Inder Singh, M.D.

March 15, 2019

Arun Bhandari, Chair
Disciplinary Panel A
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, MD 21215-2299

Re: Surrender of License to Practice Medicine
Inder Singh, M.D. License Number: D18962
Case Number: 2217-0015

Dear Dr. Bhandari and Members of Disciplinary Panel A,

Please be advised that, pursuant to Md. Code Ann., Health Occ. ("Health Occ.") §14-403 (2014 Repl. Vol. & 2017 Supp.), I have decided to **SURRENDER** my license to practice medicine in the State of Maryland, License Number D18962, effective immediately. I understand that upon surrender of my license, I may not give medical advice or treatment to any individual, with or without compensation, and cannot prescribe medications or otherwise engage in the practice of medicine in the State of Maryland as it is defined in the Maryland Medical Practice Act (the "Act"), Health Occ. §§ 14-101 *et seq.* and other applicable laws. In other words, as of the effective date[1] of this Letter of Surrender, I understand that the surrender of my license means that I am in the same position as an unlicensed individual in the State of Maryland.

I understand that this Letter of Surrender is a **PUBLIC DOCUMENT**, and upon Disciplinary Panel A's ("Panel A") acceptance, becomes a **FINAL ORDER** of Panel A of the Maryland State Board of Physicians (the "Board").

I acknowledge that the Board initiated an investigation of my practice and on August 10, 2018, Panel A issued disciplinary charges against me under Health Occ. § 14-404(a) (22) (fails to meet adequate standards for quality medical care) and (40) (fails to keep adequate medical records). A copy of the charges is attached as Attachment 1. I have decided to surrender my license to practice medicine in the State of Maryland to avoid further investigation and prosecution of these disciplinary charges and due to my retirement.

I wish to make it clear that I have voluntarily, knowingly and freely chosen to submit this Letter of Surrender to avoid further prosecution of the disciplinary charges. I

[1] This Letter of Surrender will go into effect 90 days from the date of acceptance by the Executive Director of the Board to provide time for Dr. Singh to transition his patients and wind down his practice.

acknowledge that for all purposes related to medical licensure, the charges will be treated as if proven.

I understand that by executing this Letter of Surrender I am waiving my right to a hearing to contest the disciplinary charges. In waiving my right to contest the charges, I am also waiving the right to be represented by counsel at the hearing, to confront witnesses, to give testimony, to call witnesses on my own behalf, and all other substantive and procedural protections provided by law, including the right to appeal to circuit court.

I understand that the Board will advise the Federation of State Medical Boards, the National Practitioner Data Bank, and the Healthcare Integrity and Protection Data Bank of this Letter of Surrender. I also understand that in the event I would apply for licensure in any form in any other state or jurisdiction that this Letter of Surrender may be released or published by the Board to the same extent as a final order that would result from disciplinary action, pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014), and that this Letter of Surrender constitutes a disciplinary action by Panel A.

I affirm that I will provide access to and copies of medical records to my patients in compliance with Title 4, subtitle 3 of the Health General Article.

I further recognize and agree that by submitting this Letter of Surrender, my license will remain surrendered unless and until the Board grants reinstatement. In the event that I apply for reinstatement of my Maryland License, I understand that Panel A or its successor is not required to grant reinstatement; and, if it does grant reinstatement, may impose any terms and conditions the disciplinary panel considers appropriate for public safety and the protection of the integrity and reputation of the profession. I further understand that if I file a petition for reinstatement, I will approach Panel A or its successor in the same position as an individual whose license has been revoked.

I acknowledge that I may not rescind this Letter of Surrender in part or in its entirety for any reason whatsoever. Finally, I wish to make clear that I have been advised of my right to be represented by an attorney of my choice throughout proceedings before Panel A, including the right to consult with an attorney prior to signing this Letter of Surrender. I have consulted with and was represented by an attorney prior to signing this letter permanently surrendering my license to practice medicine in Maryland. I understand both the nature of Panel A's actions and this Letter of Surrender fully. I acknowledge that I understand and comprehend the language, meaning and terms and effect of this Letter of Surrender. I make this decision knowingly and voluntarily.

Very truly yours,

Signature on File

Inder Singh, M.D.

NOTARY

STATE OF Maryland
CITY/COUNTY OF Carroll

I HEREBY CERTIFY that on this 15 day of March, 2019 before me, a Notary Public of the City/County aforesaid, personally appeared Inder Singh, M.D., and declared and affirmed under the penalties of perjury that the signing of this Letter of Surrender was a voluntary act and deed.

