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

In the Matter of the First Amended Accusation Against: Manbir Singh, M.D. Physician's & Surgeon's Certificate No. A 44591 Respondent.	Case No. 800-2018-042148

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 May 27, 2022.

IT IS SO ORDERED: April 27, 2022.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D. Chair
Panel B

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

In the Matter of the First Amended Accusation Against: **MANBIR SINGH, M.D.** **733 3rd Street** **McFarland, California 93250-1008** **Physician's and Surgeon's Certificate No. A 44591,** Respondent.	Case No. 800-2018-042148 OAH No. 2021060190 **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, and by Joseph F. McKenna III, Deputy Attorney General.

2. Respondent Manbir Singh, M.D. (Respondent) is represented in this proceeding by attorney Dennis R. Thelen, Esq., whose address is: 5001 E. Commerce Center Dr., Suite 300, Bakersfield, California, 93309-1687.

3. On or about March 21, 1988, the Board issued Physician's and Surgeon's Certificate No. A 44591 to 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 November 30, 2023, unless renewed.

JURISDICTION

4. On March 1, 2021, Accusation No. 800-2018-042148 was filed against Respondent before the Board. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent on March 1, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. On January 24, 2022, First Amended Accusation No. 800-2018-042148 was filed before the Board, and is currently pending against Respondent. A true and correct copy of the First Amended Accusation and all other statutorily required documents were properly served on Respondent on January 24, 2022. A true and correct copy of the First Amended Accusation is attached hereto as Exhibit A and hereby incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, discussed with his counsel, and fully understands the charges and allegations in First Amended Accusation No. 800-2018-042148. Respondent has also carefully read, discussed with his counsel, and fully 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 contained in the First Amended 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, having been fully advised of same by his counsel.

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations contained in First Amended Accusation No. 800-2018-042148, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. A 44591.

10. Respondent stipulates that, at a hearing, Complainant could establish a *prima facie* case or factual basis for the charges and allegations contained in the First Amended Accusation; that he gives up his right to contest those charges and allegations contained in the First Amended Accusation; and that he has thereby subjected his Physician's and Surgeon's Certificate to disciplinary action.

CONTINGENCY

11. 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 Board 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.

12. Respondent agrees that if an accusation is ever filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2018-042148 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.

ADDITIONAL PROVISIONS

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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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 Respondent Manbir Singh, M.D.'s Physician's and Surgeon's Certificate No. A 44591 shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a), subsection (4). This Public Reprimand, which is issued in connection with the charges and allegations contained in First Amended Accusation No. 800-2018-042148, is as follows:

1. PUBLIC REPRIMAND.

Respondent failed to adequately document in the progress notes of Patients A, B, C, and D the necessary information for the prescribing of controlled substances to said patients. This constitutes an inadequate record for each patient, as more particularly alleged in First Amended Accusation No. 800-2018-042148.

2. EDUCATION COURSE.

Within sixty (60) calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval forty (40) hours of educational program(s) or course(s) which 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.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the educational program(s) or course(s).

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Failure to successfully complete the educational program(s) or course(s) within one (1) year of the effective date of the Decision is a violation of this agreement and shall be deemed an act of unprofessional conduct and a separate and distinct basis for discipline, in addition to any other action that may be taken based on Respondent's failure to successfully complete the educational program(s) or course(s).

3. MEDICAL RECORD KEEPING COURSE.

Within sixty (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 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within ten (10) months 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.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the medical record keeping course.

Failure to successfully complete the medical record keeping course within one (1) year of the effective date of the Decision is a violation of this agreement and shall be deemed an act of unprofessional conduct and a separate and distinct basis for discipline, in addition to any other action that may be taken based on Respondent's failure to successfully complete the medical record keeping course.

A medical record keeping course taken after the acts that gave rise to the charges contained in the First Amended 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.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE).

Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program that meets the requirements of Title 16, California Code of Regulations, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and complete the longitudinal component of the program within ten (10) months of enrollment.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the professionalism program.

Failure to successfully complete the professionalism program within one (1) year of the effective date of the Decision is a violation of this agreement and shall be deemed an act of unprofessional conduct and a separate and distinct basis for discipline, in addition to any other action that may be taken based on Respondent's failure to successfully complete the professionalism program.

A professionalism program taken after the acts that gave rise to the charges in the First Amended 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 program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

5. INVESTIGATION/ENFORCEMENT COST RECOVERY.

Respondent is hereby ordered to reimburse the Board its costs of enforcement, including legal review and expert review, as applicable, in the amount of $1,760 (one thousand seven hundred sixty dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of this agreement and shall be deemed an act of unprofessional conduct and a separate and distinct basis for discipline.

Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board.

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).

6. FAILURE TO COMPLY.

Any failure by Respondent to comply with the terms and conditions of the Disciplinary Order set forth above shall constitute unprofessional conduct and grounds for further disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Dennis R. Thelen, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 44591. 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: 2-9-22

MANBIR SINGH, M.D.
Respondent

I have read and fully discussed with Respondent Manbir Singh, 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: 2-9-22

DENNIS R. THELEN, ESQ.
Attorney for Respondent

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ENDORSEMENT

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

DATED: February 9, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

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Doc.No.83259200

Exhibit A

First Amended Accusation No. 800-2018-042148

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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In the Matter of the First Amended Accusation Against: **MANBIR SINGH, M.D.** **733 3rd Street** **McFarland, CA 93250-1008** **Physician's and Surgeon's Certificate No. A 44591,** Respondent.	Case No. 800-2018-042148 OAH No. 2021060190 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about March 21, 1988, the Board issued Physician's and Surgeon's Certificate No. A 44591 to Manbir Singh, 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 November 30, 2023, unless renewed.

JURISDICTION

3. This First Amended Accusation which supersedes Accusation No. 800-2018-042148, filed on March 1, 2021, in the above-entitled matter, 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.

STATUTORY PROVISIONS

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. 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 constituted repeated negligent acts.

...

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

7. 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.

COST RECOVERY

8. Section 125.3 of the Code states:

(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.

PERTINENT DRUG INFORMATION

9. Opioids are Schedule II controlled substances pursuant to Health and Safety Code section 11055, and are a dangerous drug pursuant to Business and Professions Code section 4022. The DEA has identified opioids as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at pp. 38-39.)

(a) Morphine Sulfate Extended Release is an opioid used to treat the symptoms of acute pain and chronic severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. According to the black box warning, Morphine Sulfate Extended Release tablets are not indicated as an "as needed" (prn) analgesic.

(b) Norco is an opioid used for the management of moderate to severe pain. Norco is a brand name for hydrocodone-acetaminophen.

10. Benzodiazepines are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, and are a dangerous drug pursuant to Business and Professions Code section 4022. The risk of respiratory depression, drug overdose, and death is increased with the concomitant use of benzodiazepines and opioids. The Drug Enforcement Administration (DEA) has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

(a) Ativan is a benzodiazepine used for the treatment of anxiety and insomnia. Ativan is a brand name for lorazepam.

(b) Restoril is a benzodiazepine used for the short-term treatment (7-10 days) of insomnia. Restoril is a brand name for temazepam.

(c) Valium is a benzodiazepine used for the treatment of anxiety, alcohol withdrawal symptoms, or muscle spasms and stiffness. Valium is a brand name for diazepam.

(d) Xanax is a benzodiazepine used for the short-term treatment (4-6 weeks) of severe anxiety, panic attacks, or muscle spasms when other modalities have failed. Xanax is a brand name for alprazolam.

11. Soma, a muscle relaxant, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Soma is a brand name for carisoprodol. When properly prescribed and indicated, it is used for the short-term treatment of acute and painful musculoskeletal conditions. Soma is commonly used by those who abuse opioids to potentiate the euphoric effect of opioids, to create a better "high."

PERTINENT CASE INFORMATION

12. Respondent, at all times relevant to the charges and allegations brought in First Amended Accusation No. 800-2018-042148, owned McFarland Singh Medical Clinic (MSMC), and also employed a physician assistant (PA) and an advanced practice registered nurse at MSMC. Respondent is the sole owner of MSMC, and he operates the clinic as a solo practice and is the only physician practicing there. Respondent has no specialty training in the field of Pain Medicine.

13. On May 11, 2020, Respondent, with his attorney present, was interviewed by a Division of Investigation investigator and a district medical consultant working on behalf of the Board. During the interview, Respondent answered a number of general background questions, including questions asked about supervising physician assistants, and delegation of services agreements (DSA) with those he supervised at MSMC. Respondent also answered questions about specific patients seen by him and other providers whom he supervised, which are relevant to the charges and allegations brought in First Amended Accusation No. 800-2018-042148. Respondent stated that he was not currently board-certified. He explained that he was previously

board certified with the American Board of Internal Medicine, but that he did not take the recertification exam after 2005.

