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

In the Matter of the Accusation Against: Stephen Kyo-Sung Kim, M.D. Physician's and Surgeon's Certificate No. G 76433 Respondent.	Case No. 800-2017-037145

DECISION

The attached Stipulated Surrender of License and 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 January 14, 2022.

IT IS SO ORDERED January 7, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
ROBERT BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
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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 Accusation Against: **STEPHEN KYO-SUNG KIM, M.D.** **1125 South Beverly Dr, Suite 111** **Los Angeles, CA 90035-1148** **Physician's and Surgeon's Certificate No. G 76433** Respondent.	Case No. 800-2017-037145 **STIPULATED SURRENDER OF LICENSE AND 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 Vladimir Shalkevich, Deputy Attorney General.

2. STEPHEN KYO-SUNG KIM, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about May 3, 1993, the Board issued Physician's and Surgeon's Certificate No. G 76433 to STEPHEN KYO-SUNG KIM, M.D. (Respondent). The Physician's and Surgeon's

Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-037145. It expired on February 28, 2019, and has not been renewed.

JURISDICTION

4. Accusation No. 800-2017-037145 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 December 14, 2021 and in person on December 27, 2021. A copy of Accusation No. 800-2017-037145 is attached as Exhibit A and incorporated by reference. Respondent did not submit a Notice of Defense.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2017-037145. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; 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.

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

CULPABILITY

8. Respondent admits all of the charges and allegations in the Accusation No. 800-2017-037145, a copy of which is attached hereto as Exhibit A and is incorporated herein by reference.

9. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

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CONTINGENCY

10. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. 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 Surrender 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.

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

12. 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 Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 76433, issued to Respondent STEPHEN KYO-SUNG KIM, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

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3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-037145 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2017-037145 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/27/2021

Stephen K. Kim MD

STEPHEN KYO-SUNG KIM, M.D.
Respondent

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ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: December 28, 2021

Respectfully submitted,

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

Electronically Signed

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-037145

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

In the Matter of the Accusation Against:	Case No. 800-2017-037145
STEPHEN KYO-SUNG KIM, M.D. 1125 South Beverly Drive, Suite 111 Los Angeles, CA 90035 Physician's and Surgeon's Certificate G 76433, Respondent.	**ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California (Board).

2. On May 3, 1993, the Board issued Physician's and Surgeon's Certificate Number G 76433 to Stephen Kyo-Sung Kim, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein. On January 22, 2018, Respondent's Physician's and Surgeon's Certificate was suspended by an Interim Suspension Order. Respondent's Physician's and Surgeon's Certificate expired on February 28, 2019, and has not been 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 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.

5. 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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that 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.

6. Section 2236 of the Code states:

(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter [Chapter 5, the Medical Practice Act]. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

(b) The district attorney, city attorney, or other prosecuting agency shall notify the Medical Board of the pendency of an action against a licensee charging a felony or misdemeanor immediately upon obtaining information that the defendant is a licensee. The notice shall identify the licensee and describe the crimes charged and the facts alleged. The prosecuting agency shall also notify the clerk of the court in which the action is pending that the defendant is a licensee, and the clerk shall record prominently in the file that the defendant holds a license as a physician and surgeon.

(c) The clerk of the court in which a licensee is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the board. The division may inquire into the circumstances surrounding the commission of a crime in order to fix the degree of discipline or to determine if the conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon.

(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

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7. Section 2239 of the Code states:

(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The Division of Medical Quality may order discipline of the licensee in accordance with Section 2227 or the Division of Licensing may order the denial of the license when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

8. Section 2280 of the Code states:

> No licensee shall practice medicine while under the influence of any narcotic drug or alcohol to such an extent as to impair his or her ability to conduct the practice of medicine with safety to the public and his or her patients. Violation of this section constitutes unprofessional conduct and is a misdemeanor.

9. Effective on January 1, 2022, Section 125.3 of the Code will provide, in pertinent part, the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

10. On or about September 26, 2017, Patient 1[1], a 71-year-old male, with a significant past history of diabetes, hypertension and mild chronic renal insufficiency, was scheduled to undergo a cosmetic procedure under Monitored Anesthesia Care, which was to include local anesthetic and IV sedation. Respondent was to serve as an anesthesiologist for the procedure.

[1] The Patient is designated by a number for privacy. His name is known to Respondent and/or shall be disclosed to Respondent upon Request for Discovery.

11. Respondent performed a preoperative assessment and documented that despite the patient having consented only to a local anesthetic with IV sedation, the patient would be subjected to general anesthesia during the procedure. The patient was subsequently intubated and had a laryngeal mask airway (LMA) placed for the operation. According to the anesthesia record, Respondent administered 4 mg of midazolam to the patient following induction of anesthesia.

12. At the time, and unbeknownst to the patient, Respondent had a serious ongoing drug abuse problem. He had been using narcotics that had been stolen from various surgical centers prior to and during surgeries for two to three years before he cared for Patient 1. On the day of Patient 1's surgery, Respondent injected himself with 50 milligrams of Demerol[2] stolen from the surgical center after he arrived at the facility. Respondent was under the influence of controlled substance when he administered unconsented general anesthesia to Patient 1.

13. Respondent left the operating room during the surgery to inject himself with an additional 50 milligrams of Demerol and 60 milligrams of Toradol[3] and he fell and struck his head when he returned to the operating room. He told other healthcare providers in the operating room that he was fine and able to continue. The operation took approximately five hours and was performed by a surgeon without reported complications.

