

**IN AND BEFORE THE OKLAHOMA STATE BOARD  
OF MEDICAL LICENSURE AND SUPERVISION  
STATE OF OKLAHOMA**

**FILED**

**STATE OF OKLAHOMA** )  
**EX REL. THE OKLAHOMA BOARD** )  
**OF MEDICAL LICENSURE** )  
**AND SUPERVISION,** )

APR 01 2011

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Plaintiff,** )

**v.** )

**Case No. 10-09-4088**

**PAUL LYNN FIRTH, M.D.,** )  
**LICENSE NO. 19610,** )

**Defendant.** )

**COMPLAINT**

COMES NOW the Plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Elizabeth A. Scott, Assistant Attorney General, and for its Complaint against the Defendant, Paul Lynn Firth, M.D., alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq.*

2. Defendant, Paul Lynn Firth, M.D., holds Oklahoma license no. 19610 and at the time of the incidents in question, practiced as a pediatrician in Elk City, Oklahoma and Clinton, Oklahoma.

**PRESCRIPTION VIOLATIONS-ELK CITY CLINIC**

3. In and around 2010, Defendant worked at his Elk City clinic ½ day Monday and Wednesday, and all day Tuesday, Thursday and Friday. He employed two (2) Nurse Practitioners to work at the Elk City clinic four (4) days per week.

4. In September 2010, Board Investigators received information that Defendant was leaving blank pre-signed prescriptions in an unlocked drawer for use by his employees. When questioned by Board Investigators, Defendant admitted that he does leave pre-signed prescriptions in his office for the use of his Nurse Practitioners so that they could write a prescription for a Schedule II controlled dangerous substance if Defendant was not present in the clinic.

5. Under the Oklahoma Nursing Practice Act, Nurse Practitioners with prescriptive authority are **not allowed** to prescribe Schedule II controlled dangerous substances.

6. When Board Investigators interviewed Defendant at his office, they found two (2) separate prescription pads, one (1) with twenty (20) pre-signed blank prescriptions and one (1) with twenty-seven (27) pre-signed blank prescriptions. These pre-signed prescriptions were found in an unlocked drawer in the common area of the clinic.

7. Defendant admitted to Board Investigators that he was aware that some of the pre-signed prescriptions had been issued by his staff without his authorization.

8. Title 21 CFR §1306.05 provides as follows:

**Manner of issuance of prescriptions.**

(a) All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use, and the name, address and registration number of the practitioner.

**PRESCRIPTION VIOLATIONS-CLINTON CLINIC**

9. In or around 2010, Defendant worked at his Clinton clinic ½ day on Monday and ½ day on Wednesday. He employed a Physician Assistant, Jeremy Lamb, to work at the Clinton clinic. PA Lamb worked at the Clinton clinic without any supervision on Tuesdays, Thursdays and Fridays and at the Elk City clinic on Mondays and Wednesdays. PA Lamb was initially licensed on April 1, 2010 and had only been practicing as a Physician Assistant five (5) months when he began working at the Clinton clinic by himself.

10. Board Investigators interviewed PA Lamb at the Clinton clinic the same day they interviewed Defendant at the Elk City clinic. When questioned as to whether or not PA Lamb utilized prescriptions pre-signed by Defendant, PA Lamb admitted that he had issued prescriptions to patients that had been pre-signed by Defendant. PA Lamb additionally admitted that Defendant had called him earlier that day and told him to shred all of the pre-signed prescriptions on site.

11. PA Lamb admitted that he had shredded approximately thirty (30) pre-signed prescriptions at Defendant's request. PA Lamb additionally admitted that the pre-signed prescriptions had been kept in an unlocked drawer in a desk.

12. When questioned about the use of the pre-signed prescriptions, PA Lamb admitted that he had prescribed Schedule II controlled dangerous substances on the pre-signed prescriptions both with and without Defendant's prior knowledge.

13. With respect to new patients who came in on days PA Lamb was practicing by himself, he admitted that he would actually see the new patient then discuss his assessment with Defendant by telephone. Defendant would not physically see the patient but would in some instances authorize a Schedule II controlled dangerous substance to be prescribed to the patient. PA Lamb would then fill out the pre-signed prescription left by Defendant for the Schedule II controlled dangerous substance and give it to the patient.

14. Defendant admitted that he does leave pre-signed prescriptions in his office for the use of his Physician Assistant so that his PA could write a prescription for a Schedule II controlled dangerous substance if Defendant was not present in the clinic.

15. Under the Oklahoma Physician Assistant Practice Act, Physician Assistants are **not allowed** to prescribe Schedule II controlled dangerous substances in an outpatient setting.

16. Oklahoma Administrative Code Section 435:15-5-11 (b) provides as follows as it relates to violations of the Physician Assistant laws on unprofessional conduct:

(b) A physician who knowingly allows or participates with a physician assistant who is in violation of the above will be prohibited from supervising physician assistants for so long as the Board deems appropriate.

### **NARCOTICS LAWS VIOLATIONS**

17. On or about October 7, 2010, Board Investigators subpoenaed nine (9) patient charts of minor children being treated in Defendant's clinics. A review of pharmacy records reflects that of these nine (9) patients, four (4) received prescriptions for Schedule II controlled dangerous substances which were not documented in the patient charts as follows:

- a. Patient ABL                    12/22/09.....Concerta 36 mg #30  
    05/19/10.....Concerta 54 mg #20
- b. Patient EHL                    08/11/10.....Focalin #30
- c. Patient AWL                    02/03/10.....Daytrana Patch #30  
    05/27/10.....Daytrana Patch #30
- d. Patient WSL                    12/11/09.....Vyvanase 30mg #30  
    12/11/09.....Vyvanase 50mg #30  
    02/11/10.....Vyvanase 30mg #30  
    08/04/10.....Focalin #14

18. Defendant is guilty of unprofessional conduct in that he:
- A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public in violation of 59 O.S. §509(8) and OAC 435:10-7-4(11).
  - B. Committed any act which is a violation of the criminal laws of any state when such act is connected with the physician's practice of medicine in violation of 59 O.S. §509(9).
  - C. Confessed to a crime involving violation of the antinarcotic or prohibition laws and regulations of the federal government or the laws of this state in violation of 59 O.S. §509(7).
  - D. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509 (12).
  - E. Failed to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act, including but not limited to an initial in-person patient examination. Adequate medical records to support diagnosis, procedure, treatment or prescribed medications must be produced and maintained. 59 O.S. §509 (20) and OAC 435:10-7-4(36).
  - F. Failed to establish a physician/patient relationship prior to providing patient-specific medical services, care or treatment in violation of OAC 435:10-7-4(49).
  - G. Violated any state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27).
  - H. Aided or abetted, directly or indirectly, the practice of medicine by any person not duly authorized under the laws of this state in violation of 59 O.S. §509(14) and OAC 435:10-7-4(21).
  - I. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509(18) and OAC 435:10-7-4(41).

- J. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509(13) and OAC 435:10-7-4(39).

***Conclusion***

WHEREFORE, the Plaintiff respectfully requests that the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,



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