AS WITNESS my hand and Notarial seal.

Notary Public

My commission expires:

DONNA G MORTIMER
Notary Public-Maryland
Carroll County
My Commission Expires
4/27/19

ACCEPTANCE

On behalf of Disciplinary Panel A, on this 15th day of March, 2019, I, Christine A. Farrelly, accept the **PUBLIC SURRENDER** of Inder Singh, M.D.'s license to practice medicine in the State of Maryland.

Christine A. Farrelly, Executive Director
Maryland Board of Physicians

Attachment 1

IN THE MATTER OF	*	**BEFORE THE**
INDER SINGH, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D18962	*	**Case Number: 2217-0015-A**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") hereby charges **INDER SINGH M.D.** (the "Respondent"), License Number: D18962, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* The Respondent is charged under the following provisions of Health Occ. II § 14-404(a):

> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital or any other location in this State; [and]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

ALLEGATIONS OF FACT[1]

The Board bases its charges on the following facts that the Board has cause to believe are true:

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[1] The allegations set forth in this document are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with these charges.

I. BACKGROUND

1. At all relevant times, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on January 30, 1976. The Respondent's license is presently active.

2. The Respondent specializes in internal medicine but was never board-certified.

3. The Respondent operates a general solo practice in Baltimore, Maryland.

II. COMPLAINT

4. On February 13, 2017, the Board received an anonymous complaint stating that the Respondent was overprescribing controlled dangerous substances (CDS) to a drug addicted patient population for a nominal fee of $100.00.

5. After receiving the Complaint, the Board initiated an investigation.

6. In furtherance of its investigation the Board interviewed the Respondent and subpoenaed nine (9) patient medical records.

7. The Board then requested that two peer reviewers review the patient records to determine whether the Respondent complied with the appropriate standard of care and medical recordkeeping.

III. SUMMARY OF PEER REVIEW FINDINGS

8. The peer reviewers determined that overall the Respondent did not meet the appropriate standard of care for the delivery of quality medical care care in 5 of the 9 cases reviewed, for a number of reasons, including but not limited to the following:

(a) The medical record did not include adequate information regarding the location, timing, frequency and intensity of pain;

(b) The medical records often did not include adequate information on the reasons for continuing to prescribe opioids or the reasons for increasing or decreasing dosage;

(c) The medical records did not include an adequate plan of care, or referrals to other specialists;

(d) The Respondent frequently prescribed opioids with highly abusable medications such as benzodiazepines; and

(e) The Respondent did not follow appropriate guidelines to prevent narcotic diversion and abuse, such as urine or blood toxicology screenings, pain contracts, and did not monitor drug databases.

9. The Experts also agreed that the Respondent did not meet the requirements for maintaining adequate medical records in 5 of the 9 cases reviewed for a number of reasons, including but not limited to the following:

(a) Some of the notes in the medical records were handwritten, not legible and lacked detail;

(b) The records did not contain adequate justification for filling or refilling controlled substances;

(c) The Respondent's documentation is brief, and frequently does not include detailed descriptions of the medical problems, summaries of

labs and imaging findings, referrals to specialists and consultation findings;

(d) The Respondent's records lack a reasonable assessment of medical issues or a plan of care; and

(e) 'The medical record did not document adequate screening for drug diversion and addiction.

III. PATIENT-SPECIFIC ALLEGATIONS

10. Examples of the above investigative findings are set forth in the following patient-specific findings. These summaries are not intended as, and do not represent, a complete description of the evidence with respect to the Respondent's conduct in this matter.

Patient One

11. The Respondent provided treatment for a male Patient, identified hereinafter as "Patient One." The records for Patient One covered the years from 1993 to 2017. In 1993 the Respondent treated Patient One for right shoulder pain with non-narcotic medication. Several years later Patient One complained about knee pain and the Respondent prescribed Percocet.[2]

12. The medical record indicates that the Respondent prescribed Percocet for Patient One as early as August 2002; Patient One was maintained on narcotic medication for complaints of pain through 2017. The Respondent also treated Patient One for insomnia, hepatitis, muscle spasms and anxiety.

[2] Percocet is a schedule II narcotic pain reliever.

13. In 2006, Patient One was prescribed narcotics for chronic knee pain and later had knee replacement surgery.

14. On January 22, 2009, the Respondent saw Patient One for an office visit, where Patient One complained of back pain, chronic anxiety and insomnia. The Respondent renewed prescriptions for Percocet 10/325 (one pill four times daily), Soma 350 mg (1 pill twice a day), Xanax 1 mg (at bedtime p.r.n.), and Ambien 12.5 mg (at bedtime p.r.n.). According to an entry in the record, Patient One "was cautioned about the mixing of these medications."

