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

In the Matter of the Accusation Against: Andrew Howard Glatt, M.D. Physician's and Surgeon's Certificate No. G 87831 Respondent.	Case No.: 800-2019-052007

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 March 17, 2023.

IT IS SO ORDERED: February 17, 2023.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
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GREGORY W. CHAMBERS
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW HOWARD GLATT, M.D.** **1860 El Camino Real, Ste 301** **Burlingame, CA 94010-3114** **Physician's and Surgeon's Certificate** **No. G 87831** Respondent.	Case No. 800-2019-052007 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

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2. Respondent Andrew Howard Glatt, M.D. (Respondent) is represented in this proceeding by attorney Bradford J. Hinshaw, Esq. whose address is: Hinshaw, Marsh, Still & Hinshaw, LLP, 12901 Saratoga Ave., Saratoga, CA 95070; Email: bhinshaw@hinshaw-law.com.

3. On or about September 13, 2006, the Board issued Physician's and Surgeon's Certificate No. G 87831 to Andrew Howard Glatt, 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. 800-2019-052007, and will expire on January 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-052007 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 January 20, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-052007 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-052007. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. 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.

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

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CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2019-052007.

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 probationary terms as set forth in the Disciplinary Order below.

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

CONTINGENCY

12. 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.

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-052007 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

14. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 87831 issued to Respondent Andrew Howard Glatt, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME, of which 40 hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no later than six (6) months after the effective date of the Decision. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal

relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, 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. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the

name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, 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. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising more than one physician assistant and one advanced practice nurse in his practice.

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. 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 $16,000 (sixteen thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs (if applicable).

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California Physician's and Surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Decision and Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in

determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

17. 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. 800-2019-052007 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Bradford Hinshaw. 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: 11/9/22

ANDREW HOWARD GLATT, M.D.
Respondent

I have read and fully discussed with Respondent Andrew Howard Glatt, 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: 11-11-22

BRADFORD J. HINSHAW
Attorney for Respondent

ENDORSEMENT

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

DATED: 11/17/2022

Respectfully submitted,

ROB BONTA
Attorney General of California
GREGORY W. CHAMBERS
Supervising Deputy Attorney General

Lynne K. Dombrowski

LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-052007

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Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2019-052007
ANDREW HOWARD GLATT, M.D. **1860 El Camino Real, Ste 301** **Burlingame, CA 94010-3114** **Physician's and Surgeon's Certificate No. G 87831,** Respondent.	**ACCUSATION**

PARTIES

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

2. On or about September 13, 2006, the Board issued Physician's and Surgeon's Certificate Number G 87831 to Andrew Howard Glatt, 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 January 31, 2024, unless renewed.

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3. At all times relevant to the allegations herein, Respondent was board-certified in Internal Medicine. Since February 2015, Respondent has practiced medicine at Glatt Medical, in a group practice with his father and his brother who are both physicians. In 2019, Respondent obtained an additional certification in Addiction Medicine.

JURISDICTION

4. 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.

5. 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.

6. Section 2234 of the Code, states, in pertinent part:

> "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. . . ."

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7. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

8. Section 2228.1 of the Code states.

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

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

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

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

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendere or other similar compromise that

does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

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

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

(1) The patient is unconscious or otherwise unable to comprehend the 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.

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

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

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

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

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

9. 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.

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CALIFORNIA HEALTH AND SAFETY CODE

10. Section 11165.4 of the California Health and Safety Code, effective January 1, 2017, operative as of October 2, 2018, requires a health care practitioner to consult the CURES database to review a patient's controlled substance history before prescribing controlled substances (Schedule II – IV) to the patient for the first time, and at least once every four months thereafter, if the prescribing continues as treatment.

COST RECOVERY

11. 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.

DESCRIPTIONS OF PERTINENT DRUGS

12. Ativan, a trade name for lorazepam, is a benzodiazepine and central nervous system (CNS) depressant used in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and by section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Long-term or excessive use of Ativan can cause dependency. Concomitant use of alcohol or other CNS depressants may have an additive effect.

13. Avinza is a trade name for morphine sulfate (morphine). It is an opioid pain medication used to treat moderate to severe pain. It is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code and by Section 1308.12 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Use of morphine sulfate together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

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14. Cymbalta is a trade name for duloxetine, a serotonin-norepinephrine reuptake inhibitor antidepressant (SSNRI). It is used to treat major depressive order and is also used to treat diabetic neuropathy or chronic muscle or joint pain. It is a dangerous drug as defined in Business and Professions Code section 4022.

15. Dilaudid is a trade name for hydromorphone hydrochloride. It is a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code, and by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Dilaudid is a hydrogenated ketone of morphine and is a narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

16. Eszopiclone, known by the trade name Lunesta, belongs to the class of drugs called sedative-hypnotics. It is used to treat insomnia. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and by section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.

