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

In the Matter of the Accusation Against: **Henry Geoffrey Watson, M.D.** **5709 Market St. Ste. 5715,** **Oakland, CA 94608** **Physician's and Surgeon's Certificate No. C 41403,** Respondent.	Case No. 800-2019-055115 **A C U S A T I O N**

PARTIES

1. William Prasifka (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 May 29, 1984, the Board issued Physician's and Surgeon's Certificate Number C 41403 to Henry Geoffrey Watson, 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 August 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 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.
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> (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.
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> (d) Incompetence.
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> (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.
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> (f) Any action or conduct that would have warranted the denial of a certificate.
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> (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.

7. Section 3501 of the code requires a physician and surgeon who supervises a physician assistant to oversee the activities of and accept responsibility for the medical services rendered by the physician assistant, and further provides that the physician assistant acts as an agent of the supervising physician.

8. Section 3502 of the Code requires a physician who supervises a physician assistant to take ensure adequate supervision of the care provided by the physician assistant, by among other things, reviewing and countersigning charts, conducting regular chart review meetings, and identifying those cases which pose the greatest potential for patient risk or harm.

9. Section 3502.1 of the Code provides that physician assistants to whom the authority to prescribe medications act on behalf of, and as an agent for the supervising physician.

10. California Code of Regulations, title 16, section 1399.542, provides that the delegation of procedures to a physician assistant shall not relieve the supervising physician of primary continued responsibility for the welfare of the patient.

11. California Code of Regulations, title 16, section 1399.545 provides states, in part:

> (e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:
>
> (1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;
>
> (2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;
>
> (3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the

patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

(4) Other mechanisms approved in advance by the board.

(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

COST RECOVERY

12. 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

(Unprofessional Conduct: Repeated Negligent Acts: Patient 1[1])

13. Respondent Henry G. Watson, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under code section 2234, subdivision (c) in his care and treatment, acts and/or omissions, of Patient 1, a 39-year-old female, as alleged herein.

14. Patient 1 had a history of a rare connective tissue disorder, chronic pain, previous ankle surgery, migraine, depression, anxiety, fibromyalgia, PTSD, and hypertension. Respondent provided outpatient care to Patient 1 from 2016 to 2017, and was the supervising physician for a

[1] Patients are referred to by number to protect privacy.

physician assistant, Omar Staples[2] (PA Staples), who treated the patient from 2016-2020, and provided the majority of care to the patient. Physician assistants require oversight by a supervising physician for all activities and medical services.

15. On September 19, 2019, Patient 1 was seen by Respondent for a medication refill. The medications prescribed by Respondent included Fioricet[3], Soma[4], Norco[5], Morphine Extended Release[6], and Motrin. Respondent did not document a pain assessment or pain scale, and documented a normal physical examination. Respondent's assessment included back pain. The management plan was to discontinue Ativan. In October 2017, Patient 1 signed a narcotic contract.

16. Respondent's medical record for Patient 1 includes documentation that in July 2017, Patient 1 was admitted to the hospital with acute chronic back pain and right ankle pain. Her use of opioids was noted in the record. Imaging studies were normal and the patient's neurosurgical evaluation was documented at full strength. The discharge recommendations included outpatient multi-modal pain management including physical therapy, treatment coordinated by a pain specialist, possible steroid injections to SI joint, and outpatient MRI of her left ankle. In 2018, Respondent's records note that the patient was seen at UCSF for a consultation regarding her connective tissue disease. The UCSF specialist recommended non-opioid treatment, focusing on muscle strengthening and physical therapy.

17. On January 19, 2019, PA Staples notified Patient 1 that Soma will not be prescribed with narcotics and Klonopin[7] and Adderall[8] would no longer be prescribed at all. Patient 1 was also given a referral to psychiatry for evaluation.

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[2] An Accusation has been filed and is pending against physician assistant Omar Staples.