15. On March 10, 2012, Patient One complained of anxiety, low back pain and left knee pain, but the record does not reflect any details about the symptoms. The Respondent performed a brief non-specific physical examination.

16. The Respondent prescribed oxycodone[3] (10 mg) four times per day; Xanax[4] (1 mg) twice a day (b. i.d.), Ambien[5] (12.5 mg) at bedtime (q.h.s)[6], and Soma[7] (350 mg b.i.d.). The Respondent saw Patient One every four weeks and maintained him on these medications for many years.

17. On March 1, 2014, Patient One was diagnosed with autoimmune hepatitis. He was prescribed Subutex[8] for a few months, and then the oxycodone was resumed.

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[3] Oxycodone is a schedule II narcotic pain reliever with a high abuse potential.
[4] Xanax is a benzodiazepine that is used to treat anxiety.
[5] Ambien is a sedative used to treat insomnia.
[6] The abbreviation q.h.s. means every day at bedtime.
[7] Soma is a muscle relaxer that blocks pain sensation between the nerves and the brain.
[8] Subutex (buprenorphine) is a Schedule III Narcotic pain reliever, which is also used to treat opiate addiction.

18. The Experts agreed that the Respondent did not meet the appropriate standard of care for the delivery of quality medical care while treating Patient One for a number of reasons, including but not limited to the following:

(a) The medical record does not include information regarding the location, timing, frequency and intensity of pain;

(b) The medical record does not include adequate information on the reasons for continuing to prescribe opioids;

(c) The medical record does not include a specific plan of care, or referral to other specialists to determine the cause of Patient One's pain;

(d) The Respondent prescribes opioids with highly abusable medications such as Xanax and Soma;

(e) The Respondent does not follow appropriate guidelines to prevent narcotic diversion and abuse such as, pill counts, toxicology screening, pharmacy checks and regular urine drug tests;

(f) The Respondent prescribed medication to wean Patient One off narcotics but fails to refer the Patient to an addiction specialist when these efforts are not successful; and

19. The Experts also agreed that the Respondent did not meet the requirements for maintaining adequate medical records for a number of reasons, including but not limited to the following:

(a) Some of the notes in the medical record were handwritten and not legible and lacked detail;

(b) The records did not contain adequate justification for filling or refilling controlled substances;

(c) The Respondent's documentation is brief, and frequently does not include detailed descriptions of the medical problems, summaries of labs and imaging findings, referrals to specialists and consultation findings; and

(d) The Respondent's records lack a reasonable assessment of medical issues or a plan of care.

Patient Two

20. The Respondent provided care from 2005 through 2017, for a female patient, hereinafter "Patient Two," who was diagnosed with cervical spine disc disease. Patient Two complained of pain in her feet as well as low back.

21. Diagnostic tests confirmed that Patient Two had cervical degenerative disc disease (DDD)[9], and a neck electromyogram[10] revealed a chronic R C5-C6 radiculopathy[11] and mild carpal tunnel syndrome.[12] Patient Two was also treated for anxiety and depression.

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[9] Cervical degenerative disc disease is a cause of neck pain and radiating arm pain. It develops when one or more of the cushioning discs in the cervical spine starts to breakdown due to wear and tear.

[10] Electromyogram (EMG) is a test used to measure the electrical activity of muscles. The test is used to detect abnormalities that can be caused by certain diseases and medical conditions.

[11] Radiculopathy is a compressed nerve in the spine that causes, pain, numbness, tingling, or weakness along the nerve. This condition is most common in the lower back.

[12] Carpal tunnel syndrome is a medical condition due to compression of the median nerve as it travels through the wrist at the carpal tunnel. The main symptoms are pain and numbness and tingling in the fingers.

22. The Respondent saw Patient Two on November 30, 2005, for complaints of neck pain radiating to the right arm. He prescribed Percocet 10/325 mg (three times per day), and Patient Two was referred to a neurologist for an EMG.

23. Patient Two complained of low back pain and pain in her feet; the Respondent prescribed Percocet 10/325 mg (3-4 times per day), and she was maintained on this regimen for many months. The Respondent prescribed Valium as well.