17. Fentanyl is an opioid analgesic which can be administered by an injection, through a transdermal patch (known as Duragesic), as an oral lozenge (known as Actiq), or in tablet form (known as Fentora). It is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl's primary effects are anesthesia and sedation. It is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and that requires continuous opioid administration. Fentanyl presents a risk of serious or

life-threatening hypoventilation. When patients are receiving fentanyl, the dosage of central nervous system depressant drugs should be reduced. Use of fentanyl together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

18. Hydrocodone bitartrate with acetaminophen, known by the trade names of Vicodin and Norco, combines hydrocodone bitartrate which is a semisynthetic narcotic analgesic with acetaminophen (Tylenol) which is a non-opiate, non-salicylate analgesic and antipyretic. It belongs to the class of medications called analgesics, opioid combos. It is used to treat symptoms of moderate to severe pain. It is a Schedule II controlled substance as defined by section 11055, subdivision (e) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

19. Ketamine is a short-acting dissociative anesthetic that comes in either liquid or powder form and has some hallucinogenic effects. It induces a trance-like state while providing pain relief, sedation, and memory loss. It is a Schedule III controlled substance, as defined by section 11056 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Although primarily used in humans as an anesthetic, it may also be used for post-operative pain management or to treat major depression. In some limited cases it may be used to treat complex regional pain syndrome. Ketamine may increase the effects of other sedatives, such as alcohol, benzodiazepines, opioids, and barbiturates. It also has a high potential for abuse and for diversion.

20. Lyrica is a trade name for pregabalin and is used to treat pain caused by nerve damage due to diabetes, shingles, or infection. It is a Schedule V controlled substance, as defined by section 11058 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

21. Methadone hydrochloride is a synthetic opioid analgesic with multiple actions quantitatively similar to those of morphine. Methadone may be administered as an injectable liquid or in the form of a tablet, disc, or oral solution. It is a Schedule II controlled substance as defined by section 11055, subdivision (c) of the Health and Safety Code, and by Section 1308.12 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business

and Professions Code section 4022. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other opioid analgesics.

22. Oxycodone hydrochloride is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1)(N), of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.

OxyContin and Xtampza ER are trade names for oxycodone hydrochloride controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

23. Oxymorphone hydrochloride, known by the trade names of Opana or Opana ER (extended release), is an opioid analgesic medication used for the management of moderate to severe pain. It is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code and as defined by Section 1308.12 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.

24. Trazodone, known by the trade name Desyrel, is an antidepressant used in the treatment of depression and it is also used to treat insomnia, anxiety, or panic attacks. It is a dangerous drug as defined in Business and Professions Code section 4022.

25. Zolpidem tartrate, known by the trade name Ambien, is a non-benzodiazepine hypnotic of the imidazopyridine class. It is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(32) and is a dangerous drug as defined in Business and Professions Code section 4022. It is indicated for the short-term treatment of insomnia. It is a central nervous system (CNS) depressant and should be used cautiously in combination with other CNS

depressants. Any CNS depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

FIRST CAUSE FOR DISCIPLINE

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

26. Respondent Andrew Howard Glatt, M.D. is subject to disciplinary action for unprofessional conduct through gross negligence and/or repeated negligent acts under sections 2234, subdivision (b) and/or subdivision (c) in his care and treatment, acts and/or omissions, of Patient A, a male born in 1956, as alleged herein.

27. From at least 2012 until about August 17, 2015, Patient A was seen and treated by other physicians and health providers for pain management at Glatt Medical approximately every two months. Patient A had complex chronic pain and suffered multiple medical problems. Patient A had a history of alcohol abuse and a resultant recurrent acute pancreatitis condition.

28. On or about August 17, 2015, Respondent first saw Patient A for a two months' follow-up visit. The primary diagnosis for Patient A was opioid dependence with opioid-induced sleep disorder. It was noted that the patient had seen a pain specialist for a trigger point injection for left scapular (shoulder) pain. Respondent refilled the patient's pain medications, a combination of fentanyl patches, Avinza (morphine), and Norco. A urine sample was obtained from the patient at the visit.

29. On or about November 20, 2015, Patient A was seen by another physician at Glatt Medical who noted that the patient was recently released from the hospital after a one week stay because of acute pancreatitis. It was noted that the patient has a history of recurrent acute pancreatitis mostly related to alcoholism and reported not having an alcoholic drink in over five years.

30. On or about December 10, 2015, Respondent saw Patient A, who requested a prescription of Ativan 0.5 mg. to help deal with stress at home. The patient reported that his

psychiatrist, who usually prescribes the daily Ativan, was out of town. In addition to prescribing two months' refills of the current opioid regimen (fentanyl patches, morphine sulfate 90 mg., Norco) Respondent prescribed #60 Ativan. Respondent noted that he encouraged the patient to get back to AA meetings to help deal with the stress rather than relying on medication. Other than the vital signs, the only information noted for a physical examination was: "Constitutional: appears stable."

31. In 2016, Respondent saw Patient A on approximately a monthly basis. Respondent continued to prescribe monthly refills of: #120 morphine sulfate 90 mg.; #20 fentanyl 100 mcg. transdermal patches; #120 Norco 325/10 mg.; and #60 Ativan 0.5 mg. (lorazepam).

32. According to the CURES database, Patient A filled the following prescriptions (30 days' supply) from Respondent on either January 3 or January 4, 2016: #60 lorazepam 0.5 mg; #20 Duragesic 100 mcg. patches; #120 morphine sulfate 90 mg.; and #120 Norco 325/10 mg.