14. The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent has subjected his Physician's and Surgeon's Certificate No. A 44591 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patients A, B, and C,[1] as more particularly alleged hereinafter:

16. **Patient A**

(a) Between in or around April 2016 and in or around March 2018, Patient A treated with Respondent at MSMC. During that timeframe, Respondent saw Patient A for a number of medical issues including, low back pain and knee pain.

(b) On or about April 12, 2016, Patient A, a then-52-year-old male, presented at Respondent's clinic for medication refills and complained of low back pain, according to the progress note for the visit. The medications documented

[1] To protect the privacy of the patients involved in this matter, patient names have not been included in this pleading. Respondent is aware of the identities of Patients A, B, C, and D.

under plan in the note were morphine sulfate extended release (100 mg) ("q6 hrs prn prescription")[2] and Soma (350 mg) ("q6 hrs prn prescription"). However, a notation in the note indicated that both of these two medications were "not prescribed" at this visit.[3] Notably, on the same date of the visit, CURES showed that Patient A had filled both prescriptions and they had been issued by Respondent.

(c) Between in or around April 2016, through in or around March 2018, Respondent charted approximately fifty (50) clinical visits with Patient A at MSMC. During this timeframe of approximately two (2) years, Respondent consistently prescribed morphine sulfate extended release (100 mg) with directions to be taken on an "as needed" basis by Patient A.

(d) During the subject interview held on May 11, 2020, Respondent answered specific questions regarding the care and treatment he had provided to Patient A. When Respondent was asked why he had prescribed extended release morphine on an "as needed" (prn) basis, Respondent replied, "[b]ecause I didn't want him to take it routinely. Unless he has pain, do not take it. So I always insisted him to take it only if you need it." When Respondent was asked whether he was concerned about the potency of extended release morphine being prescribed for intermittent use by Patient A, Respondent replied, "Looking at the severity of his pain ... he was always in pain and that's the only way he felt better. So I felt to monitor him closely and ... at the same time not to use it routinely."

17. Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to, the following:

(a) Respondent improperly prescribed morphine sulfate extended release (100 mg) to Patient A with directions to be taken on an "as needed" basis.

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[2] Prescription to be taken every 6 hours (q6 hrs), or as needed (prn).

[3] The same notation is repeated in every progress note for Patient A between 2016 and 2018. Furthermore, CURES showed that Respondent issued those prescriptions and that Patient A filled them on or near dates of his scheduled clinical visits at MSMC.

18. **Patient B**

(a) Between in or around June 2016 and in or around February 2018, Patient B treated with Respondent at MSMC. During that timeframe, Respondent saw Patient B for a number of medical issues including, pain, panic disorder, anxiety, insomnia, diabetes mellitus, and high blood pressure.

(b) On or about Jun 20, 2016, Patient B, a then-66-year-old female, presented for medication refills at MSMC. Respondent issued prescriptions for Norco and Xanax to Patient B, according to the progress note for the visit. A cursory physical examination was performed, but the progress note does not contain any relevant information regarding history of pain, subjective pain levels, or conditions for which controlled substances were being prescribed. Under plan, the note refers to ordering x-rays of the elbows and cervical spine. The progress note does not document whether informed consent was obtained, in light of the concurrent prescriptions for combined use of an opioid and a benzodiazepine. Finally, the progress note does not document any information about consultations or referrals to a specialist for Patient B's chronic pain issues.

(c) On or about July 5, 2016, Patient B returned to MSMC for medication refill and to discuss x-ray results. Respondent noted that the x-ray results were "discussed with patient, patient understood and accepted," according to the progress note for this visit. However, no further information was documented about the x-rays, nor any information about a plan and objectives for treatment of Patient B's chronic pain. Again, a cursory physical examination was performed, but the progress note does not contain any relevant information regarding history of pain, subjective pain levels, or conditions for which controlled substances were being prescribed. Respondent refilled Patient B's prescriptions for Norco and Xanax at this visit.

