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

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

In the Matter of the Accusation Against: **WILLIAM GLATT, M.D.** **1860 El Camino Real, Suite 301** **Burlingame, CA 94010** **Physician's and Surgeon's Certificate No. G 15309** Respondent.	Case No. 800-2019-058296 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

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

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2. Respondent William Glatt, M.D. 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 August 26, 1968, the Board issued Physician's and Surgeon's Certificate No. G 15309 to William 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. 800-2019-058296 and will expire on May 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-058296 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 17, 2022. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2019-058296 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-058296. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

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CULPABILITY

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

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

CONTINGENCY

10. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent 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 Surrender and Disciplinary Order shall be of no force or effect and, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

ORDER

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

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

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

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

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

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

ACCEPTANCE

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

DATED: Nov 17, 2022

WILLIAM GLATT, M.D.
Respondent

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. HINSHAW, ESQ.
Attorney for Respondent

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

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Exhibit A

Accusation No. 800-2019-058296

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

In the Matter of the Accusation Against: **WILLIAM GLATT, M.D.** **1860 El Camino Real, Suite 301** **Burlingame, CA 94010** **Physician's and Surgeon's Certificate No. G 15309,** Respondent.	Case No. 800-2019-058296 **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 August 26, 1968, the Board issued Physician's and Surgeon's Certificate Number G 15309 to William 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 May 31, 2022, unless renewed.

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JURISDICTION

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

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

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> ...

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

7. Section 2228.1 of the Code states:

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

the board 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:

...

(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 contendre 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.

...

COST RECOVERY

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

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the 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.

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

(c) A certified copy of the actual costs, or a good faith estimate of costs where 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 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.

(d) The administrative law judge shall make a proposed finding of the amount 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 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 the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as 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 the board may have as to any licensee to pay costs.

(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.

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

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

conditionally renew or reinstate for a maximum of one year the license of any 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.

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

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

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

DEFINITIONS

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

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

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

12. 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 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 CNS depressant drugs should be reduced. Use of fentanyl together with other CNS depressants, including alcohol, can result in increased risk to the patient.

13. Hydromorphone (trade name Dilaudid) is a dangerous drug as defined in section 4022 of the Code, and a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code. 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, it should be prescribed and administered with caution. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. The usual starting dosage for injections is 1-2 mg. The usual oral dose is 2 mg every two to four hours as necessary. Patients receiving other narcotic analgesics, anesthetics, phenothiazines,

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

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

15. 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 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.

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

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

18. Oxycodone hydrochloride (trade names OxyContin® and Xtampza) 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 Code section 4022. 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 CNS depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

19. Tramadol hydrochloride (trade name Ultram), is a centrally acting synthetic analgesic compound. It is a dangerous drug as defined Code section 4022, and a Schedule II controlled substance as defined by section 11057 of the Health and Safety Code. Ultram is 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 2016[2], 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 syndrome (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, CURES[3] 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 (MEDD[4]) of 480 mg.

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[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.

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

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

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

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

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

[5] During that time period, other providers in the Glatt Practice Group intermittently issued 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.

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

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

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

a. Respondent did not have a written and signed pain management agreement and/or informed consent documentation;

b. Respondent failed to refer this patient for orthopedic and/or pain management consultations for surgical management of back pain, or more comprehensive medical management of her complaints of pain;

c. Respondent failed to recommend physical therapy or chiropractic manipulation for chronic sciatica pains for this patient;

d. Respondent did not refer Patient 1 to a mental health consultation;

e. Respondent failed to conduct an objective opioid risk assessment;

f. Respondent failed to conduct urine toxicology testing that would test for fentanyl metabolites, and did not address anomalous urine screening test results;

g. Respondent prescribed a combination of two long-acting narcotics with the highest potency for management of fibromyalgia and chronic headaches, and prescribed in high dosages over a lengthy period of time;

h. Respondent did not prescribe a naloxone antidote to mitigate the risks of accidental overdose in this patient;

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

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

SECOND CAUSE FOR DISCIPLINE

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

32. 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 2, a female born in 1965, as alleged herein. The circumstances are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Respondent did not have a written and signed pain mangement agreement and/or informed consent documentation;

b. Respondent failed to risk-stratify the patient;

c. Respondent failed to refer this patient to mental health staff for cognitive behavioral therapy and to anesthesia pain service for pain reduction interventions;

d. Respondent failed to try other, safer, non-narcotic medications to reduce the patient's dependency on narcotics;

e. Respondent failed to refer the patient to, or consider, non-opioid management of this patient's chronic pain syndrome;

f. Respondent failed to further investigate the inconsistent urine toxicology tests and discuss the issue with the patient;

g. Respondent failed to recognize the patient's high opiate tolerance and to pursue opioid rotation with methadone tapering;

h. Respondent did not prescribe a naloxone antidote to reduce risks of accidental overdose from methadone;

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

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

THIRD CAUSE FOR DISCIPLINE

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

47. 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 3, a female born in 1940, as alleged herein. The circumstances are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Respondent did not have a written and signed pain managment agreement and informed consent;

b. Respondent did not conduct an opioid risk stratification of the patient, or document such;

c. Respondent failed to try other safer and non-addictive classes of pain medication;

d. Respondent failed to consider, or refer the patient to, chiropractic manipulation and acupuncture treatments and weight loss programs;

e. Respondent failed to consider non-opiate management of chronic low back pain;

f. Respondent failed to appropriately follow-up on urine toxicology testing for this patient that was negative for the prescribed fentanyl;

g. Respondent prescribed benzodiazepines to this patient who was on a high-dose fentanyl patch with high MEDD, exposing her to unnecessary dangers of a drug overdose;

h. Respondent did not prescribe a naloxone antidote therapy, to reduce risks of fatal respiratory failure in this elderly patient, until 2019;

i. Respondent did not document the findings of abnormal physical examinations and lacked detailed functional assessment in opioid monitoring in the medical records; and

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

FOURTH CAUSE FOR DISCIPLINE

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

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

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

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 Certificate Number G 15309, issued to Respondent William Glatt, M.D.;

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

3. Ordering Respondent William 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: FEB 17 2022

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

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