33. At a visit on January 21, 2016, Patient A reported losing a bag containing his pain medications and requested early refills of the morphine and fentanyl patches. Respondent issued prescriptions for fifteen days' supply: #60 morphine sulfate 90 mg. and #10 Duragesic 100 mcg. patches.

34. According to the CURES database, between January 28 and January 31, 2016, Patient A filled the following prescriptions (30 days' supply) from Respondent: #60 lorazepam 0.5 mg; #20 Duragesic 100 mcg. patches; #120 morphine sulfate 90 mg.; and #125 Norco 325/10 mg.

35. At the visit on or about June 14, 2016, Patient A reported begin released from the hospital five days' prior after being treated for an upper GI bleed and hepatic encephalopathy. Respondent continued to prescribe, on a monthly basis, refills for: #120 morphine sulfate 90 mg., #20 Duragesic 100 mcg. patches, #125 Norco, and #60 Ativan/lorazepam. Respondent noted that he encouraged the patient to see a psychiatrist regarding his anxiety.

36. On or about August 9, 2016, Respondent noted that he agreed to Patient A's request to take over the prescribing of his psychiatric medications.

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37. At a visit on September 20, 2016, it was documented by another physician that Patient A was generally "feeling much better" and that the patient was unable to give a urine specimen but "we will get one, on his next visit." The patient's prescriptions were refilled.

38. According to Respondent's medical records for Patient A, the next urine drug screen taken for Patient A was on or about August 6, 2020, almost four years later.

39. Respondent saw Patient A on an irregular basis in 2017. Respondent continued to issue refill prescriptions for pain medications and for Ativan. By March 2017, Respondent was prescribing, on approximately a monthly basis: #180 morphine sulfate 90 mg; #20 Duragesic 100 mcg. patches; #125 Norco 325/10 mg.; and #60 Ativan 0.5 mg.

40. In 2018, Respondent continued to see Patient A, on an irregular basis. Respondent continued to refill the chronic pain medications and the psychiatric medications. By July 2018, Respondent was prescribing, on approximately a monthly basis: #180 morphine sulfate 90 mg; #20 Duragesic 100 mcg. patches; #125 Norco 325/10 mg.; and #60 Ativan 0.5 mg.

41. At the visit on February 6, 2018, Respondent noted that Patient A reported increased anxiety, agitation and depression and wanted to increase his dose of Trazodone at bedtime, which in the past had worked for him. Respondent refilled the pain medications and increased the dosage of trazodone to 400 mg.

42. In 2019, Respondent continued to see Patient A on an irregular basis between one month and two months. At most 2019 visits, Respondent noted that Patient A was doing well with his chronic pain medications. Respondent continued to issue monthly refills of Patient A's pain medications: #180 morphine sulfate 90 mg; #20 Duragesic 100 mcg. patches; and #120 Norco 325/10 mg.

43. On or about September 19, 2019, Respondent noted that Patient A reported that the fentanyl was reformulated and that he was unable to take it at home due to the lower dose and subsequent withdrawal. It was noted that the patient reported not doing well with either Dilaudid or oxycodone in the past but had never tried Opana. Respondent prescribed Opana to control the pain and to convert from the fentanyl patches. On or about September 26, 2019, Respondent

prescribed to Patient A #20 oxymorphone 30 mg. (Opana ER) and #60 oxymorphone 10 mg. (Opana).

44. Between January 24, 2020 and August 6, 2020, Respondent saw Patient A on an irregular basis, for a total of five visits. Respondent continued to refill the patient's monthly pain medications, in about two months' intervals.

45. At a visit on or about August 6, 2020, Respondent noted that Patient A was scheduled for hip surgery at Stanford in one week and that he advised the patient that there may be a pain management service assigned to help with the patient's post-op pain needs, given his high dose opiate regimen. Respondent refilled Patient A's pain medications for the next two months: Opana ER 40 mg.; morphine sulfate (Avinza) 90 mg.; and Norco 325/10 mg.

46. On or about September 23, 2020, Patient A spoke by telephone with another physician at Glatt Medical because he had overused his Opana ER medicine and needed a refill. Patient A was five weeks' post-op hip surgery and reported still having lots of pain.

47. Respondent's most recent visit with Patient A, that was documented in the medical records produced to the Board, occurred on or about October 1, 2020. Respondent reported that the patient had urinary frequency and hip pain after surgery. Respondent issued refills of the following medications "given for chronic pancreatitis": #90 oxymorphone 40 mg. (Opana ER); #180 morphine sulfate 90 mg; #120 Norco 325/10 mg.; #45 Ativan 0.5 mg.; and #150 trazodone 100 mg.