[3] Fioricet is a combination of acetaminophen, butalbital, and caffeine. It is a pain reliever and both a barbiturate and a stimulant. Fioricet is a Schedule III controlled substance.

[4] Soma is a prescription muscle relaxant. The generic name of Soma is carisoprodol. It is a Schedule IV controlled substance.

[5] Norco is a trade name for hydrocodone bitartrate with acetaminophen. It is a Schedule II controlled substance.

[6] Morphine is a Schedule II controlled substance.

[7] Clonazepam (Klonopin) is a benzodiazepine.

[8] Adderall is a combination drug containing four salts of amphetamine.

18. On December 31, 2020, Patient 1 was seen by PA Staples for left wrist and right ankle pain. Patient 1 reported standing on her feet 10-12 hours per day while operating heavy machinery, and chronic low back pain. Patient 1 was referred for consultations, including pain management.

19. CURES[9] and pharmacy documents demonstrate Patient 1 was prescribed multiple controlled substances from several practitioners from 2013-2016. Respondent prescribed controlled substances to Patient 1 for several months in 2017, and under his supervision, PA Staples prescribed a number of controlled substances to Patient 1 including opioids, benzodiazepines, sedative/hypnotics, muscle relaxants, and barbiturates on a regular basis from 2016 to 2020.

20. The records for the treatment provided to Patient 1 by the physician assistant under Respondent's supervision do not contain a complete initial pain assessment, a justification for continued long-term treatment with opiates, an assessment for harm resulting from the opiate prescribing, and a complete or meaningful periodic review of Patient 1's treatment plan over the course of treatment including assessing for harm.

21. There was no change in Patient 1's treatment plan utilizing high dose narcotics despite recommendations that are included in Respondent's medical record, from specialists at Stanford in 2017 and UCSF in 2018 emphasizing mainstay of management for the patient's connective tissue disease should be physical therapy, strengthening to minimize strain on joints. Functional goals, pain goals, CURES review, and urine drug testing should have been part of the ongoing treatment and monitoring provided by Respondent and PA Staples.

22. Despite the fact that PA Staples prescribed multiple controlled substances at regular intervals for a prolonged period of time, there is no indication in the record that either PA Staples or Respondent conducted any assessment for appropriateness for continued controlled substance use or completely evaluated the Patient for harm in this high-risk patient who was on multiple controlled substances, despite the fact that physical examination was consistently noted as normal

[9] CURES (Controlled Substance Utilization Review and Evaluation System) is a database of controlled substance prescriptions dispensed in California serving public health, regulatory oversight agencies, and law enforcement.

and imaging studies did not show significant pathology, and despite the fact the patient reported that she operated heavy machinery at work.

23. The medical record does not document consistent or adequate supervision by Respondent of PA Staples. Many of the chart entries that were co-signed by Respondent were on pages in which the plan and assessment were blank. There is no documentation of oversight such as Respondent's examination of the patient or medical record review meetings with the PA. There is no indication in the chart that Respondent provided any meaningful oversight or supervision of PA Staples.

24. Respondent is subject to disciplinary action for repeated negligent acts under code section 2234(c) in that he repeatedly, and over a long period of time failed to provide adequate mid-level practitioner supervision to PA Staples for his treatment of Patient 1, and failed to conduct and/or document any meaningful review of PA Staples for the care and treatment provided to Patient 1, as required by the standard of care and sections 3501, 3501 and 3502.1 of the Code.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts: Patient 2)

25. Respondent Henry G. Watson, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under code section 2234, subdivision (c), in his care and treatment, acts and/or omissions, of Patient 2, a 61-year-old male, as alleged herein.

26. Patient 2 was a 61-year-old man with a number of medical conditions, including arthritis, hip replacement, back and shoulder pain. Patient 2 was treated primarily by PA Staples from 2016 to 2020.

27. CURES and pharmacy documents demonstrate that Respondent prescribed a limited amount of controlled substances to Patient 2 in 2017 and 2018. However, from 2015 to 2018, PA Staples regularly prescribed a number of controlled substances to Patient 2 including opioids, amphetamine salt combination, muscle relaxants, and sedative/hypnotics.