24. Patient Two was referred to a pain management specialist in December 2006. Her medication was changed to oxycodone 15 mg and Xanax 1 mg (b.i.d.). The Respondent was maintained on narcotic medication for over 11 years.

25. The Experts found that the Respondent did not meet the appropriate standard of care for the delivery of quality medical care while treating Patient Two for a number of reasons, included but not limited to the following:

(a) The Respondent maintained Patient Two on narcotics for many years, and on a high dose of oxycodone (15 mg) with Xanax (2 mg) for a prolonged period of time without appropriate monitoring or a plan of care;

(b) Office notes did not contain enough information to explain why controlled substances were being refilled;

(c) The medical record did not contain adequate informed consent for narcotic medication;

(d) The Respondent did not adequately monitor for abuse and/or diversion of narcotics, with urine screening, blood toxicology tests, pill counts, or pharmacy checks.

26. Both Experts opined that the Respondent did not maintain adequate records for a number of reasons, included but not limited to the following:

(a) The medical records lacked detailed descriptions of the patient's pain, such as location, radiation, severity, timing etc.;

(b) Peer Reviewer B noted in his report, that the record contained inadequate general statements about pain such as, "movements of lumbar spine are painful and somewhat limited," or "examination is essentially unchanged;"

(c) The medical record did not adequately document reasons for changing medication, or dose amounts; and

(e) The medical record did not document monitoring for abuse or diversion of narcotics, such as urine drug screenings, blood toxicology tests, pill counts, or pharmacy checks.

Patient Three

27. The Respondent provided care to a male patient, hereinafter Patient Three. Patient Three had a history of obesity, chronic low back pain and gout. Patient Three was taking Xanax for anxiety and admitted that he was illegally buying oxycodone off the street.

28. On April 21, 2012, the Respondent prescribed Patient Three oxycodone 10 mg (two times per day) and Xanax 2mg (two times per day).

29. In August 2012, the oxycodone was increased to 10 mg, (three times a day), and in February 2014, Patient Three's dose was increased to oxycodone 10 mg, (four times a day) and Xanax 2mg (three times a day). Eventually the Xanax was increased to 8 mg per day, and the patient was maintained on this regimen for many months.

30. The Experts found that the Respondent did not meet the appropriate standard of care for providing quality medical care while treating Patient Three for a number of reasons, included but not limited to the following:

(a) The Respondent maintained a morbidly obese patient on a high dose of benzodiazepines with a high dose of oxycodone for a prolonged period of time.

(b) The Patient had a history of purchasing narcotics illegally, but the Respondent did not monitor for drug diversion, with urine drug toxicology screening or blood tests. The Respondent did not require Patient Three to sign a pain contract, and the Respondent did not monitor the prescription drug database for diversion.

31. Both Experts opined that the Respondent did not maintain adequate records for a number of reasons, included but not limited to the following:

(a) The medical records lacked detailed descriptions of the patient's pain, such as location, radiation, severity, timing etc.;

(b) Peer Reviewer B noted in his report, that the record contained inadequate general statements about pain such as, "movements of lumbar spine are painful and somewhat limited," or "examination is essentially unchanged;"

(c) The medical record did not adequately document reasons for changing medication, or dose amounts; and

(d) The medical record did not document monitoring for abuse or diversion of narcotics, such as urine drug screenings, blood toxicology tests, pill counts, or pharmacy checks.

Patient Four

32. Beginning in 1985 the Respondent provided care for a female patient, hereinafter Patient Four. Patient Four had a history of morbid obesity and pain complaints, including hip knee, back, and generalized osteoarthritis.

33. The Respondent began prescribing Percocet for Patient Four as early as September 28, 2004, and she was continued on narcotic medication for almost 13 years.

34. On November 15, 2010, the Respondent prescribed Patient Four Percocet 5/325 mg (8 tablets per day), a total of 240 tablets per month.

35. In 2013 the Respondent was prescribing oxycodone 15 mg (2 tabs every 6 hours). Patient Four was also prescribed Klonopin[13] (1 mg b.i.d).

[13] Klonopin is a benzodiazepine, a class of depressants that produce sedation, induce sleep, relieve anxiety and muscle spasms, and prevent seizures.

36. On May 30, 2015, Patient Four was seen at a pain management clinic, which made recommendations. By May 2015, Patient Four was taking 15 mg of oxycodone four times a day; she was maintained on this dose for many months.