48. In summary, from about December 2015 through at least October 2019, Respondent prescribed to Patient A chronic high dosages of fentanyl, morphine sulfate, hydrocodone with acetaminophen, along with benzodiazepines, other sedatives, and oxymorphone. Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient A, pursuant to section 2234 subd. (b) [gross negligence] and/or subd. (c) [repeated negligent acts] as follows:

a. Respondent did not have a pain management agreement, verbal or written, with Patient A that specified treatment parameters, expectations, and the consequences of noncompliance with the chronic prescribing of opioid medications.

b. Respondent did not regularly conduct random urine drug screening, with quantitative analysis, to monitor the patient's compliance with the treatment plan of prescribed medications.

c. Respondent did not thoroughly conduct clinical assessments, including a psychological evaluation with assessment tools and appropriate monitoring of the patient with screening tools, and/or did not otherwise evaluate the effectiveness, including the potential benefits and potential risks, of the prescribed opioid therapy.

d. Respondent did not develop and document a treatment plan with goals and specific objectives to evaluate and maximize the patient's function and to use the lowest effective dosages of controlled substances. Respondent did not adequately pursue other treatment modalities.

e. Respondent failed to adequately document that he counseled Patient A to recognize the signs of an opioid overdose and how to respond.

f. Respondent did not conduct appropriate ongoing assessments of his pain management therapy through regular reviews and monitoring of the patient's progress toward treatment objectives and of possible substantial risks or adverse events, such as overdose or diversion.

g. After October 2, 2018, Respondent failed to document his compliance with the requirements of regularly checking the CURES/PDMP database, as set forth in Section 11165.4 of the California Health and Safety Code.

h. Respondent did not appropriately consider or make any efforts to taper or to discontinue the long-term therapy of opioids.

SECOND CAUSE FOR DISCIPLINE

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

49. Respondent Andrew Howard Glatt, M.D. is subject to disciplinary action for unprofessional conduct through gross negligence and/or repeated negligent acts under sections 2234, subdivision (b) and/or subdivision (c) in his care and treatment, acts and/or omissions, of Patient B, a male born in 1943, as alleged herein.

50. From at least 2013 until about January 2017, Patient B was seen and treated by other physicians and health providers at Glatt Medical, approximately every two months. Patient B had

chronic pain due to osteoarthritis involving multiple joints and suffered multiple medical problems, including a diagnosis of opioid-type dependence.

51. On or about March 30, 2017, Respondent saw Patient B for a pain management follow-up visit. At the time, Patient B was being prescribed monthly, among other medications: #240 methadone 10 mg.; #120 OxyContin 80 mg.; #240 Norco 325/10 mg.; and #30 diazepam 5 mg. Patient B reported not getting adequate relief with the Norco. Respondent prescribed refills of: #240 methadone 10 mg.; #120 OxyContin 80 mg.; and #30 diazepam 5 mg. Respondent discontinued the Norco and issued a prescription for #120 oxycodone 30 mg.

52. On or about May 15, 2017, Respondent saw Patient B for a follow-up pain management visit and refilled monthly prescriptions for: #240 methadone 10 mg.; #120 OxyContin 80 mg.; and #120 oxycodone 30 mg.

53. On or about May 15, 2017, Respondent saw Patient B for a follow-up pain management visit and refilled two months of prescriptions, each for: #240 methadone 10 mg.; #120 OxyContin 80 mg.; #120 oxycodone 30 mg.; and #30 diazepam 5 mg.

54. In 2017, Respondent continued to see Patient B about every six to eight weeks. At each visit, Patient B reported that he was doing well with his pain medications. Respondent did not document any details about the patient's pain, the patient's ability to function, and no focused physical examination was documented. At each visit, Respondent refilled the two months' worth of the following monthly medications: #240 methadone 10 mg.; #120 OxyContin 80 mg.; #120 oxycodone 30 mg.; and #30 diazepam 5 mg.

55. In 2018, Respondent continued to see Patient B about every six to eight weeks. At each visit, Respondent prescribed refills of the following monthly medications: #240 methadone 10 mg.[1]; #120 OxyContin 80 mg.; #120 oxycodone 30 mg.; and #30 diazepam 5 mg.[2] Respondent documented the patient's report that he was doing well with his medications and had no side effects. The chronic pain was not described at each visit or, when described, it was in

[1] At visits on 02/05/2018 and 03/02/2018, Respondent prescribed #180 methadone 10 mg. but went back to prescribing #240 pills on or about 03/29/2018, which continued to at least October 2019.

[2] The diazepam appears to have been discontinued by Respondent in July 2018.

very general terms, e.g. "back pain and multiple joint osteoarthritis," or "in his neck and in multiple joints from osteoarthritis," or "in the knees and shoulders."

56. On January 31, 2018, Respondent also issued a prescription for #30 Dilaudid 4 mg., in response to Patient B's complaint of pain post-surgery on his right thumb and middle finger.

57. On or about October 26, 2018, Respondent ordered a drug screen for Patient B.

58. In 2019, Respondent continued to see Patient B about every six to eight weeks. At each visit, Respondent prescribed two months' of refills of the same monthly pain medications: #240 methadone 10 mg.[3]; #120 OxyContin 80 mg.; and #120 oxycodone 30 mg.

59. In his progress notes of his 2019 visits with Patient B, Respondent noted that the patient was stable on the pain medications and taking them as prescribed, based almost exclusively on the patient's self-reporting. The patient's pain and ability to function was described only in general terms.