28. The medical records contains no indication that either PA Staples or Respondent conducted a complete initial pain assessment or ongoing periodic review of the treatment plan, including an assessment of potential harm. There is no documentation of the appropriateness of ongoing narcotic use, and no indication of a comprehensive treatment plan that included defined pain goals, functional objectives, utilization of non-narcotic drugs, or rehabilitation programs.

29. Adequate physician supervision was not documented by Respondent. The medical record did not document episodes of oversight such as same day examination of the patient, co-signatures, opiate management protocols, or medical record review meetings with PA Staples. The medical record did not establish that Respondent was involved in the longitudinal pain management treatment decision making for PA Omar Staples.

30. Respondent is subject to disciplinary action for unprofessional conduct and repeated negligent acts under code sections 2234 and 2234(c) in that he repeatedly, and over a long period of time failed to provide adequate mid-level practitioner supervision to PA Staples for his treatment of Patient 2, and failed to conduct and/or document any meaningful review of PA Staples for the care and treatment provided to Patient 2, as required by the standard of care and sections 3501, 3501 and 3502.1 of the Code.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts: Patient 3)

31. Respondent Henry G. Watson, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under code sections 2234, subdivision (c) in his care and treatment, acts and/or omissions, of Patient 3, as alleged herein.

32. Patient 3 is a 59-year-old woman with medical conditions that include chronic pain and arthritis. PA Staples prescribed a number of controlled substances to Patient 3 from 2015 to 2017, and Respondent prescribed multiple controlled substances including diazepam[10], opiates, and muscle relaxants to Patient 3 from 2017 to 2020.

[10] Diazepam (Valium) is used to relieve anxiety and to control agitation caused by alcohol withdrawal.

33. There is no indication in the medical record that either Respondent or PA Staples performed an initial pain assessment, or that there was a complete exam in the area of reported pain and details of previous diagnostic evaluations and prior treatments for each pain syndrome were poorly documented.

34. There is no indication in the record that either Respondent or PA Staples ever performed complete periodic reviews of the Patient 3's treatment plan, or that an assessment of functional goals and pain goals were performed. CURES reviews and urine drug testing should have been part of the periodic monitoring and risk assessment. The documentation details of prior evaluation for pain syndromes, prior treatment and informed consent discussing the long-term use of opiates in combination with benzodiazepines and muscle relaxants was inadequate.

35. PA Staples' handwritten office visit notes were illegible and incomplete in that they lacked assessment and management plans. Yet, Respondent co-signed a number of the records.

36. Respondent's records reflect that on October 23, 2020, Patient 3 was admitted to the hospital after being found unresponsive next to empty alcohol bottles. She had alcohol poisoning with a blood alcohol level of 502 mg/dl, alcohol intoxication, alcohol withdrawal syndrome, UTI, lactic acidosis, alcoholic hepatitis, cirrhosis due to alcohol and hepatitis C, and thrombocytopenia. X-rays revealed mild degenerative joint disease, chronic right hip dislocation, and stable left hip arthroplasty. A toxicology screen was positive for opiates. Patient 3 was treated with IVF, antibiotics, decrease in Methadone dose and alcohol rehabilitation. Even at this point, neither Respondent nor PA Staples conducted a harm re-assessment, timely de-escalated controlled substances or addressed chemical dependency.

37. Respondent is subject to disciplinary action for unprofessional conduct and repeated negligent acts under code section 2234(c) in that he repeatedly and over a long period of time failed to provide adequate mid-level practitioner supervision to PA Staples for his treatment of Patient 3, and failed to conduct and/or document any meaningful review of PA Staples for the care and treatment provided to Patient 3, as required by the standard of care and sections 3501, 3501 and 3502.1 of the Code.

