

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

In the Matter of the Accusation Against:

William Glatt, M.D.

Physician's and Surgeon's
Certificate No. G 15309

Respondent.

Case No. 800-2019-058296

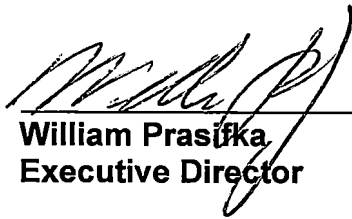
DECISION

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 2, 2023

IT IS SO ORDERED November 22, 2022.

MEDICAL BOARD OF CALIFORNIA



William Prasifka
Executive Director

1 ROB BONTA
Attorney General of California
2 GREGORY CHAMBERS
Supervising Deputy Attorney General
3 LYNNE K. DOMBROWSKI
Deputy Attorney General
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8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2019-058296

13 **WILLIAM GLATT, M.D.**

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

14 **1860 El Camino Real, Suite 301**
Burlingame, CA 94010

15 **Physician's and Surgeon's Certificate No.**
16 **G 15309**

17 Respondent.

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19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Rob Bonta, Attorney General of the State of California, by Lynne K. Dombrowski,
26 Deputy Attorney General.

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1 CULPABILITY

2 8. Respondent admits the truth of each and every charge and allegation in Accusation
3 No. 800-2019-058296, and he agrees that cause exists for discipline and hereby surrenders his
4 Physician's and Surgeon's Certificate No. G 15309 for the Board's formal acceptance.

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

8 CONTINGENCY

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

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

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

23 ORDER

24 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 15309, issued
25 to Respondent William Glatt, M.D., is surrendered and accepted by the Board.

26 1. Respondent shall lose all rights and privileges as a physician and surgeon in
27 California as of the effective date of the Board's Decision and Order, which shall be on December
28 31, 2022.

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

3 3. If Respondent ever files an application for licensure or a petition for reinstatement in
4 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
5 comply with all the laws, regulations and procedures for reinstatement of a revoked or
6 surrendered license in effect at the time the petition is filed, and all of the charges and allegations
7 contained in Accusation No. 800-2019-058296 shall be deemed to be true, correct and admitted
8 by Respondent when the Board determines whether to grant or deny the petition.

9 4. Respondent shall pay the agency its costs of investigation and enforcement in the
10 amount of \$14,000.00 prior to applying for issuance of a new or reinstated license.

11 5. If Respondent should ever apply or reapply for a new license or certification, or
12 petition for reinstatement of a license, by any other health care licensing agency in the State of
13 California, all of the charges and allegations contained in Accusation, No. 800-2019-058296 shall
14 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
15 Issues or any other proceeding seeking to deny or restrict licensure.

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17 **ACCEPTANCE**

18 I have carefully read the above Stipulated Surrender of License and Order and have fully
19 discussed it with my attorney Bradford J. Hinshaw, Esq. I understand the stipulation and the
20 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
21 Surrender of License and Order voluntarily, knowingly, and intelligently, and I agree to be bound
22 by the Decision and Order of the Medical Board of California.

23
24 DATED: NOV 17, 2022 William Glaty, M.D.

25 WILLIAM GLATY, M.D.
26 Respondent
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I have read and fully discussed with Respondent William Glatt, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 11-17-22 
BRADFORD J. HINGSRAW, ESQ.
Attorney for 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: 11/18/2022

Respectfully submitted,
ROB BONTA
Attorney General of California
GREGORY CHAMBERS
Supervising Deputy Attorney General

Lynne K. Dombrowski
LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

SF2021402231

Exhibit A

Accusation No. 800-2019-058296

1 ROB BONTA
Attorney General of California
2 JANE ZACK SIMON
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9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:
13 **WILLIAM GLATT, M.D.**
14 **1860 El Camino Real, Suite 301**
Burlingame, CA 94010
15 **Physician's and Surgeon's Certificate**
16 **No. G 15309,**
17 **Respondent.**

Case No. 800-2019-058296
A C C U S A T I O N

18
19 **PARTIES**

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

23 2. On August 26, 1968, the Board issued Physician's and Surgeon's Certificate Number
24 G 15309 to William Glatt, M.D. (Respondent). The Physician's and Surgeon's Certificate was in
25 full force and effect at all times relevant to the charges brought herein and will expire on May 31,
26 2022, unless renewed.

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JURISDICTION

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

5 4. Section 2227 of the Code provides that a licensee who is found guilty under the
6 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
7 one year, placed on probation and required to pay the costs of probation monitoring, or such other
8 action taken in relation to discipline as the Board deems proper.

9 5. Section 2234 of the Code, states:

10 The board shall take action against any licensee who is charged with
11 unprofessional conduct. In addition to other provisions of this article, unprofessional
conduct includes, but is not limited to, the following:

12 (a) Violating or attempting to violate, directly or indirectly, assisting in or
13 abetting the violation of, or conspiring to violate any provision of this chapter.

14 (b) Gross negligence.