60. In his progress note for the November 5, 2020 visit with Patient B, Respondent noted that he asked the patient to bring a copy of an EKG to the next visit in two months so that he could look at the QT interval to determine if he needed to lower the dose of methadone. No further mention was made about an EKG at the next two visits on July 23, 2019 and on September 17, 2019.

61. In his progress note for the November 7, 2019 visit with Patient B, Respondent again noted only general descriptions of the patient's pain and his ability to function. For the first time, Respondent noted that he reviewed a pain sheet questionnaire and that the patient's pain levels had come down from 8/10 to 3/10, without any explanation or context. It was also noted that Respondent asked the patient to "recheck" his EKG.

62. In 2020, Respondent continued to see Patient B about every six to eight weeks.[4] At each visit, Respondent prescribed two months' of refills of the same monthly pain medications: #240 methadone 10 mg.; #120 OxyContin 80 mg.; and #120 oxycodone 30 mg.

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[3] At visits on 02/05/2018 and 03/02/2018, Respondent prescribed #180 methadone 10 mg. but went back to prescribing #240 pills on 03/29/2018.

[4] Because of the pandemic, the 2020 visits on 04/20, 06/18, 08/13, and 10/07 were conducted by telephone.

63. Respondent's most recent visit with Patient B that was documented in the medical records produced to the Board occurred on or about November 5, 2020. Respondent noted that the patient had an EKG in April 2020 that showed a QT interval of 418 ms. It is unclear whether this information came from the patient or Respondent reviewed a copy of the EKG report. Respondent continued to refill the pain medicine prescriptions for Patient B.

64. In summary, during the course of his treatment of Patient B through at least November 2020, Respondent prescribed to Patient B chronic high dosages of OxyContin, methadone, and oxycodone, often in combination with benzodiazepines. Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient B, pursuant to section 2234 subd. (b) [gross negligence] and/or subd. (c) [repeated negligent acts] as follows:

a. Respondent did not regularly conduct random urine drug screening, with quantitative analysis, to monitor the patient's compliance with the treatment plan of prescribed medications.

b. While prescribing long-term use of opioids to Patient B, Respondent did not thoroughly conduct clinical assessments, including a psychological evaluation with assessment tools, and appropriate monitoring of the patient with screening tools and/or did not otherwise evaluate the effectiveness, the potential benefits and potential risks, of the prescribed opioid therapy.

c. Respondent did not develop and document treatment goals with specific objectives to evaluate and maximize the patient's function and to use the lowest effective dosages of controlled substances. Respondent did not adequately pursue other treatment modalities.

d. Respondent did not have a pain management agreement, verbal or written, with Patient B that specified treatment parameters, expectations, and the consequences of noncompliance.

e. Respondent did not conduct appropriate ongoing assessments of his pain management therapy through regular reviews and monitoring of the patient's progress toward treatment objectives and of possible substantial risks or adverse events, such as overdose or diversion.

f. After October 2, 2018, Respondent failed to document his compliance with the requirements of regularly checking the CURES/PDMP database, as set forth in Section 11165.4 of the California Health and Safety Code.

g. Respondent did not appropriately consider or make any efforts to taper or to discontinue the long-term therapy of opioids.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts re Patient C)

65. Respondent Andrew Howard Glatt, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under section 2234, subdivision (c) in his care and treatment, acts and/or omissions, of Patient C, a male born in 1959, as alleged herein.

66. From at least November 2012 to February 2015, Patient C was seen and treated by other physicians and health providers at Glatt Medical, approximately every one to two months. Patient C was a high-risk patient for the use of controlled substances for his chronic pain syndrome. He was a recovering alcoholic with chronic pain due to alcoholic pancreatitis, and had half his pancreas removed. Patient C had multiple health conditions, including a diagnosis of Type II diabetes mellitus that required insulin injections.

67. On or about February 10, 2015, Respondent first saw Patient C for a pain management follow-up visit. It was noted that patient had pain in his bilateral shoulders after two surgeries on each side. Respondent refilled the monthly pain medications: #240 hydromorphone 8 mg. and #480 methadone 10 mg.

68. In 2015, Patient C was seen on approximately a monthly basis at Glatt Medical.

69. On or about June 4, 2015, Respondent saw Patient C and issued prescription refills for #240 hydromorphone 8 mg. and #480 methadone 10 mg.

70. On or about July 30, 2015, Respondent saw Patient C and issued monthly prescription refills, for two months, of #240 hydromorphone 8 mg. and #480 methadone 10 mg.

71. On or about September 22, 2015, Respondent saw Patient C. It was noted that an EKG was performed that showed a QTC of 481 ms "significantly higher than where it was in the

past." Respondent's plan noted that the patient had long QTC related to methadone and that the methadone dose would be dropped by 20 mg to 40/30/30/40 while the Dilaudid would continue at 16 mg. qd. It was noted that the patient was not happy with the plan but "understands the safety concerns." Patient C, however, continued to receive the same monthly prescriptions for #240 hydromorphone 8 mg. and #480 methadone 10 mg.

72. On or about December 4, 2015, Respondent saw Patient C and noted that the patient had "a bout of severe constipation necessitating trip to ER. He is much better now." Respondent issued monthly prescription refills of #240 hydromorphone 8 mg. and #480 methadone 10 mg.