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FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts: Patient 4)

38. Respondent Henry G. Watson, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under code section 2234 subdivision (c) in his care and treatment, acts and/or omissions, of Patient 4, a 66-year-old female, as alleged herein.

39. Respondent prescribed high dose opiates and benzodiazepines to Patient 4 on a regular basis from 2015 to 2020. Specialists were involved in the care of Patient 4, however, Respondent was the primary provider prescribing controlled substances. Over the course of treatment, the patient complained of shoulder pain, back pain, and arthritis. Physical examinations were documented as normal. Respondent's medical record does not contain information to support continued long-term treatment with high-dose opiates or benzodiazepines. While Respondent's chart contains notes from cancer specialists who noted no complaints of pain, Respondent did not respond to or assess this information.

40. Respondent's written notes of his treatment of Patient 4 were illegible and missing key elements including vital signs, medication lists, accurate assessments or management plans. Electronic records were template driven with unchanged subjective and objective data over many visits. Details of prior evaluations for pain syndromes, support for diagnosis of complex regional pain syndrome, cord compression, rheumatoid arthritis, cancer related pain, and prior treatment were absent.

41. Respondent's records contain no periodic review of Patient 4's treatment plan, and no assessment of functional or pain goals, functional status, or examination of the areas of reported pain. There was no indication of any discussion or consideration of opioid tapering.

42. Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient 4, pursuant to code section 2234 subdivision (c) as he failed to support indication for long-term treatment with controlled substances for pain and/or failed to perform complete periodic reviews of treatment utilizing controlled substances for pain.

FIFTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts: Patient 5)

43. Respondent Henry G. Watson, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under code sections 2234, subdivision (c) in his care and treatment, acts and/or omissions, of Patient 5, a 68-year-old female, as alleged herein.

44. Patient 5 was a 68-year-old woman with a history of hypertension, congestive heart failure, degenerative joint disease, morbid obesity, chronic obstructive pulmonary disease /asthma, chronic respiratory failure requiring home oxygen, grief, and major depression. Respondent provided care to her from 2011 to 2018.

45. Patient 5 was on high-dose narcotics and benzodiazepines from previous providers when Respondent initiated her care. Respondent prescribed high-dose opiates (oxycodone) and benzodiazepines (Valium) to Patient 5 on a regular basis from 2017 to 2018 without a change in dose. The medical record does not contain evidence of CURES review or urine toxicology screens. The record reflects Patient 5 was non-compliant with diagnostic test requests and referrals, including referrals for pain management in 2018.

46. Respondent's record does not reflect ongoing periodic reviews and harm assessments of the patient's treatment plan, or that informed consent regarding the risks and benefits of high-dose narcotics and benzodiazepines was provided. There is no documentation of consideration of the risks posed by opioids given Patient 5's comorbidities of respiratory and heart issues and obesity. There is no indication Respondent attempted to taper the patient's opioid and benzodiazepine use.

47. Respondent's medical records contain illegible notes that do not include key elements such as vital signs, medication lists, assessments or management plans. Electronic records were templates with unchanged subjective and objective data over many of the encounters. Details of the evaluation of pain, prior treatment, informed consent, and treatment goals were poorly documented.

48. Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient 5, pursuant to code section 2234 subdivision (c) as he failed to perform complete periodic review of assessments and treatments and failed to perform adequate assessments for potential harm while prescribing opioids and benzodiazepines.

SIXTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts: Patient 6)

49. Respondent Henry G. Watson, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under code section 2234 subdivision (c), in his care and treatment, acts and/or omissions, of Patient 6, a 63-year-old male, as alleged herein.

50. Patient 6 has a history of hypertension, congestive heart failure, cerebral vascular accident with late effects, right sided weakness, pulmonary embolus, chronic obstructive pulmonary disease, obstructive sleep apnea requiring continuous positive airway pressure, morbid obesity, and major depression. Patient 6 was started on controlled substances for pain from previous providers related to a workplace injury.

