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

In the Matter of the Accusation Against: Luke Chong Bi, M.D. Physician's and Surgeon's Certificate No. A 73340 Respondent.	Case No. 800-2021-075461

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 June 20, 2025.

IT IS SO ORDERED May 23, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD
Michelle Anne Bholat, M.D., Chair
Panel A

ROB BONTA
Attorney General of California
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Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LUKE CHONG BI, M.D.** **P.O. Box 4161** **Foster City, CA 94404** **Physician's and Surgeon's Certificate No. A 73340** Respondent.	Case No. 800-2021-075461 OAH No. 2024050945 **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. Reji Varghese (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 Ryan J. Yates, Deputy Attorney General.

2. Respondent Luke Chong Bi, M.D. (Respondent) is represented in this proceeding by attorney Paul Chan, whose address is: 1851 Heritage Lane, Suite 128, Sacramento, CA 95815-4996. On or about October 26, 2000, the Board issued Physician's and Surgeon's Certificate No. A 73340 to Luke Chong Bi, 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. 800-2021-075461, and will expire on September 30, 2026, unless renewed.

JURISDICTION

3. Accusation No. 800-2021-075461 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 February 16, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2021-075461 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-075461. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary 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 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 understands and agrees that the charges and allegations in Accusation No. 800-2021-075461, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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9. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case or factual basis with respect to the charges and allegations in Accusation No. 800-2021-075461, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 73340 to disciplinary action, and that Respondent hereby gives up his right to contest those charges.

10. 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.

CONTINGENCY

11. 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.

12. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreement of the parties in this above-entitled 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 opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

1. PUBLIC REPRIMAND. IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 73340 issued to Respondent LUKE CHONG BI, M.D. shall be and is hereby Publicly Reprimanded pursuant to Business and Professions Code section sections 2234 subdivisions (b) and (c), 2227, and 2266. This Public Reprimand is issued in connection with Respondent's care and treatment and medical record-keeping of Patients A, B, C, and D; as well as engaging in unprofessional conduct. The allegations, as set forth in Accusation No. 800-2021-075461, are as follows:

> "On July 19, 2018, you arranged an endoscopic procedure for a patient. As a result of the delayed start time, you cancelled the procedure and went home, without finding a replacement physician and without notifying the patient. You failed to properly inform staff of the change of plans. You later performed a less invasive procedure, with dubious value.
>
> Between February 24, 2017, and July 26, 2023, you were witnessed by hospital staff 'dosing off,' while performing colonoscopies on several occasions.
>
> In June of 2020, a patient came into the hospital with nausea and vomiting. The patient had eaten earlier and, per hospital policy, this required an 8 hour wait before performing an endoscopic procedure. Instead, you attempted to clear out the patient's stomach with erythromycin, in order to cut down the waiting time. The time of operation was delayed to 4:00 P.M., however, you did not perform the procedure and went home, causing a one-day delay.
>
> In February of 2022, prior to performing a procedure, you did not wait the necessary sedation time and proceeded, which caused the patient to wake up mid procedure. You grabbed the patient by the head and held the patient's head down onto the table.
>
> In August of 2021, you failed to appropriately place a guide wire in a patient's bile duct and a perforation to the duct occurred. This caused the patient to have an ultimately successful emergency surgery.
>
> Between February 24, 2017, and July 26, 2023, you engaged in several instances of unprofessional conduct with several colleagues, including instances of rudeness and aggressive physical contact.
>
> Finally, between July 6, 2018 and July 26, 2023, you failed to maintain adequate medical records."

2. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 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 as determined by the program for the assessment and clinical education and 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 the 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. The 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 the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on an Accusation and/or a Petition to revoke probation.

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3. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $48,930.18 (forty-eight thousand, nine hundred thirty dollars and eighteen cents). Costs shall be payable to the Medical Board of California.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

4. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2021-075461 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 license.

5. FAILURE TO COMPLY CLAUSE. If Respondent fails to enroll in, participate in, or successfully complete the agreed upon program(s) and/or course(s), and/or complete the term(s) and condition(s) as described above, within the designated time period as set forth in the Decision and Order, Respondent shall receive and comply with 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 or fulfillment in the agreed upon program(s) and/or course(s), and/or completion of the term(s) and condition(s) has been provided to the Board as required by the express language of the Decision and Order. In addition, failure to successfully complete said program(s) and/or course(s), and/or complete the term(s) and condition(s) outlined above shall also constitute separate grounds for general unprofessional conduct and will be grounds for further immediate disciplinary action against Respondent's license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Paul Chan, Esq. 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: _____ Luke Bi (Dec 24, 2024 04:56 PST)

LUKE CHONG BI, M.D.
Respondent

I have read and fully discussed with Respondent Luke Chong Bi, 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: 12-26-24

PAUL CHAN, ESQ.
Attorney for Respondent

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DATED: 2/3/2025

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

Ryan Yates

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

In the Matter of the Accusation Against: **Luke Chong Bi, M.D.** **P.O. Box 4161** **Foster City, CA 94404** **Physician's and Surgeon's Certificate No. A 73340,** Respondent.	Case No. 800-2021-075461 **ACCUSATION**

PARTIES

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

2. On or about October 26, 2000, the Medical Board issued Physician's and Surgeon's Certificate No. A 73340 to Luke Chong Bi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2024, unless renewed.