15 (c) Repeated negligent acts. To be repeated, there must be two or more
16 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.

17 (1) An initial negligent diagnosis followed by an act or omission medically
18 appropriate for that negligent diagnosis of the patient shall constitute a single
negligent act.

19 (2) When the standard of care requires a change in the diagnosis, act, or
20 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
21 licensee's conduct departs from the applicable standard of care, each departure
constitutes a separate and distinct breach of the standard of care.

22 (d) Incompetence.

23 ...

24 6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
25 adequate and accurate records relating to the provision of services to their patients constitutes
26 unprofessional conduct.

27 7. Section 2228.1 of the Code states:

28 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c),

1 the board shall require a licensee to provide a separate disclosure that includes the
2 licensee's probation status, the length of the probation, the probation end date, all
3 practice restrictions placed on the licensee by the board, the board's telephone
4 number, and an explanation of how the patient can find further information on the
5 licensee's probation on the licensee's profile page on the board's online license
6 information Internet Web site, to a patient or the patient's guardian or health care
7 surrogate before the patient's first visit following the probationary order while the
8 licensee is on probation pursuant to a probationary order made on and after July 1,
9 2019, in any of the following circumstances:

10 (1) A final adjudication by the board following an administrative hearing or
11 admitted findings or prima facie showing in a stipulated settlement establishing any
12 of the following:

13 ...

14 (D) Inappropriate prescribing resulting in harm to patients and a probationary
15 period of five years or more.

16 (2) An accusation or statement of issues alleged that the licensee committed any
17 of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a
18 stipulated settlement based upon a nolo contendere or other similar compromise that
19 does not include any prima facie showing or admission of guilt or fact but does
20 include an express acknowledgment that the disclosure requirements of this section
21 would serve to protect the public interest.

22 (b) A licensee required to provide a disclosure pursuant to subdivision (a) shall
23 obtain from the patient, or the patient's guardian or health care surrogate, a separate,
24 signed copy of that disclosure.

25 (c) A licensee shall not be required to provide a disclosure pursuant to
26 subdivision (a) if any of the following applies:

27 (1) The patient is unconscious or otherwise unable to comprehend the
28 disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a
guardian or health care surrogate is unavailable to comprehend the disclosure and
sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit
is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to
the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following
information, with respect to licensees on probation and licensees practicing under
probationary licenses, in plain view on the licensee's profile page on the board's
online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes
alleged in the operative accusation along with a designation identifying those causes
by which the licensee has expressly admitted guilt and a statement that acceptance of
the settlement is not an admission of guilt.

1 (2) For probation imposed by an adjudicated decision of the board, the causes
for probation stated in the final probationary order.

2 (3) For a licensee granted a probationary license, the causes by which the
3 probationary license was imposed.

4 (4) The length of the probation and end date.

5 (5) All practice restrictions placed on the license by the board.

6 (e) Section 2314 shall not apply to this section.

7 ...

8 COST RECOVERY

9 8. As of January 1, 2022, Business and Professions Code section 125.3 states that:

10 (a) Except as otherwise provided by law, in any order issued in resolution of a
11 disciplinary proceeding before any board within the department or before the
12 Osteopathic Medical Board upon request of the entity bringing the proceeding, the
administrative law judge may 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.

13 (b) In the case of a disciplined licentiate that is a corporation or a partnership,
14 the order may be made against the licensed corporate entity or licensed partnership.

15 (c) A certified copy of the actual costs, or a good faith estimate of costs where
16 actual costs are not available, signed by the entity bringing the proceeding or its
designated representative shall be prima facie evidence of reasonable costs of
17 investigation and prosecution of the case. The costs shall include the amount of
investigative and enforcement costs up to the date of the hearing, including, but not
limited to, charges imposed by the Attorney General.

18 (d) The administrative law judge shall make a proposed finding of the amount
19 of reasonable costs of investigation and prosecution of the case when requested
pursuant to subdivision (a). The finding of the administrative law judge with regard
20 to costs shall not be reviewable by the board to increase the cost award. The board
may reduce or eliminate the cost award, or remand to the administrative law judge if
21 the proposed decision fails to make a finding on costs requested pursuant to
subdivision (a).

22 (e) If an order for recovery of costs is made and timely payment is not made as
23 directed in the board's decision, the board may enforce the order for repayment in any
appropriate court. This right of enforcement shall be in addition to any other rights
24 the board may have as to any licensee to pay costs.

25 (f) In any action for recovery of costs, proof of the board's decision shall be
conclusive proof of the validity of the order of payment and the terms for payment.

26 (g)(1) Except as provided in paragraph (2), the board shall not renew or
27 reinstate the license of any licensee who has failed to pay all of the costs ordered
under this section.

28 (2) Notwithstanding paragraph (1), the board may, in its discretion,

1 conditionally renew or reinstate for a maximum of one year the license of any
2 licensee who demonstrates financial hardship and who enters into a formal agreement
with the board to reimburse the board within that one-year period for the unpaid
costs.