51. Respondent prescribed high-dose opiates and benzodiazepines to Patient 6 from 2015 to 2019. A number of hospice providers also prescribed controlled substances from 2017 to 2020.

52. Respondent failed to provide complete periodic reviews and harm assessments of Patient 6's pain treatment plan. There is no indication that the patient was provided with informed consent regarding the risks and benefits of continued treatment with high-dose narcotics and benzodiazepines, or that the risks associated with his co-morbidities were discussed or considered. Even after the patient was hospitalized in 2016 with over-sedation from controlled substances, which contributed to respiratory failure and aspiration pneumonias, no serious discussion or assessment was conducted, and no consideration of timely de-escalation of controlled substances was noted. Written notes are illegible and missing key elements including vital signs, medication lists, accurate assessments and management plans. Electronic records were template driven with unchanged subjective and objective data over many of the encounters.

Details of prior evaluations for pain syndromes, prior treatment, informed consent discussing the long-term use of opiates in combination with high-dose benzodiazepines, and treatment goals were poorly documented. Patient 6 was enrolled in hospice on several occasions; however, the medical record was not clear of the reasons for repeated hospice disenrollment.

53. Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient 5, pursuant to code section 2234 subdivision (c) as he failed to perform complete periodic reviews of treatment, conduct harm assessments, or implement a timely tapering plan for this high-risk patient.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts: Patient 7)

54. Respondent Henry G. Watson, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under code sections 2234 subdivision (c) in his care and treatment, acts and/or omissions, of Patient 7, a 58-year-old male, as alleged herein.

55. Patient 7 has a history of HIV, kidney disease, hypertension, diabetes with neuropathy, sickle cell trait, asthma, toe amputation, depression, anxiety, and chronic pain. Respondent prescribed high-dose opiates, muscle relaxants and benzodiazepines to Patient 7 from 2015 to 2020. There is evidence for opiate and benzodiazepine tapering starting in 2019.

56. Respondent documented the patient's poorly controlled neuropathic pain from multiple potential causes, and referred the patient for non-narcotic treatment and evaluation. He added Lyrica to assist with pain. However, Respondent did not document complete periodic reviews of Patient 7's treatment plan, nor did he document informed consent regarding the risks and benefits of ongoing high-dose narcotics and benzodiazepines.

57. Respondent's record reflects that in 2019, Patient 7 saw a pain management specialist, who noted significant pain in upper and lower extremities and throughout the spine despite Oxycontin, Norco, Valium, Soma. The specialist also felt the patient had a strong

component of psychological involvement in symptoms with some overlap of fibromyalgia due to the diffuse, non-localizing nature of his pain syndrome. He recommended neuropathic class medications (Lyrica), continuation of Cymbalta, physical therapy, aquatic therapy, and psychology follow-up. He discussed the risks of the high-dose opioids combined with the multiple sedating agents that Patient 7 was receiving and recommended a weaning protocol, avoiding polypharmacy, and transitioning from Soma to another muscle relaxant.

58. During the time Respondent prescribed to Patient 7, his record keeping was inadequate and incomplete. Respondent's written notes were illegible and missing key elements including vital signs, medication lists, accurate assessments and management plans. Electronic records were template driven with unchanged subjective and objective data over many of the encounters. Details of prior evaluations for pain syndromes, prior treatments, informed consent discussing the long-term use of opiates in combination with high-dose benzodiazepines, and treatment goals were poorly documented in the patient's follow-up visits.

59. Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient 7, pursuant to code section 2234 subdivision (c), as he failed to perform complete periodic review of treatment, complete harm assessment and timely polypharmacy mitigation while prescribing narcotics and benzodiazepines.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate Medical Records)

60. Paragraphs 33 through 59, above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2266 in that he failed to maintain adequate and accurate records of the treatment of Patients 3, 4, 5, 6, and 7.

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 C 41403, issued to Respondent Henry Geoffrey Watson, M.D.;

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

3. Ordering Respondent Henry Geoffrey Watson, 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: APR 19 2022

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

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