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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

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 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.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent's license is subject to discipline under section 2234, subdivision (b), of the Code, in that he committed gross negligence during his care and treatment of patients and interactions with colleagues. The circumstances are as follows:

9. Respondent is a gastroenterologist. At all times pertinent to this Accusation, he worked at a Northern California hospital (Hospital).

Patient A:

10. Patient A,[1] a, then, 28 year old female, had type 1 diabetes and had gallbladder removal surgery on July 6, 2018. Prior to coming under the care of Respondent, Patient A had an ultrasound, which revealed multiple gallbladder stones and a dilated common bile duct. Patient A was admitted to Hospital on July 19, 2018, with abnormal liver function. At the time of her admission, she did not have a fever or increased white blood cells. An Abdominal Ultrasound at time of admission revealed a dilated common bile duct.

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[1] Patient names and information have been redacted to protect privacy. All witnesses will be identified in discovery.

11. Respondent arranged for an endoscopic retrograde cholangiopancreatography[2] (ERCP) on or about July 19, 2018. Patient A was transferred to an operating room and prepared for the surgery. Due to scheduling issues, however, the procedure was delayed for approximately two hours. As a result of the delayed start time, Respondent cancelled the procedure. Respondent then went home, without finding a replacement physician to perform the procedure, without notifying Patient A of the change in plans, and without documenting that the cancelled procedure was safe. Moreover, Respondent failed to discuss with Patient A and Hospital staff why the procedure was being cancelled, and failed to bring Patient A and staff up to speed regarding what would be happening next. This caused confusion amongst staff, and Patient A to become extremely upset.

12. At the time Respondent left the hospital and went home, there was an elevated likelihood of a common bile duct stone and infection. After canceling the procedure, Respondent suggested doing a magnetic resonance cholangiopancreatography[3] (MRCP) to confirm the presence of a common biliary duct stone. The MRCP was completed on or about July 19, 2018, but had limited effectiveness. On or about July 20, 2018, the ERCP was performed by another physician, with successful removal of stones and puss. Respondent additionally failed to maintain adequate medical records, regarding Patient A.

Inappropriate Operating Room Behavior:

13. Between February 24, 2017, and July 26, 2023, Respondent fell asleep while performing colonoscopies on at least ten occasions. On or about June 10, 2019, Respondent was performing an endoscopic procedure on a patient. The scope began going in and out of the patient's rectal area. Respondent was observed with his eyes closed and he appeared to be drifting in and out of sleep. This happened several times during the procedure, until Respondent completed the procedure and removed the scope. On or about August 23, 2022 Respondent was

[2] ERCP, is a procedure to diagnose and treat problems in the liver, gallbladder, bile ducts, and pancreas. It combines X-ray and the use of an endoscope—a long, flexible, lighted tube. The healthcare provider guides the scope through the mouth and throat, then down the esophagus, stomach, and small intestine.

[3] MRCP uses a magnetic field, radio waves and a computer to evaluate the liver, gallbladder, bile ducts, pancreas and pancreatic duct for disease.

performing a colonoscopy on a patient. During the procedure, Respondent was observed "dosing off." This caused a delay in the removal of the scope. On at least eight other occasions, staff witnessed similar conduct with other patients.

14. On or about June 23, 2020, a patient came into the hospital with intractable nausea and vomiting. The patient had eaten breakfast earlier and, per hospital policy, it was expected that at least eight hours should elapse before beginning a gastroenterological procedure. In order to cut the timeframe down, Respondent requested an erythromycin[4] order, to clear out the patient's stomach. Hospital staff informed Respondent that this would not change the timeframe. Despite warnings from staff that it would be unsafe, Respondent attempted to continue with the erythromycin order. After the internal medicine team decided that the patient was not emergent, it was agreed that the medical providers would wait the recommended eight hours before performing the procedure. This pushed the time of operation to 4:00 P.M. Rather than perform the procedure, Respondent went home, and the procedure was delayed until the next day.