3 (h) All costs recovered under this section shall be considered a reimbursement
4 for costs incurred and shall be deposited in the fund of the board recovering the costs
to be available upon appropriation by the Legislature.

5 (i) Nothing in this section shall preclude a board from including the recovery of
6 the costs of investigation and enforcement of a case in any stipulated settlement.

7 (j) This section does not apply to any board if a specific statutory provision in
8 that board's licensing act provides for recovery of costs in an administrative
disciplinary proceeding.

9 DEFINITIONS

10 9. Baclofen (trade name Lioresal) is a muscle relaxant and antispastic. It is a dangerous
11 drug within the meaning of Code section 4022. Baclofen is useful for the alleviation of signs and
12 symptoms of spasticity resulting from multiple sclerosis, particularly for the relief of flexor
13 spasms and concomitant pain, clonus, and muscular rigidity. It is not indicated in the treatment of
14 skeletal muscle spasm resulting from rheumatic disorders. Hallucinations and seizures have
15 occurred on abrupt withdrawal of baclofen so the dose should be reduced slowly when the drug is
16 discontinued. The central nervous system (CNS) effects of baclofen may be additive to those of
17 alcohol and other CNS depressants. When introduced directly into the intrathecal space, effective
18 cerebrospinal fluid (CSF) concentrations can be achieved with resultant plasma concentrations
19 100 times less than those occurring with oral administration.

20 10. Benzodiazepines belong to the CNS group of medicines, which slow down the
21 nervous system. Some benzodiazepines are used to relieve anxiety. However, benzodiazepines
22 should not be used to relieve nervousness or tension caused by the stress of everyday life. Some
23 benzodiazepines are used to treat insomnia (trouble in sleeping). However, if used regularly (for
24 example, every day) for insomnia, they usually are not effective for more than a few weeks. Some
25 commonly used brand names are: Ativan (lorazepam), Dalmane (flurazepam), Diastat or Valium
26 (diazepam), Doral (quazepam), Halcion (triazolam), Klonopin (clonazepam), Librium
27 (chlordiazepoxide), Paxipam (halazepam), ProSom (estazolam), Restoril (temazepam), Serax
28 (oxazepam), Tranxene-SD (clorazepate), Xanax (alprazolam).

1 11. Cyclobenzaprine HCl, (trade name Flexeril) a muscle-relaxant. It is a dangerous drug
2 within the meaning of Code section 4022. Flexeril may enhance the effects of alcohol,
3 barbiturates, and other CNS depressants. Cyclobenzaprine is closely related to tricyclic
4 antidepressants such as amitriptyline and imipramine and may, like the tricyclic antidepressants,
5 produce arrhythmias, sinus tachycardia, and prolongation of the conduction time leading to
6 myocardial infarction and stroke

7 12. Fentanyl is an opioid analgesic which can be administered by an injection, through a
8 transdermal patch (known as Duragesic), as an oral lozenge (known as Actiq), or in tablet form
9 (known as Fentora). It is a Schedule II controlled substance as defined by section 11055 of the
10 Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal Regulations,
11 and is a dangerous drug as defined in Code section 4022. Fentanyl's primary effects are
12 anesthesia and sedation. It is a strong opioid medication and is indicated only for treatment of
13 chronic pain (such as that of malignancy) that cannot be managed by lesser means and that
14 requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening
15 hypoventilation. When patients are receiving fentanyl, the dosage of CNS depressant drugs
16 should be reduced. Use of fentanyl together with other CNS depressants, including alcohol, can
17 result in increased risk to the patient.

18 13. Hydromorphone (trade name Dilaudid) is a dangerous drug as defined in section 4022
19 of the Code, and a Schedule II controlled substance as defined by section 11055, subdivision (d)
20 of the Health and Safety Code. Dilaudid is a hydrogenated ketone of morphine and is a narcotic
21 analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical
22 dependence, and tolerance may develop upon repeated administration of narcotics; therefore, it
23 should be prescribed and administered with caution. Physical dependence, the condition in which
24 continued administration of the drug is required to prevent the appearance of a withdrawal
25 syndrome, usually assumes clinically significant proportions after several weeks of continued use.
26 Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. The
27 usual starting dosage for injections is 1-2 mg. The usual oral dose is 2 mg every two to four hours
28 as necessary. Patients receiving other narcotic analgesics, anesthetics, phenothiazines,

1 tranquilizers, sedative-hypnotics, tricyclic antidepressants and other CNS depressants, including
2 alcohol, may exhibit an additive CNS depression. When such combined therapy is contemplated,
3 the use of one or both agents should be reduced.

4 14. Lorazepam (trade name Ativan) is used for anxiety and sedation in the management
5 of anxiety disorders for short-term relief from the symptoms of anxiety or anxiety associated with
6 depressive symptoms. It is a dangerous drug as defined in section 4022 of the Code, and a
7 Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.
8 Lorazepam is not recommended for use in patients with primary depressive disorders. The initial
9 dose of this drug for elderly patients should not exceed 2 mg per day. Sudden withdrawal from
10 lorazepam can produce withdrawal symptoms including seizures. The usual dosage range is 2-6
11 mg per day given in divided doses, the largest dose being taken before bedtime, but the daily
12 dosage may vary from 1-10 mg per day.