73. In 2016, Patient C continued to be seen at Glatt Medical for pain management, approximately every one or two months.

74. On or about July 18, 2016, Respondent saw Patient C. It was noted that the patient had a recent EKG at another office and was told "there is nothing wrong." There was also a note that the patient's sobriety "continues for 15 years now." Respondent issued monthly prescription refills, for two months, of #240 hydromorphone 8 mg. and #480 methadone 10 mg.

75. On or about September 12, 2016, Respondent saw Patient C and noted that the patient's QT interval with his last EKG was 510 ms. The plan noted was to decrease the methadone from 16 tabs per day to 14 tabs per day and to follow-up in two months. Respondent issued monthly prescriptions for #240 hydromorphone 8 mg. .and #420 methadone 10 mg.

76. On or about November 3, 2016, Respondent saw Patient C and noted that the patient "remains in chronic pain." It was noted that an EKG showed a QTC of 485 and the plan was to reduce methadone from 14 tablets per day to 12 tablets per day. The Dilaudid dosage was to continue and Opana 10 mg., four times a day, was to be started. Patient C was given prescriptions for #360 methadone 10 mg., #240 hydromorphone 8 mg., and #120 oxymorphone 10 mg.

77. On or about December 30, 2016, Respondent saw Patient C and refilled his monthly pain medications, for the next two months, for: #360 methadone 10 mg.; #240 hydromorphone 8 mg.; and #120 oxymorphone 10 mg.

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78. In 2017, Patient C continued to be seen at Glatt Medical for pain management, approximately every two months.

79. On or about February 28, 2017, Respondent saw Patient C and noted that the patient still had chronic pain and said that he needed an increased dose of pain meds. Respondent's plan was to change the prescription for Opana 10 mg. four times a day to Opana ER 30 mg. twice a day, noting that would be a 20 mg. dose increase. Patient C filled monthly prescriptions of pain medications, for the next two months, for #360 methadone 10 mg., #240 hydromorphone 8 mg., and #120 oxymorphone 10 mg.

80. According to the CURES database, on March 14, 2017, Patient C filled a prescription from Respondent for #10 fentanyl transdermal patches 25 mcg., for a 30-day supply.

81. On or about April 25, 2017, Respondent saw Patient C and noted that the patient still had diabetic neuropathy pain in his hands and feet. The patient has tried and failed with the fentanyl patch. Although the patient had been prescribed Opana ER, it was not covered by insurance, so he has been on methadone and Dilaudid without adequate relief. The patient stated he had taken extra methadone for his risk and Respondent noted that he spoke with him "about not doing that from a heart standpoint as it is not safe." Respondent issued monthly prescriptions, for the next two months, for: #240 hydromorphone 8 mg., #360 methadone 10 mg., and #60 Opana ER 30 mg., along with Cymbalta.

82. On or about June 20, 2017, Respondent saw Patient C and noted that he discussed with the patient about stopping use of Opana ER because of a recent FDA warning about abuse potential and about using Opana IR 10 mg., two tabs three times a day. It was also noted that the patient wanted to try Lyrica for diabetic neuropathy. Respondent issued monthly prescriptions for the next two months of: #240 hydromorphone 8 mg., #360 methadone 10 mg., and #60 Opana ER 30 mg., along with #60 Lyrica 50 mg.

83. Respondent continued to see Patient C for pain management in 2017 on August 18 and October 19, and refilled the patient's pain medications. At the October 19, 2017 visit, Respondent noted that the patient reported being in "a fair amount of pain" and wanted to increase his pain medications. Respondent's plan was to increase the Opana ER to 40 mg., twice

daily, and to follow up in two months. So, on October 19, 2019, Respondent issued monthly prescriptions, for the next two months, for: #240 hydromorphone 8 mg., #360 methadone 10 mg., and #60 Opana ER 40 mg., along with a three months' supply of #180 Lyrica 50 mg.

84. On or about December 14, 2017, Respondent saw Patient C who presented an inconsistent report about the neuropathy in his hands and feet but reported doing well with the pain medications and having no side effects from them. Respondent's plan was to increase the Lyrica and to refill the pain medications of methadone and hydromorphone. Respondent issued monthly prescriptions, for the next two months, for: #240 hydromorphone 8 mg.; #360 methadone 10 mg.; and #60 Opana ER 40 mg.

85. In 2018, Respondent continued to see Patient C for pain management, approximately every seven or eight weeks, with office visits on February 8, April 5, June 4, July 26, September 20, November 15, and December 18. Respondent continued to issue monthly prescriptions for: #240 hydromorphone 8 mg.; #360 methadone 10 mg.; and #60 Opana ER 40 mg.

86. In his progress note for the July 26, 2018 visit, Respondent noted that Patient C reported falling and fracturing his left hip that required surgery on June 6, 2018.

87. In his progress note for the November 15, 2018 visit, Respondent noted that Patient C requested a change to his pain medications, due to "ineffectiveness" and requested oxycodone because it worked well for him after his hip surgery. Respondent's plan was to discontinue the oxymorphone 40 mg. and start Xtampza (oxycodone) 18 mg. twice a day while continuing to refill the hydromorphone and methadone, with a follow-up in one month.