(d) On or about September 13, 2016, Patient B returned to MSMC for medication refill and complaints of cold congestion. Consistent with prior clinical

visits, a cursory physical examination was performed, but the progress note does not contain any relevant information regarding history of pain, subjective pain levels, or conditions for which controlled substances were being prescribed. Respondent refilled Patient B's prescriptions for Norco and Xanax at this visit, and also added a prescription for promethazine-codeine oral syrup for her cough.[4]

(e) Between in or around June 2016, through in or around February 2018, Respondent charted approximately fifty (50) clinical visits with Patient B at MSMC. Significantly, the progress notes rarely document any substantial history of pain or contain any relevant physical examination of conditions for which controlled substances were being prescribed. The progress notes also lack clear objectives regarding symptom control, and there is no periodic review of the treatment plan, other than refilling medications. Respondent consistently refilled Patient B's prescriptions for Norco and Xanax on a monthly basis during this time-frame. The progress notes fail to adequately document whether informed consent was obtained, in light of the concurrent prescriptions for combined use of an opioid, a benzodiazepine, and a sedative.[5] Finally, the progress notes do not document any information about consultations or referrals to a specialist for Patient B's chronic medical issues

(f) During the subject interview held on May 11, 2020, Respondent answered specific questions regarding the care and treatment he had provided to Patient B. When asked whether he was concerned about the effects of sedation with the combined use of Norco, Xanax, and the promethazine with codeine, Respondent replied, "Oh yes. We had ... several conversations in this regard." When asked about Patient B's refusal to reduce her pain medication in 2016,

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[4] Respondent prescribed promethazine-codeine oral syrup to Patient B for a six-month period (August 2017–January 2018), but did not document an explanation for prescribing "as needed" (prn) controlled medicine for a chronic/recurring symptom.

[5] Respondent prescribed Soma to Patient B from June 2017 through February 2018.

Respondent admitted that he had "several discussion" with the patient and that he had tried to decrease the Xanax many times. When asked if he had considered giving her a tapering prescription, Respondent replied, "Yes. I have ... told her to try to take it two times rather than three times ... but she was not happy. And ... my part was to keep on trying."

19. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to, the following:

(a) Respondent failed to appropriately prescribe controlled substances to Patient B due to a consistent failure to adequately document in the progress notes the necessary information for the prescribing of controlled substances.

20. **Patient C**

(a) Between in or around April 2012 and in or around December 2012, Patient C treated with PA C.L.[6] at MSMC for a number of medical issues including, hip pain, neck pain, back pain, insomnia, and Dercum's disease.

(b) On or about April 3, 2012, Patient C, a then-63-year-old male, presented for medication refills at MSMC. PA C.L. issued prescriptions for Norco, Restoril, Valium, and Soma to Patient C, according to the progress note for the visit. The progress note does not contain any medical history beyond a scant reference to "[patient] states his condition is stabilizing" and "[patient] now able to sleep." The progress note does not contain any information or data of a physical examination beyond "V.S. – STABLE."[7] The progress note does not document a treatment plan other than the refill of controlled pain medications and return to clinic in four (4) weeks. The progress note does not document whether informed consent was

[6] During the subject interview held on May 11, 2020, PA C.L. was mistakenly referred to as "Walter Lee" by Respondent.

[7] Under the physical examination section of the progress note, the only information recorded is an "x" under "WNL" (i.e., "within normal limits.") No further information or data is provided in the note.

obtained, in light of the concurrent prescriptions for combined use of an opioid, multiple benzodiazepines, and a sedative. Finally, the progress note does not document any information about consultations or referrals to a specialist for Patient C's chronic medical issues.

(c) In 2012, PA C.L. charted approximately eleven (11) more clinical visits with Patient C: on or about April 26, May 22, June 14, June 19, July 12, July 17, August 14, September 11, October 11, November 8, and December 6. Significantly, PA C.L. did not adequately document Patient C's progress notes for these clinical visits including, but not limited to: did not adequately document patient history; did not adequately document performance of a physical examination except for scant notations; did not document treatment plan, clear objectives, or periodic review of treatment plan; did not document informed consent; and did not document any information about consultations or referrals to a specialist for Patient C's chronic medical issues.

(d) Between in or around April 2012 and in or around December 2012, PA C.L. routinely refilled Patient C's prescriptions for opioids, benzodiazepines, and other controlled substances, according to the progress notes of the visits. Significantly, however, all of those prescriptions were actually issued by Respondent, according to CURES.

(e) On or about March 28, 2011, PA C.L. signed a DSA in connection with his employment at MSMC.[8] The DSA documented that Respondent would be PA C.L.'s supervising physician and it memorialized standard procedures under the agreement. The DSA enumerated Respondent's responsibilities and also emphasized specific conditions regarding the prescribing of controlled substances at MSMC. Under the DSA, Respondent "shall review, audit and countersign every medical record written" by PA C.L. within twenty-nine (29) days of the patient

[8] As of May 11, 2020, PA C.L. remained employed by Respondent as a physician assistant.

encounter. Furthermore, Respondent "shall review, countersign, and date the medical record of any patient for whom PA issues or carries out a drug order for a Schedule II Controlled Substance within seven (7) days." Significantly, however, Respondent did not co-sign and date any of the progress notes and/or medical records for Patient C during this timeframe.