13 15. Methadone hydrochloride is a synthetic opioid analgesic with multiple actions
14 quantitatively similar to those of morphine. Methadone may be administered as an injectable
15 liquid or in the form of a tablet, disc, or oral solution. It is a Schedule II controlled substance as
16 defined by section 11055, subdivision (c) of the Health and Safety Code, and by Section 1308.12
17 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Code
18 section 4022. Methadone can produce drug dependence of the morphine type and, therefore, has
19 the potential for being abused. Methadone should be used with caution and in reduced dosage in
20 patients who are concurrently receiving other opioid analgesics.

21 16. Morphine is for use in patients who require a potent opioid analgesic for relief of
22 moderate to severe pain. Morphine is a Schedule II controlled substance and narcotic as defined
23 by section 11055, subdivision (b)(1) of the Health and Safety Code, and a dangerous drug as
24 defined in Code section 4022. Morphine can produce drug dependence and has a potential for
25 being abused. Tolerance and psychological and physical dependence may develop upon repeated
26 administration. Abrupt cessation or a sudden reduction in dose after prolonged use may result in
27 withdrawal symptoms. After prolonged exposure to morphine, if withdrawal is necessary, it must
28 be undertaken gradually.

1 17. Naloxone is a medication approved by the Food and Drug Administration (FDA)
2 designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to
3 opioid receptors and can reverse and block the effects of other opioids such as heroin, morphine,
4 and oxycodone. Administered when a patient is showing signs of opioid overdose, naloxone is a
5 temporary treatment and its effects do not last long. Therefore, it is critical to obtain medical
6 intervention as soon as possible after administering/receiving naloxone. The medication can be
7 given by intranasal spray (into the nose), intramuscular (into the muscle), subcutaneous (under the
8 skin), or intravenous injection. A practitioner should assess the need to prescribe naloxone for
9 patients who are receiving medication-assisted treatment (MAT) or otherwise considered a risk
10 for opioid overdose.

11 18. Oxycodone hydrochloride (trade names OxyContin® and Xtampza) is a Schedule II
12 controlled substance as defined by section 11055, subdivision (b)(1)(N), of the Health and Safety
13 Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of
14 the Code of Federal Regulations, and is a dangerous drug, as defined in Code section 4022.
15 Oxycodone is a white, odorless crystalline powder derived from an opium alkaloid. It is a pure
16 agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of
17 oxycodone include anxiolysis, euphoria, and feelings of relaxation. Respiratory depression is the
18 chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and
19 started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently
20 receiving other CNS depressants including sedatives or hypnotics, general anesthetics,
21 phenothiazines, other tranquilizers, and alcohol.

22 19. Tramadol hydrochloride (trade name Ultram), is a centrally acting synthetic
23 analgesic compound. It is a dangerous drug as defined Code section 4022, and a Schedule II
24 controlled substance as defined by section 11057 of the Health and Safety Code. Ultram is
25 indicated for the management of moderate to moderately severe pain.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts re: Patient 1)¹

20. Respondent William Glatt, M.D. is subject to disciplinary action for unprofessional conduct through gross negligence and/or repeated negligent acts under Code sections 2234 and/or 2234, subdivision (b) and/or subdivision (c), in his care and treatment, acts, and/or omissions of Patient 1, a female born in 1961, as alleged herein. The circumstances are as follows:

21. Respondent provided primary care and pain management to Patient 1 from 2009 through the end of 2016², at the Glatt Medical Practice. Respondent's medical records for Patient 1 starts with a patient information summary that includes a section titled "Problem List... as of November 10, 2020" and lists the following conditions and time frames: knee pain, bilateral (12/12/2013 to present), sciatica associated with disorder of lumbosacral spine (11/2/2012 to present), polymyalgia rheumatic (10/5/2021 to present), migraine without aura (1/14/2010 to present), systemic lupus erythematosus (1/14/2010-11/2/2012), systemtic lupus (2/21/2013-6/22/2017), and systemic lupus erythematosus related syndromie (11/21/2017 to present).

22. No formal, objective, opioid risk assessment was ever performed or documented. There was no signed pain management contract in the charts. There was no documentation of informed consent.

23. By May of 2013, CURES³ shows Respondent was prescribing this patient a fentanyl patch at 100 mcg/hour in addition to 30 mg of daily methadone, for a morphine equivalent daily dose (MEDD⁴) of 480 mg.

¹ Names are redacted to protect privacy interests. Respondent knows the names of the patients and can confirm identities through discovery.

² Patient 1 remained with the Glatt Medical Practice and Respondent also issued prescriptions to this patient on the following dates: January 16, 2018; February 15, 2018; and October, 24, 2018.

³ The Controlled Substance Utilization Review and Evaluation System (CURES) database is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California. The CURES database serves the public health, regulatory oversight agencies, and law enforcement.