88. According to the CURES database, on November 23, 2018, Patient C filled a prescription from Respondent for #60 oxymorphone 40 mg. and on November 27, 2018 filled a prescription for #60 Xtampza ER 18 mg.

89. On or about December 14, 2018, Respondent saw Patient C who reported that the Xtampza gave him better pain relief than the oxymorphone previously. Respondent refilled the monthly pain medications, for the next two months: #240 hydromorphone 8 mg.; #360 methadone 10 mg.; and #60 Xtampza ER 18 mg.

90. About five weeks later, on or about January 22, 2019, Respondent saw Patient C who reported that he lost his second refill of pain medications and went into withdrawal from opiates, losing a lot of weight due to worsening pain from chronic pancreatitis. Respondent issued refills of #360 methadone 10 mg. and #60 Xtampza ER 18 mg.

91. On or about March 19, 2019, Respondent saw Patient C who reported being hospitalized at Kaiser for a lung abscess but was now doing better. Respondent noted that the patient had not seen his primary care doctor in seven months. Respondent issued refills for one month of pain medications, telling the patient that he would return to two months' intervals of visits and prescriptions after he saw his primary care doctor.

92. On or about April 16, 2019, Respondent saw Patient C who reported seeing his primary care doctor who said things were all good, except for a low Vitamin D level. Respondent issued refill prescriptions for monthly pain medications, for the next two months: #240 hydromorphone 8 mg.; #360 methadone 10 mg.; and #60 Xtampza ER 18 mg.

93. Respondent continued to see Patient C in 2019 for pain management visits on June 14, August 9, and on October 8. At each visit, Respondent noted that the patient was stable with his pain medications and issued monthly refill prescriptions, for two months, of #240 hydromorphone 8 mg.; #360 methadone 10 mg., and #60 Xtampza ER 18 mg.

94. On or about December 26, 2019, Patient C was seen by a nurse practitioner at Glatt Medical who issued two months of refills of the chronic pain medications.

95. In 2020, Respondent continued to see Patient C for pain management approximately every seven or eight weeks and continued to issue refill pain medications for hydromorphone, methadone, and Xtampza.

96. In his progress note for the June 25, 2020 visit with Patient C, Respondent noted that an EKG was done that showed a QTC of 495 ms on dosing of 120 mg. of methadone per day. The plan was to decrease methadone to not exceed 11 tablets per day, to continue the Dilaudid and Xtampza, and to follow-up in two months.

97. On or about August 25, 2020, Respondent saw Patient C and noted a QTC of 484 ms on dosing of 110 mg. of methadone per day, "which is too long." The plan was to decrease methadone to 10 mg., three tabs three times a day and to refill the other medications.

98. On or about October 20, 2020, Respondent saw Patient C and noted that his QTC was 492 ms on current methadone dosing. Respondent also noted that he reviewed Patient C's concurrent medications and that he is on mirtazapine, which can lengthen the QT interval. The patient expressed that he wanted to take both methadone and mirtazapine. The plan was to continue the mirtazapine "for now," decrease the methadone to 80 mg. daily, increase the Xtampza, and refill the Dilaudid. Follow-up in two months.

99. Respondent's next visit with Patient C was conducted by telephone on or about November 30, 2020, due to the pandemic. The patient reported having trouble getting the Xtampza prescription filled at the pharmacy. Respondent issued monthly refills, for the next two months, for: #240 hydromorphone 8 mg., #240 methadone 10 mg., and #90 Xtampza ER 36 mg.

100. In summary, Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient C, pursuant to section 2234 subd. (c) [repeated negligent acts] as follows:

a. Respondent did not regularly conduct random urine drug screening or blood testing, with quantitative analysis, to monitor the patient's claims of alcohol sobriety and to monitor compliance with the treatment plan of prescribed medications.

b. Respondent did not consider tapering the patient off methadone after his chart notes reflected concern over the EKG QTC interval increases.

c. Respondent did not consider referring Patient C to a pain specialist for advanced pain management and/or made any efforts to taper or to discontinue the long-term prescribing of high dosages of triple opioids.

d. While prescribing long-term use of opioids to Patient C, Respondent did not thoroughly conduct clinical assessments, including a psychological evaluation with assessment tools, and appropriate monitoring of the patient and/or did not otherwise evaluate the effectiveness, the potential benefits and potential risks, of the prescribed opioid therapy.

e. Respondent did not develop and document treatment goals with specific objectives to maximize the patient's function and to use the lowest effective dosages of controlled substances. Respondent did not consider or adequately pursue other treatment modalities.

f. Respondent did not have a pain management agreement, verbal or written, with Patient C that specified treatment parameters, expectations, and the consequences of noncompliance.

g. Respondent failed to adequately document that he counseled Patient C to recognize the signs of an opioid overdose and how to respond.

h. After October 2, 2018, Respondent failed to document his compliance with the requirements of regularly checking the CURES/PDMP database, as set forth in Section 11165.4 of the California Health and Safety Code.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts re Patient D)

101. Respondent Andrew Howard Glatt, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts under section 2234, subdivision (c) in his care and treatment, acts and/or omissions, of Patient D, a male born in 1931, as alleged herein.