37. The Experts found that the Respondent did not meet the appropriate standard of care for the delivery of quality medical care while treating Patient Four for a number of reasons, included but not limited to the following:

(a) The Respondent inappropriately prescribed benzodiazepines and oxycodone for a morbidly obese patient for many years, when that combination can cause respiratory depression;

(b) Respondent did not monitor for drug diversion, with urine drug toxicology screening. The Respondent did not require Patient Four to sign a pain contract, and the Respondent did not monitor the prescription drug database for diversion; and

(c) The medical record did not contain enough information to document why controlled substances were being prescribed.

38. Both Experts opined that the Respondent did not keep adequate records for Patient Four for a number of reasons, included but not limited to the following:

(a) The medical records lacked detailed descriptions of the patient's pain, such as location, radiation, severity, timing etc.;

(b) Peer Reviewer B noted in his report, that the record contained inadequate general statements about pain such as, "movements of

both knees are painful and somewhat limited," or "movements of lumbar spine are painful and somewhat limited; and

(c) The medical record did not adequately document reasons for changing medication and/or dose amounts; and the medical record did not document monitoring for abuse or diversion of narcotics, such as urine drug screenings.

Patient Five

39. In 2009 the Respondent began providing care for a male patient, hereinafter Patient Five. Patient Five had a history of chronic low back pain. On October 28, 2009, the Respondent prescribed Percocet 5/325. In July 2011 the Respondent prescribed Percocet 7.5/325 (two times per day) By November 4, 2011, the Respondent had increased the dosage to Percocet 7.5/325 mg (three times per day), a total of 90 tablets per month.

40. The Respondent later increased the Percocet to 10/325 mg. The Respondent continued this regimen until October 24, 2016, when Percocet was changed to oxycodone and this regimen was continued until March 2017. The medical record did not contain any urine drug screens or other diversion or addiction assessments.

41. The Experts found that the Respondent did not meet the appropriate standard of care for providing quality medical care while treating Patient Five for a number of reasons, included but not limited to the following:

(f) The Respondent prescribed Patient Five high doses of Percocet and oxycodone for many years without appropriate monitoring;

(g) Office notes did not contain enough information to explain why controlled substances were being refilled;

(h) The medical record did not contain adequate informed consent for narcotic medication;

(i) The Respondent did not assess the effect of the medication or check for aberrant behavior;

(j) The Respondent did not make referrals to a specialist or attempt to perform radiological studies to determine the source of the pain; and

(k) The Respondent did not adequately monitor for abuse and/or diversion of narcotics, with urine screening, blood toxicology tests, pill counts, or pharmacy checks.

42. Both Experts opined that the Respondent did not maintain adequate medical records for a number of reasons, included but not limited to the following:

(a) The Respondent did not describe Patient Five's pain in detail, such as location, timing and severity of pain;

(b) The Respondent did not prepare a detailed plan of care to justify the continuation of opioid medication;

(c) The medical records lacked detailed descriptions of the patient's pain, such as location, radiation, severity, timing etc.;

(d) Peer Reviewer B noted in his report, that the record contained inadequate general statements about pain such as, "movements of

lumbar spine are painful and somewhat limited," or "examination is essentially unchanged;"

(e) The medical record did not adequately document reasons for changing medication, or dose amounts; and

(f) The medical record did not document monitoring for abuse or diversion of narcotics, such as urine drug screenings.

Summary of Allegations

43. The Respondent's failure to meet standards of quality medical care constitutes evidence of violation of Health Occ. §14-404(a)(22).

44. Respondent's failure to maintain adequate medical records constitutes evidence of violation of Health Occ. §14-404(a)(40).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, a disciplinary panel of the Board finds that there are grounds for action under Health Occ. § 14-404(a)(22) and/or (40), the disciplinary panel of the Board may impose disciplinary sanctions against Respondent's license, including revocation, suspension, reprimand, probation and/or a monetary penalty.

NOTICE OF DISCIPLINARY COMMITTEE FOR CASE RESOLUTION

A Disciplinary Committee for Case Resolution ("DCCR") conference in this matter is scheduled for **Wednesday, November 14, 2018, at 9:00 a.m.,** before Panel A at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the DCCR is described in the attached letter to Respondent. If this matter is not resolved at the DCCR, a prehearing conference and hearing will be scheduled at the

Office of Administrative Hearings 11101 Gilroy Road Hunt Valley, Maryland 21031. The hearing will be conducted in accordance with § 14-405 of the Act and Md. Code Ann., State Gov't I §§ 10-201 *et seq.* (2014 Repl. Vol. and 2017 Supp.).

BRIAN E. FROSH

Attorney General of Maryland

8/10/18
Date

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