, the patient returned to the ER at San Gorgonio Hospital a second time because her IV had been bleeding; she did not have a fever, and she left without being seen. On the same day, she presented to Redlands Community Hospital, where again she was afebrile, had a normal white blood cell count, and a negative CT scan. The next day, June 16, 2015, the patient left the hospital early in the morning "against medical advice," and requested copies of her medical records as she left.

22. Later that day, on June 16, 2015, the patient was seen again at Redlands Community Hospital. A CT scan of the abdomen and pelvis was done on which showed "prominent stranding seen along the anterior abdominal wall, consistent with cellulitis." June 17, 2015, a PICC[2] line was placed for continued IV antibiotics.

23. On December 6, 2019, Respondent was interviewed by an investigator in the Health Quality Investigation Unit and by a District Medical Consultant (DMC) regarding this incident. During the interview, Respondent acknowledged that he had no hospital admitting privileges.

24. It was an extreme departure from the standard of care for (a) failing to have a transfer agreement to a local hospital should an emergency arise; (b) IV access, a pulse oximeter, blood pressure, and electrocardiogram monitoring; (c) an emergency plan with a transfer agreement; and (d) either admitting privileges at a local general acute-care hospital or have a written transfer agreement with such a hospital or with a licensed physician who has admitting privileges at such a hospital.

25. California Code of Regulations 1356.6, entitled "Liposuction Extraction Standards," states: "The physician shall either have admitting privileges at a local general acute-care hospital or have a written transfer agreement with such a hospital or with a licensed physician who has admitting privileges at such a hospital." However, Respondent did not have a written transfer agreement with local physicians at a local hospital. Therefore, he should not have been performing large-volume liposuction in his clinic.

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[2] Peripherally inserted central catheter (PICC) - A PICC is a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava.

26. An Independent Practice Association (IPA) Agreement is insufficient to meet the requirements of California Code of Regulations (CCR) 1356.6. Respondent's Internal Medicine Colleagues in the IPA cannot perform surgery; the IPA is a rotating calendar for coverage of other doctors' patient phone calls. An arrangement in which a covering Internal Medicine doctor tries to locate a surgeon does not qualify as a written transfer agreement for coverage of emergencies.

27. At this interview, Respondent acknowledged that he started the patient on pre-op antibiotics earlier than was customary because he was "concerned about her hygiene." The Medical Board's consultant asked Respondent, "So this is someone who is obviously dirty and unkempt?" to which the Respondent replied, "At times, yes." Respondent decided to perform liposuction knowing that his patient was "dirty," had hypertension, and was a chronic smoker.

28. Despite documenting abnormal findings on two occasions, Respondent failed to diagnose cellulitis. Instead, he mistakenly attributed the clinical findings to impaired circulation and smoking. At this interview, Respondent explicitly dismissed the possibility of infection, stating incorrectly there was, "no sign of infection because the incision sites were closed and there was no drainage."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

29. By reason of the facts set forth above in paragraphs 10 through 28, which are incorporated herein as if fully set forth, Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code for gross negligence. The circumstances are as follows:

A. Respondent failed to have a transfer agreement to a local hospital should an emergency arise.

B. Respondent failed to have IV access, a pulse oximeter, blood pressure, and electrocardiogram monitoring.

C. Respondent failed to have an emergency plan with a transfer agreement in place as required by California Code of Regulations section 1356.6.

D. Respondent failed to have either admitting privileges at a local general acute-

care hospital or a written transfer agreement with such a hospital or with a licensed physician who had admitting privileges at such a hospital.

E. Respondent exercised poor judgment in conducting high-volume liposuction on the patient, knowing that the patient was morbidly obese, had hypertension, was a chronic smoker, and was, as he put it, "dirty," suggesting the patient was at high risk of infection.

F. Respondent failed to diagnose cellulitis despite documenting two occasions of abnormal findings.

G. Respondent demonstrated a lack of knowledge by not suspecting or diagnosing post-op cellulitis and by incorrectly stating that there was "no sign of infection because the incision sites were closed and there was no drainage."

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

30. By reason of the facts set forth above in paragraphs 10 through 29, which are incorporated herein as if fully set forth, the Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code for repeated negligent acts.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Record Keeping)

31. By reason of the facts set forth above in paragraphs 10 through 30, which are incorporated herein as if fully set forth, the Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate medical records.

DISCIPLINARY CONSIDERATIONS

32. To determine the degree of discipline, if any, to be imposed on Respondent Joon Won Rhee, M.D., Complainant alleges that on or about November 2, 2016, in a prior disciplinary action entitled *In the Matter of the Accusation Against Joon Won Rhee, M.D.*, before the Medical Board of California, Case Number 18-2013-232643, Respondent's license was revoked, but the revocation was stayed and Respondent was placed on probation for thirty-five months for gross negligence, repeated negligent acts, incompetence, failure to maintain adequate and accurate records of patient care, false advertising, and unprofessional conduct. The probation terms and

conditions included the requirement to complete an education course, a professionalism program [that is, ethics course], a medical training program, a requirement to obey all laws, and to submit quarterly declarations, among other terms. That Decision is now final and is incorporated by reference as if fully set forth herein.

33. In addition, to determine the degree of discipline, if any, to be imposed on Respondent Joon Won Rhee, M.D., Complainant alleges that on or about April 10, 2020, in an additional disciplinary action entitled *In the Matter of the Accusation and Petition to Revoke Probation Against Joon Won Rhee, M.D.* before the Medical Board of California, Case Number 800-2019-053094, Respondent's license was revoked, but the revocation was stayed and the probation period from Respondent's prior disciplinary action was extended by one (1) year from the effective date of this Decision for gross negligence, repeated negligent acts, failure to obey all laws. Probation terms and conditions included the requirement to complete an education course, a professionalism program [ethics course] and the standard terms and conditions. That Decision is now final and is incorporated by reference 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 Number A 77852, issued to Joon Won Rhee, M.D.;

2. Revoking, suspending, or denying approval of Joon Won Rhee, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering Joon Won Rhee, M.D. to pay the Board the costs of probation monitoring; and

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

DATED: April 8, 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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