⁴ MEDD stands for Morphine Equivalent Daily Dose. This is used to convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine, so 320 mg of oxycodone is equivalent to 480 MEDD.

1 24. From May 2013 to the end of 2016, Respondent was the primary prescriber for
2 Patient 1's fentanyl 100 mcg /hour and 30-40 mg daily methadone prescriptions.⁵ There was no
3 tapering or dosage changes recorded in the medical record.

4 25. Respondent often documented plans to taper the patient from the high dosage
5 narcotics, but there was no significant tapering of the narcotic dosage in the four years
6 Respondent was the primary prescriber for this patient. By the end of 2016, the patient's daily
7 narcotic dosage remained at a total daily MEDD of 480 mg. In the clinical notes, Respondent
8 mentioned the patient's pains were well managed and stable, but he was reluctant to taper the
9 methadone due to the patient's ongoing family and marital stressors.

10 26. From 2013 through 2016, Respondent did not prescribe this patient naloxone for the
11 risk of accidental overdose.

12 27. A urine toxicology screen done in April of 2013 showed metabolites of
13 benzodiazepines and methadone, but no benzodiazepines were prescribed by Respondent.
14 Multiple urine toxicology tests from 2013 through 2016 showed methadone metabolites;
15 however, the urine toxicology tests of May and August of 2015 showed no traces of the
16 methadone prescribed by Respondent. The urine toxicology tests ordered did not test for fentanyl
17 metabolites. CURES queries were not done and/or documented in Patient 1's medical records,
18 with the exception of a single reference in the chart note of January 16, 2018.

19 28. Respondent's medical records did not have any copies or assessment of x-rays or
20 rheumatology consultations or pain management consultations or neurology consultation. The
21 records did not show any weight loss recommendation to alleviate stress on the back. No
22 physical therapy and/or chiropractic referrals were documented to help with fibromyalgia and
23 polymyalgia pains. There was no documentation for orthopedic consultation for the patient's
24 chronic bilateral sciatic pains and low back pains.

25
26 _____
27 ⁵ During that time period, other providers in the Glatt Practice Group intermittently issued
28 Patient 1's methadone/fentanyl prescriptions (including the following dates: July 15, 2014;
March 17, 2015; November 9, 2015; December 2 and 29, 2015; January 26, 2016; February 8,
2016); until one of the other providers took over as Patient 1's primary prescriber on December
20, 2016.

1 29. There were no referrals for or consultations with mental health providers documented
2 in the medical records despite Respondent's documentation of persistent mental illnesses and
3 anxiety and Respondent rationalizing his inability to taper Patient 1's methadone due to stress and
4 anxiety.

5 30. Physical examination findings were often documented as normal and copied and
6 templated from visit to visit. The clinical notes often lacked objective pain intensity scale
7 assessments and detailed functional benefits of the narcotics prescriptions.

8 31. Respondent has subjected his license to disciplinary action for unprofessional
9 conduct, as defined by sections 2234(b) and 2234(c) of the Code, for the following departures
10 from the standard of care constituting gross negligence and/or repeated negligent acts in his care
11 of Patient 1:

- 12 a. Respondent did not have a written and signed pain management agreement and/or
13 informed consent documentation;
- 14 b. Respondent failed to refer this patient for orthopedic and/or pain management
15 consultations for surgical management of back pain, or more comprehensive medical
16 management of her complaints of pain;
- 17 c. Respondent failed to recommend physical therapy or chiropractic manipulation for
18 chronic sciatica pains for this patient;
- 19 d. Respondent did not refer Patient 1 to a mental health consultation;
- 20 e. Respondent failed to conduct an objective opioid risk assessment;
- 21 f. Respondent failed to conduct urine toxicology testing that would test for fentanyl
22 metabolites, and did not address anomalous urine screening test results;
- 23 g. Respondent prescribed a combination of two long-acting narcotics with the highest
24 potency for management of fibromyalgia and chronic headaches, and prescribed in high
25 dosages over a lengthy period of time;
- 26 h. Respondent did not prescribe a naloxone antidote to mitigate the risks of accidental
27 overdose in this patient;

1 i. Respondent did not document the findings of physical examinations and there was
2 minimal functional assessment documentation in the medical records; and

3 j. Respondent failed to properly initiate and monitor chronic opiate therapy in this
4 patient.

5 **SECOND CAUSE FOR DISCIPLINE**

6 **(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts re: Patient 2)**

7 32. Respondent William Glatt, M.D. is subject to disciplinary action for unprofessional
8 conduct through gross negligence and/or repeated negligent acts under Code sections 2234 and/or
9 2234, subdivision (b) and/or subdivision (c), in his care and treatment, acts, and/or omissions, of
10 Patient 2, a female born in 1965, as alleged herein. The circumstances are as follows:

11 33. Respondent's Glatt Medical Practice began providing pain management care to
12 Patient 2 in 2012. Patient 2 had chronic abdominal pain and low back pain. Patient 2 transferred
13 her primary care to Respondent in 2016 and remained under his care until she died on January 12,
14 2020.