(f) During the subject interview held on May 11, 2020, Respondent answered specific questions regarding the care and treatment PA C.L. had provided to Patient C. Respondent admitted that he did not "co-sign" any of PA C.L.'s progress notes for Patient C.

21. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, the following:

(a) Respondent did not appropriately prescribe controlled substances to Patient C, wherein he failed to comply with the procedures and requirements under the DSA, including but not limited to: failing to review, countersign, and date progress notes wherein PA C.L. had prescribed a Schedule II Controlled Substance to Patient C; and reviewing the quality of Patient C's medical records written by PA C.L.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

22. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 44591 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, and D, as more particularly alleged hereinafter:

23. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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(b) Between in or around April 2016 through in or around March 2018, Respondent charted approximately fifty (50) clinical visits with Patient A at MSMC. During this timeframe of approximately two (2) years, Respondent did not appropriately prescribe controlled substances to Patient A due to a consistent failure to adequately document in the progress notes the necessary information for the prescribing of controlled substances, including, but not limited to: missing adequate history explaining history of pain or investigation into cause behind recent injuries; missing or only scant notations regarding physical examinations and level of pain; missing clear objectives regarding pain control; missing periodic review of the treatment plan; and referrals from specialists are not clearly incorporated into a pain management plan for Patient A.

(c) On or about March 13, 2018, according to the progress note for this clinical visit, Respondent advised Patient A that he would "no longer be giving him pain medication" and that he would refer Patient A to pain management for his pain medication. However, Respondent did not discuss (or document discussing) with Patient A what the immediate plan should be to wean him off of his pain medication and/or arrange for another provider to take over prescribing before Patient A runs out of pain medication.

24. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

(b) On or about July 31, 2017, Patient B returned to MSMC for a lab report review of her recent lab tests. Respondent only documented a scant notation regarding the glucose and A1C lab levels in the progress note for this visit. Notably, however, Respondent did not document any information in the note regarding the lab results of Patient A's CBC showing leukopenia and thrombocytopenia. Progress notes showed that Patient B had been diagnosed with thrombocytopenia, leukopenia, and a positive rheumatoid screening test. However,

there was no clear documentation of an interpretation nor plan regarding these lab results in the progress notes.

25. **Patient D**

(a) Between in or around December 2016 through in or around April 2019, Respondent charted approximately fifty (50) clinical visits with Patient D at MSMC primarily for complaints of pain. During this timeframe of approximately two (2) years and five (5) months, Respondent did not appropriately prescribe controlled substances to Patient D due to a consistent failure to adequately document in the progress notes the necessary information for the prescribing of controlled substances, including, but not limited to: missing adequate history explaining history of pain or investigation into cause behind symptoms attributed to anxiety; missing or only scant notations regarding physical examinations and level of pain; missing clear objectives regarding pain control; missing periodic review of the treatment plan; missing clear documentation about informed consent; and referrals from specialists are not clearly incorporated into a pain management plan for Patient D; Respondent continued prescribing Ativan to Patient D even after care had been transferred to another physician.

26. Respondent committed repeated negligent acts in his care and treatment of Patients A, B, and D, including, but not limited to, the following:

(a) Respondent failed to appropriately prescribe controlled substances to Patient A due to a consistent failure to adequately document in the progress notes the necessary information for the prescribing of controlled substances;

(b) Respondent failed to properly end his controlled substance prescribing relationship with Patient A;

(c) Respondent failed to appropriately follow up regarding abnormal lab results for Patient B; and

(d) Respondent failed to appropriately prescribe controlled substances to Patient D due to a consistent failure to adequately document in the

progress notes the necessary information for the prescribing of controlled substances.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

27. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 44591 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients A, B, C, and D, as more particularly alleged in paragraphs 15 through 26, above, which are hereby incorporated by reference and realleged as if fully set forth herein:

28. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

29. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

30. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

31. **Patient D**

(a) Paragraphs 25 and 26, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

32. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 44591 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which

demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 15 through 31, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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 No. A 44591, issued to Respondent Manbir Singh, M.D.;

2. Revoking, suspending or denying approval of Respondent Manbir Singh, M.D.'s authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Manbir Singh, 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 24 2022

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

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