102. From about December 2012 to at least August 2015, Patient D was seen and treated for his primary care by other physicians and health providers at Glatt Medical.

103. On or about August 14, 2015, Respondent saw Patient D for a primary care follow-up visit. The patient had multiple medical conditions: nausea, weight loss, pancreatic cyst, mesothelioma with pleurodesis for recurrent effusions, chronic pain due to multiple spinal surgeries and peripheral neuropathy. The patient had a history of a right total hip replacement, HTN, chronic kidney disease, paroxysmal atrial fibrillation, s/p cholecystectomy, and had a neurostimulator placed for right lower leg pain. Respondent's physical assessment of the patient was that he "appears chronically ill but stable." It was noted that the patient was seeing another physician for pain issues. Respondent issued a prescription for #60 Lorazepam 0.5 mg.

104. During the course of Respondent's care and treatment of Patient D, the patient was also seen and managed by multiple other physician providers.

105. In 2015, Respondent saw Patient D for a total of about four office visits and issued prescriptions for lorazepam 0.5 mg, zolpidem tartrate 10 mg. and eszopiclone 2 mg. Another physician at Glatt Medical wrote prescriptions in 2015 to Patient C for a total of #240 Norco 325/10 mg.

106. In 2016, Respondent continued to see Patient D for multiple office visits for medical issues of neuropathy, chronic hip pain, depression, and for a pre-op examination for replacement of a back neurostimulator.

107. In 2016, Respondent issued controlled substances prescriptions to Patient D for: Norco 325/10 mg.; ketamine powder; eszopiclone 2 mg., zolpidem tartrate, and lorazepam 0.5 mg.

108. In 2017, Respondent continued to see Patient D for multiple medical issues that included anxiety, restless leg syndrome, hip and back pain, problems with sleeping, mesothelioma, bilateral leg edema, chronic kidney disease, and for a pre-op examination for a total left hip replacement. In June 2017, Patient D resumed chemotherapy for mesothelioma. In August 2017, Patient D reported being on hospice for mesothelioma but in October he reported being back at home health.

109. In a progress note for a visit with Patient D on December 19, 2017, Respondent noted that the patient was confused at the beginning of the month but was much clearer the last four days. The patient was taking OxyContin nightly and Norco periodically for pain that was localized in his upper abdomen, most likely form the mesothelioma.

110. In 2017, Respondent issued controlled substances prescriptions to Patient D for: Norco 325/10 mg.; OxyContin 15 mg.; lorazepam 0.5 mg; and ketamine powder.

111. In 2018, Respondent continued to see Patient D for about fifteen visits for multiple medical issues including chronic abdominal pain, confusion, therapeutic opiate-induced constipation, multiple falls at home, weight loss, and neuropathy. Patient D was in and out of hospice care.

112. On or about July 26, 2018, Respondent took over the prescribing of Patient D's pain medications, at the patient's request. Respondent noted that Patient D reported that most of his pain was due to peripheral neuropathy in his legs, with pain also in his hands and elbows, and that his abdominal pain was quiet right now. Respondent noted that Patient D got confused between oxycodone and OxyContin and used the two terms interchangeably. Respondent also noted that there were reports that Patient D was abusing Norco and that Respondent told the patient that he would not give him any more Norco. Respondent prescribed OxyContin 15 mg. and oxycodone IR 5 mg. to manage Patient D's pain in his various joints, legs and chest area.

113. In 2018, Respondent issued controlled substances prescriptions to Patient D for Norco 325/10 mg., OxyContin 15 mg., ketamine powder, and oxycodone 5 mg.

114. In 2019, Respondent saw Patient D for three visits. The last documented office visit was on April 12, 2019. At that visit, the patient reported that most of his current pain was in his right leg and that he had lost 20 pounds over the last several months. Respondent noted that he refilled the chronic pain medications for the next two months and also continued the medications for depression and OIDC.

115. In summary, Respondent is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient D, pursuant to section 2234, subd. (d) [repeated negligent acts] as follows:

a. Respondent did not conduct adequate and ongoing assessment of the patient through regular review and monitoring of the treatment and its effectiveness and through appropriate assessment of the patient's pain and function, and the absence of substantial risks or adverse events; and,

b. Respondent did not regularly conduct random urine drug screening, with quantitative analysis, to monitor the patient's compliance with the treatment plan of prescribed medications. Respondent continued to prescribe long-term controlled substances to Patient D without adequate monitoring.

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FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Medical Records for Patient A, Patient B, Patient C, Patient D)

116. Respondent Andrew Howard Glatt, M.D. is subject to disciplinary action, jointly and severally, for unprofessional conduct under Business and Professions Code section 2266 for his failure to maintain adequate and accurate medical records regarding his treatment of Patient A and/or Patient B and/or Patient C and/or Patient D, which failures occurred after January 2015.

117. Paragraphs 26 through 115 are incorporated herein by reference, as if fully set forth.

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 G 87831, issued to Respondent Andrew Howard Glatt, M.D.;

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

3. Ordering Respondent Andrew Howard Glatt, 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: JAN 20 2022

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