15 34. Respondent's medical records for Patient 2 did not indicate any objective opioid risk
16 stratification assessment. No written signed pain management agreement appears in Patient 2's
17 medical records. The chart also did not document an informed consent discussion regarding
18 addiction risk and risk of fatal opioid overdose.

19 35. CURES reports from September 2013 through December of 2019 indicate
20 Respondent was the primary prescriber of opioids for Patient 2. Patient 2's records indicate
21 Respondent prescribed Patient 2 a steady dosage of methadone 120 mg daily (total MEDD of
22 1440) from 2013 through 2014.

23 36. In 2013, Respondent also began prescribing Patient 2 an opium tincture to help slow
24 down Patient 2's excessive fecal output through her stoma.

25 37. In May of 2014, Respondent documented that Patient 2 was experiencing stable pain
26 control on 120 mg methadone daily. In 2014, Respondent was prescribing Patient 2 methadone at
27 120 mg daily, which constitutes a daily MEDD of 1440 mg.

28

1 38. Respondent's August 18, 2014, medical records note that Patient 2 "would like to
2 increase her methadone." The medical records for this visit documented Patient 2's physical
3 examination and review of systems (ROS) as normal; however, Respondent increased the
4 methadone prescription to 160 mg daily (MEDD of 1920), instead of tapering down. This dosage
5 was maintained throughout 2015 and 2016. Respondent did not prescribe naloxone to reduce the
6 risks of accidental overdose.

7 39. Patient 2's February 2015 and May 2015 urine toxicology tests showed methadone
8 metabolites and oxycodone metabolites. The CURES report showed Patient 2 had no oxycodone
9 prescriptions issued in 2015. No discussion with the patient of these toxicology tests was
10 documented in the medical records. No additional confirmation urine tests were requested to
11 determine if the results were false positives.

12 40. Respondent's July 2018 clinical notes for Patient 2 document an abnormal
13 electrocardiogram (EKG). The EKG was done as part of the monitoring of methadone toxicity.
14 Respondent did not document an evaluation or assessment of the abnormal EKG, and continued
15 to prescribe methadone at the dosage of 160 mg daily until almost a year later when the dosage
16 was reduced to 120 mg.

17 41. In August of 2018, Respondent prescribed hydrocodone 30 mg daily (post operatively
18 after hip surgery) to Patient 2 in addition to her methadone, for a total MEDD of 1950 mg daily.

19 42. In August of 2019, Respondent began tapering down Patient 2's methadone dosage
20 due to the prolonged QT interval on the EKG noted in July 2018. Respondent noted that Patient
21 2's methadone should be tapered slowly; however, the toxicology testing done in August of 2019
22 showed no presence of methadone, but continued to show traces of unprescribed oxycodone.
23 Respondent did not request a more specific confirmation test of the urine sample for oxycodone.
24 Respondent did not document any other action taken in the face of these test results.

25 43. By the end of 2019, according to CURES, Patient 2 was tapered to a methadone dose
26 of 120 mg daily with 30 mg of hydrocodone daily (MEDD of 1470). Patient 2 died on January
27 12, 2020. Respondent signed her death certificate and listed the cause of death as Crohn's
28 disease.

1 44. Respondent's medical records notes were often templated and copied from visit to
2 visit with hardly any changes in physical examination findings to justify narcotic dosage
3 increases, and without any explanation for the dosage increases. Despite Patient 2's complaints
4 of chronic abdominal pains, the gastrointestinal examination was often marked as normal. There
5 was no range of motion examination of the spine, despite claimed persistent low back pains. No
6 pain intensity scales were recorded and Patient 2's functionality was rarely assessed.

7 45. Patient 2's chart shows no referral to mental health for cognitive behavior therapy,
8 anesthesia pain intervention, or other non-narcotic pharmacotherapy.

9 46. Respondent has subjected his license to disciplinary action for unprofessional
10 conduct, as defined by sections 2234(b) and 2234(c) of the Code, for the following departures
11 from the standard of care constituting gross negligence and/or repeated negligent acts in his care
12 of Patient 2:

- 13 a. Respondent did not have a written and signed pain management agreement and/or
14 informed consent documentation;
- 15 b. Respondent failed to risk-stratify the patient;
- 16 c. Respondent failed to refer this patient to mental health staff for cognitive behavioral
17 therapy and to anesthesia pain service for pain reduction interventions;
- 18 d. Respondent failed to try other, safer, non-narcotic medications to reduce the patient's
19 dependency on narcotics;
- 20 e. Respondent failed to refer the patient to, or consider, non-opioid management of this
21 patient's chronic pain syndrome;
- 22 f. Respondent failed to further investigate the inconsistent urine toxicology tests and
23 discuss the issue with the patient;
- 24 g. Respondent failed to recognize the patient's high opiate tolerance and to pursue
25 opioid rotation with methadone tapering;
- 26 h. Respondent did not prescribe a naloxone antidote to reduce risks of accidental
27 overdose from methadone;
- 28

1 i. Respondent failed to immediately reduce the methadone dosage after the prolonged
2 EKG QT interval noted in the July 2018 chart note or to articulate or document any reason
3 for his failure to do so; and

4 j. Respondent failed to properly initiate and monitor chronic opiate therapy in this
5 patient.