15. On or about February 23, 2021, Respondent was performing an Esophagogastroduodenoscopy[5] (EGD) procedure on a patient. During the procedure, Respondent requested forceps from a Gastroenterology Technician (Colleague A). Colleague A took longer than expected, due to an encumbrance with positioning the patient. After approximately fifteen seconds, Respondent forcefully nudged Colleague A with his elbow and stated, "hurry up with the forceps!" or words to that effect. Similar aggressive physical contacts occurred with hospital staff on at least two other occasions. Between February 24, 2017, and July 26, 2023, Respondent was preparing to perform a biopsy on a patient, which required scoped forceps. Just prior to the insertion of the scope, Respondent began to "nod off." Out of concern for everyone's safety, a Gastroenterology Technician (Colleague B), grabbed the forceps from Respondent, as he appeared to be losing balance. Respondent then hit Colleague B on the arm, with an open palm. Between the aforementioned dates, Respondent was performing a procedure on a patient, requiring scoped forceps. Respondent was being assisted by a Gastroenterology Technician

[4] Erythromycin is used to prevent and treat infections in many different parts of the body.
[5] EGD is a diagnostic common endoscopic procedure that includes visualization of the oropharynx, esophagus, stomach, and proximal duodenum.

(Colleague C). As Colleague C was working with forceps, Respondent abruptly elbowed Colleague C in the arm with his right elbow and grabbed the forceps from her.

16. On or about February of 2022, Respondent was performing an EGD on a patient. The patient was intubated and sedated. The patient required additional sedation and Respondent was asked to wait a short period of time for the sedation to take effect. Respondent did not wait the requested time and proceeded with the EGD. This caused the patient to wake up during the procedure. Respondent grabbed the patient by the head and held the patient's head down onto the table.

17. Respondent committed gross negligence as follows:

A. Withdrawing from Patient A's treatment, without giving reasonable notice, explanation or providing a replacement;

B. Each separate act of falling asleep during procedures, between February 24, 2017, and July 26, 2023;

C. Each separate act of physical abuse against colleagues, between February 24, 2017, and July 26, 2023;

D. Failure to adhere to hospital safety policies, on or about June 23, 2020; and

E. Inappropriate physical contact with a patient during each examination.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent's license is subject to discipline under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patient A, as more fully described in paragraphs 8 through 17, above, and those paragraphs are incorporated by reference as if fully set forth herein. Additionally, Respondent engaged in repeated negligent acts in his care for Patients B, C, D, and E.

Patient B:

19. On or about February 22, 2021, Respondent performed an EGD on Patient B, but results were inconclusive. A second EGD occurred on or about February 24, 2021. During Respondent's care and treatment of Patient B, Respondent failed to maintain adequate medical

records. Specifically, Respondent included only one line for Patient B's history and no assessment. Respondent's records for Patient B lack the standard elements and do not adequately reflect his thought process and assessment.

Patient C:

20. On or about February 15, 2021, Patient C was admitted to Hospital. Patient C was, a, then, 77-year-old male with evidence of septic shock, irregular heartbeat, and history of lung cancer. On or about February 15, 2021, Respondent was consulted and discussed Patient C with the Intensive Care Unit (ICU) team. Respondent returned to the hospital, on or about February 16, 2021, and performed an ERCP on Patient C, which was technically unsuccessful. An attempt was made to decompress the biliary system by drainage of the gallbladder by interventional radiology, but this, too, was unsuccessful. Patient C remained critically ill and died on or about February 17, 2021. During Respondent's care and treatment of Patient C, Respondent failed to maintain adequate medical records.

Patient D:

21. Patient D was a, then, 72-year-old female, who was admitted to Hospital on or about January 21, 2022, with evidence of an upper gastrointestinal (GI) tract bleed and low number of red blood cell count. Respondent performed an EGD on or about January 24, 2022. Respondent repeated the EGD on or about February 1, 2022. On or about February 2, 2022, another EGD was performed, and Respondent arranged the takeover of care with the hospital's intensive care unit team. During Respondent's care and treatment of Patient D, Respondent failed to maintain adequate medical records.

Patient E:

22. Patient E was a, then, 61-year-old female, who was admitted to Hospital on or about August 21, 2021, with jaundice, stomach pain, and nausea/vomiting. Respondent was consulted for diagnosis and possible biliary stone removal and/or stent placement. Respondent performed the ERCP on or about August 23, 2021. During the procedure, Respondent failed to appropriately place a guide wire in Patient E's bile duct and a perforation to the duct occurred. Shortly after the

ERCP, Patient E experienced increased abdominal pain and x-rays revealed evidence of a perforated viscus. This caused Patient E to have an emergency surgery, which was successful.

23. Respondent committed repeated negligent acts, as follows:

A. Respondent failed to maintain adequate medical records during the care and treatment of Patient B;

B. Respondent failed to maintain adequate medical records during the care and treatment of Patient C;

C. Respondent failed to maintain adequate medical records during the care and treatment of Patient D; and

D. Respondent failed to appropriately place a guide wire in Patient E's bile duct.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

24. Respondent's license is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C, and D, as more fully described in paragraphs 8 through 24 above, and those paragraphs are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent's license is subject to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 8 through 24, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

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

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1. Revoking or suspending Physician's and Surgeon's Certificate No. A 73340, issued to Respondent, Luke Chong Bi, M.D.;

2. Revoking, suspending or denying approval of Respondent, Luke Chong Bi, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, Luke Chong Bi, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: 2/16/2024

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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