14. After the surgery the patient was returned to a post anesthesia care unit, where Respondent and nurses were responsible for his recovery and emergence from anesthesia. Upon arrival in the recovery room the patient was somnolent and unarousable. In addition, the patient was mildly bradycardic, suffering from a slow heart rate. Respondent came to evaluate the patient and then returned with two unlabeled syringes. Respondent claimed that they were glycopyrrolate and atropine, and he injected them into the patient's intravenous line. Soon after this, the patient began to decompensate and suffered a respiratory arrest, which eventually led to a cardiac arrest. A nurse repeatedly attempted to get Respondent to return to attend to the patient.

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[2] Demerol is an opioid agonist that contains meperidine. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c) (17)

[3] Toradol (ketorolac tromethamine), is a nonsteroidal anti-inflammatory drug (NSAID) that is used to treat moderately severe pain. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant to the federal Controlled Substances Act.

Eventually, the surgeon arrived and attempted to resuscitate the patient with bag mask ventilation. Respondent arrived and attempted to re-intubate the patient. Respondent was acting in a confused and erratic manner. He did not bring the correct equipment to intubate the patient and struggled in his attempts, out of character for a trained anesthesiologist. This led to an esophageal intubation, when endotracheal tube was mistakenly placed in the patient's esophagus and not in his trachea.

15. Paramedics were called and arrived to find the patient in asystole. The paramedics noted the incorrect esophageal intubation. During the resuscitative efforts, Respondent entered the room with a syringe and began to inject an intravenous medication into the patient's IV. Respondent had to be physically pulled away by a paramedic from the Patient's IV. Respondent later acknowledged that the syringe contained Demerol, a completely inappropriate medication for a patient during resuscitative efforts in the circumstances of this case. Resuscitation was unsuccessful and the patient died.

16. The police were called to the clinic and their reports, photos and witness interviews demonstrated fresh injection sites on Respondent's arm. Respondent admitted to using Demerol to the police officers. Laboratory values confirmed high levels of Demerol in Respondent's blood stream. Subsequent investigation, which included an inspection of the surgical center's drug log indicated that 1800 mg of Demerol was removed from the surgical center's pharmacy during the procedure, with only 900 mg having been documented as given to the patient.

17. Blood and urine samples collected from Respondent indicated that he had a significant amount of Demerol and traces of Fentanyl in his system. Respondent admitted that he had used Demerol about 150 times prior to or during other medical procedures. Respondent was arrested and criminally prosecuted.

18. On December 3, 2021, in the case of *People vs. Stephen Kim*, Los Angeles Superior Court Case Number BA464557, Respondent was convicted, upon his plea of guilty, of involuntary manslaughter, in violation of Penal Code section 192, subdivision (b). Respondent was ordered to be confined in the county jail for two years, and his sentencing was postponed

until December 4, 2023. As a part of the plea agreement, Respondent agreed to surrender his medical license and never practice in the medical field or work in any medical facility.

FIRST CAUSE FOR DISCIPLINE

(Conviction of a Crime)

19. By reasons of the facts set forth in paragraph 10 through 18, Respondent Stephen Kyo-Sung Kim, M.D. is subject to disciplinary action under sections 2236 of the Code in that he was convicted of a felony substantially related to the qualifications, functions and duties of a physician and surgeon.

SECOND CAUSE FOR DISCIPLINE

(Drug Abuse)

20. By reasons of the facts set forth in paragraph 10 through 18, Respondent Stephen Kyo-Sung Kim, M.D. is subject to disciplinary action under section 2239 of the Code in that he used controlled substances in a manner dangerous to himself and the public.

THIRD CAUSE FOR DISCIPLINE

(Practicing Medicine While Impaired)

21. By reasons of the facts set forth in paragraph 10 through 18, Respondent Stephen Kyo-Sung Kim, M.D. is subject to disciplinary action under section 2280 of the Code in that he addition, practiced medicine while under the influence of a controlled substance. The circumstances are as follows:

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent Stephen Kyo-Sung Kim, M.D. is subject to disciplinary action under sections 2234, subdivision (b) in that he was grossly negligent in the care and treatment of his patient.

23. The allegations of paragraphs 10 through 18 are incorporated herein by reference.

24. Each of the following was an extreme departure from the applicable standard of care:

A) Under the circumstances of this case, giving the patient 900 mg of Demerol was an extreme departure from the standard of care.

B) Administering general anesthesia without the patient's consent was an extreme departure from the standard of care.

C) Respondent's incorrect esophageal intubation during attempts to re-intubate the patient was an extreme departure from the standard of care for an anesthesiologist.

D) Practicing medicine while under the influence of a controlled substance was an extreme departure from the standard of care.

FIFTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. Respondent Stephen Kyo-Sung Kim, M.D. is subject to disciplinary action under sections 2234, subdivision (c) in that he committed repeated negligent acts in the care and treatment of his patient.

26. The allegations of paragraphs 10 through 18 and paragraph 24 are incorporated herein by reference.

27. Each of the following, in addition to the allegations of paragraph 24 was a departure from the applicable standard of care:

A) Under the circumstances of this case, giving the patient 4 mg of midazolam was a departure from the standard of care.

B) Respondent's attempt to treat Patient 1's delayed emergence from anesthesia was a departure from the standard of care.

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 Physician's and Surgeon's Certificate Number G 76433, issued to Stephen Kyo-Sung Kim, M.D.;

2. Revoking, suspending or denying approval of Respondent Stephen Kyo-Sung Kim, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Stephen Kyo-Sung Kim, M.D. to pay to the Board the reasonable costs of the investigation and enforcement of this case incurred after January 1, 2022.

4. If placed on probation, ordering Respondent Stephen Kyo-Sung Kim, M.D. to pay the Board the costs of probation monitoring; and

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

DATED: DEC 14 2021

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

Reji Varghese
Deputy Director

Complainant

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