6 **THIRD CAUSE FOR DISCIPLINE**

7 **(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts re: Patient 3)**

8 47. Respondent William Glatt, M.D. is subject to disciplinary action for unprofessional
9 conduct through gross negligence and/or repeated negligent acts under Code sections 2234 and/or
10 2234, subdivision (b) and/or subdivision (c), in his care and treatment, acts, and/or omissions, of
11 Patient 3, a female born in 1940, as alleged herein. The circumstances are as follows:

12 48. Respondent's medical records for Patient 3 start with a clinic visit in December of
13 2012 and span through April 2019. Patient 3 was treated for complaints of scoliosis, obesity,
14 hypertension, and osteoarthritis involving her spine, shoulders, and knees. Throughout his
15 treatment of Patient 3, Respondent prescribed a variety of controlled substances.

16 49. There was no written/signed pain management agreement. The medical records
17 showed no informed consent discussion. The medical records did not note any risk stratification
18 of the opioid addiction and aberrancy risks.

19 50. At the December 2012 clinic visit, the first documented visit, Respondent refilled
20 Patient 3's 100 mcg/hour fentanyl patch and tramadol for chronic pain management of the low
21 back pains due to osteoarthritis and scoliosis. Respondent also prescribed the muscle relaxant
22 cyclobenzaprine and selective serotonin reuptake inhibitors (SSRI) refills.

23 51. In February 2013, Respondent switched to the muscle relaxant baclofen and kept the
24 opiate medication the same.

25 52. For the 18 months following February 2013, Patient 3's pain control was described as
26 "stable" on 100 mcg/hour of fentanyl and 400 mg daily of tramadol, for a total daily MEDD of
27 280 mg.

28

1 53. Patient 3's urine toxicology tests, conducted every two to three months by the Glatt
2 Medical Practice, never listed fentanyl or results from fentanyl testing. Respondent claimed in
3 the Board interview that "[m]ost of the time -- fentanyl does not show up -- uh -- may times in -- in
4 -- in the system that we use. We don't do GCFS, and the screening tool that we use -- uh --
5 fentanyl is positive about half of the time, and I uh -- -- usually, I check, are you wearing the
6 patch, and if they're wearing the patch, and the fentanyl is negative, I think it's a laboratory error
7 rather than -- uh -- patient noncompliance." If in fact fentanyl was tested for, there were no
8 confirmatory assays conducted to verify a suspected false negative.

9 54. In November of 2014, Patient 3 told Respondent she wanted an increase in her opiate
10 therapy due to pain. Without documentation of an assessment of the complaints, Respondent
11 discontinued the tramadol and started oxycodone at 15 mg twice daily, and continued the fentanyl
12 patch for an MEDD total of 285 daily mg. Respondent then increased the oxycodone over the
13 next five months so that by May 2015, Patient 3 was receiving 90 mg of oxycodone daily and a
14 fentanyl patch of 100 mcg/hour, a daily MEDD of 375 mg.

15 55. Patient 3 had rotator cuff surgery in June of 2016, and reported worsening total body
16 pains. In August of 2016, Respondent maintained the fentanyl patch, but discontinued the
17 oxycodone and started Patient 3 on 20 mg of hydromorphone daily. The hydromorphone was
18 escalated to 32 mg daily and to 48 mg daily by June 2017. In June of 2017, Respondent also
19 began prescribing 90 mg of morphine daily to Patient 3. By June 2017 the daily MEDD between
20 the hydromorphone, morphine and fentanyl, was 492 mg.

21 56. In July of 2017, Patient 3 was diagnosed with cancer and requested higher narcotic
22 dosage for pain control. By March of 2018, Respondent was prescribing fentanyl patch at 175
23 mcg/hour with morphine at 180 mg daily and oxycodone at 120 mg daily, for a total daily MEDD
24 of 780 mg.

25 57. In August of 2018, due to reported panic attacks, Respondent prescribed Patient 3
26 daily lorazepam at 3 mg, while the patient was still being prescribed fentanyl and oxycodone.
27 Patient 3 was taken off of morphine by Respondent (the last morphine prescription given in
28 September 2018) because she developed chronic kidney disease.

1 58. By December of 2018, Patient 3 was on a daily MEDD of 915 mg, comprised of a
2 fentanyl patch at 175 mcg/hour with 330 mg of oxycodone.

3 59. In the December 27, 2018 note, Patient 3 reported low energy, lethargy, and a
4 tendency to fall asleep during the day. Respondent wrote that he would start with reducing the
5 lorazepam.

6 60. By March 2019, Respondent reduced Patient 3's daily opiate dose to an MEDD total
7 of 555 mg, comprised of fentanyl patch 175 mcg/hour and 90 mg oxycodone.

8 61. Respondent prescribed Patient 3 a naloxone antidote for the first time in March of
9 2019.

10 62. From 2014 through 2019, Respondent offered virtually no trial, or even discussion of,
11 nonsteroidal anti-inflammatory drugs (NSAIDS), gabapentin, or topical creams for the care and
12 treatment of the lower back pain, to reduce the high narcotic dosage dependency. There were no
13 referrals to chiropractic spinal manipulation or acupuncture. There was no promotion of weight
14 loss as an option to reduce chronic lower back pain. There was no referral to mental health for
15 cognitive behavior therapy to reduce the patient's narcotic dependency.

16 63. Respondent's documentation of physical examination and review of symptoms were
17 similar throughout the chart and the notes were often copied and pasted from visit to visit. Most
18 of the clinical notes showed normal physical examination findings without detailed spine or
19 shoulder examinations. The only abnormal joint examinations of shoulder and back were
20 documented by Respondent's nurse practitioner on June 8, 2016, during his absence.

21 64. Over the course of treatment, Respondent's documented review of symptoms rarely
22 mention the intensity pain scale, side effects of opiates, or the patient's affect and daily
23 functionality.

24 65. Patient 3 was hospitalized near the end of March of 2019 and her pain care
25 management was taken over by different physicians at a skilled nursing home until her death in
26 July of 2019.

27 66. Respondent has subjected his license to disciplinary action for unprofessional
28 conduct, as defined by sections 2234(b) and 2234(c) of the Code, for the following departures

1 from the standard of care constituting gross negligence and/or repeated negligent acts in his care
2 of Patient 3:

- 3 a. Respondent did not have a written and signed pain management agreement and
4 informed consent;
- 5 b. Respondent did not conduct an opioid risk stratification of the patient, or document
6 such;
- 7 c. Respondent failed to try other safer and non-addictive classes of pain medication;
- 8 d. Respondent failed to consider, or refer the patient to, chiropractic manipulation and
9 acupuncture treatments and weight loss programs;
- 10 e. Respondent failed to consider non-opiate management of chronic low back pain;
- 11 f. Respondent failed to appropriately follow-up on urine toxicology testing for this
12 patient that was negative for the prescribed fentanyl;
- 13 g. Respondent prescribed benzodiazepines to this patient who was on a high-dose
14 fentanyl patch with high MEDD, exposing her to unnecessary dangers of a drug overdose;
- 15 h. Respondent did not prescribe a naloxone antidote therapy, to reduce risks of fatal
16 respiratory failure in this elderly patient, until 2019;
- 17 i. Respondent did not document the findings of abnormal physical examinations and
18 lacked detailed functional assessment in opioid monitoring in the medical records; and
- 19 j. Respondent failed to properly initiate and monitor chronic opiate therapy in this
20 patient.

21 **FOURTH CAUSE FOR DISCIPLINE**

22 **(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Medical Records for**
23 **Patient 1, Patient 2, Patient 3)**

24 67. Respondent Andrew Howard Glatt, M.D. is subject to disciplinary action, jointly and
25 severally, for unprofessional conduct under Code sections 2234 and/or 2266 for his failure to
26 maintain adequate and accurate medical records regarding his treatment of Patient 1 and/or
27 Patient 2 and/or Patient 3.

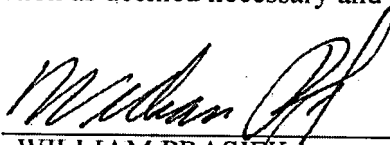
1 68. As set forth in paragraphs 20 through 66, Respondent's medical records for each of
2 the patients were inadequate. For example, Respondent failed to document any assessment or
3 acknowledgment of anomalous urine drug screens or an irregular EKG test; he failed to document
4 informed consent for the prescribing of multiple controlled substances, in combinations and often
5 at high dosages; he failed to adequately document findings of physical examinations; and rarely if
6 ever documented assessment of his patients' functionality or response to treatment. Respondent's
7 medical record entries were for the most part copied and pasted, carried forward from visit to
8 visit, and do not appear to accurately reflect the patients' status on the dates in question.
9 Respondent failed to document medical rationale for changes in prescriptions or dosages.

10 **PRAYER**

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

- 13 1. Revoking or suspending Physician's and Certificate Number G 15309, issued to
14 Respondent William Glatt, M.D.;
- 15 2. Revoking, suspending or denying approval of Respondent William Glatt, M.D.'s
16 authority to supervise physician assistants and advanced practice nurses;
- 17 3. Ordering Respondent William Glatt, M.D., to pay the Board the costs of the
18 investigation and enforcement of this case, and if placed on probation, the costs of probation
19 monitoring; and
- 20 4. Taking such other and further action as deemed necessary and proper.

21
22 DATED: FEB 17 2022

23 
24 WILLIAM PRASIFKA
25 Executive Director
26 Medical Board of California
27 Department of Consumer Affairs
28 State of California
Complainant

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