State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

July 8, 2009

Patsy Nerissa Firth, M.D.
104 Driftwood Court
Joppa, MD 21085

RE: 09-CRF-057

Dear Dr. Firth:

Please find enclosed a certified copy of the Findings, Order and Journal Entry approved and confirmed by the State Medical Board meeting in regular session on July 8, 2009.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

Very truly yours,

Lance A. Talmage MD

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL RECEIPT NO. 91 7108 2133 3934 3683 6569
RETURN RECEIPT REQUESTED

Mailed 7-9-09

Jessica L. Davis, Esq.
Roetzel & Andress
155 East Broad Street
12th Floor
Columbus, OH 43215

CERTIFIED MAIL RECEIPT NO. 91 7108 2133 3934 3683 6576
RETURN RECEIPT REQUESTED

CERTIFICATION

I hereby certify that the attached copy of the Findings, Order and Journal Entry approved by the State Medical Board, meeting in regular session on July 8, 2009, constitutes a true and complete copy of the Findings, Order and Journal Entry in the Matter of Patsy Nerissa Firth, M.D., Case No. 09-CRF-057, as it appears in the Journal of the State Medical Board of Ohio.

This Certification is made by the authority of the State Medical Board of Ohio in its behalf.

Lance A. Talmage, M.D.
Secretary

(SEAL)

July 8, 2009
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 09-CRF-057
PATSY NERISSA FIRTH, M.D.	*	

FINDINGS, ORDER AND JOURNAL ENTRY

By letter dated May 13, 2009, notice was given to Patsy Nerissa Firth, M.D., that the State Medical Board intended to consider disciplinary action regarding her license to practice medicine and surgery in the State of Ohio, and that she was entitled to a hearing if such hearing was requested within thirty (30) days of the mailing of said notice. In accordance with Section 119.07, Ohio Revised Code, said notice was sent via certified mail, return receipt requested, to the address of record of Dr. Firth, that being 104 Driftwood Court, Joppa, Maryland 21085.

A certified mail receipt was returned to the Medical Board offices documenting proper service of the notice. Dr. Firth requested a hearing on June 17, 2009; however, such request was not received within thirty (30) days of the mailing of the notice as is required by Section 119.07, Ohio Revised Code.

WHEREFORE, having reviewed the May 13, 2009, Notice of Opportunity for Hearing, including the Maryland Board of Physicians Consent Order in the matter of Patsy Firth, M.D., Case Number 2006-0016, as well as the affidavit of Debra L. Jones, Continuing Medical Education and Renewal Officer, which are attached hereto and incorporated herein, the Board hereby finds that:

> On or about October 22, 2008, the Maryland Board of Physicians issued a Consent Order, whereby Patsy Nerissa Firth, M.D., was reprimanded, her license was placed on probation for two years, and she was required to be subject to chart review and/or peer review. The Maryland Board of Physicians based its action against Dr. Firth on conclusions that she failed to meet the standard of quality medical care and failed to maintain adequate medical records as required under the Maryland Medical Practices Act.

Further, the Board hereby concludes that:

1. Section 4731.22(B)(22), Ohio Revised Code, authorizes the State Medical Board of Ohio to refuse to issue a license or to discipline a licensee following an action

taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees.

2. Dr. Firth has been subject to a disciplinary action in the state of Maryland, as described above.

Accordingly, the Board hereby ORDERS that:

A. **SUSPENSION, STAYED; PROBATION.** The certificate of Patsy Nerissa Firth, M.D., to practice medicine and surgery in the State of Ohio is hereby SUSPENDED for a period of 180 days. Such suspension is STAYED, subject to PROBATIONARY terms, conditions, and limitations as follows for a period of at least two years.

1. **Obey the Law**: Dr. Firth shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in the state in which she is practicing.

2. **Personal Appearances**: Dr. Firth shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective or as otherwise ordered by the Board. Dr. Firth shall also appear upon her request for termination of the probationary period, and/or as otherwise requested by the Board.

3. **Quarterly Declarations**: Dr. Firth shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent declarations must be received in the Board's offices on or before the first day of every third month.

4. **Medical Records Course**: Within one year of the effective date of this Order, Dr. Firth shall provide acceptable documentation of satisfactory completion of a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Firth submits the documentation of successful completion of the course or courses on maintaining adequate and appropriate medical records she shall also submit to the Board a written report describing the course, setting forth what she learned from the course, and identifying

with specificity how she will apply what she has learned to her practice of medicine in the future.

5. **Practice Plan**: Prior to Dr. Firth's commencement of practice in Ohio, or as otherwise determined by the Board, Dr. Firth shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Firth's activities will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Firth shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

   At the time Dr. Firth submits her practice plan, she shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary or Supervising Member will give preference to a physician who practices in the same locale as Dr. Firth and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Firth and her medical practice, and shall review Dr. Firth's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Firth and her medical practice, and on the review of Dr. Firth's patient charts. Dr. Firth shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Firth's quarterly declaration.

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Firth must immediately so notify the Board in writing. In addition, Dr. Firth shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Firth shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

6. **Violation of Terms of Probation**: If Dr. Firth violates probation in any respect, the Board, after giving her notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of her certificate.

B. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Firth's certificate will be fully restored.

C. **REQUIRED REPORTING AND DOCUMENTATION OF REPORTING**

1. **Required Reporting To Employers and Others**: Within 30 days of the effective date of this Order, or as otherwise determined by the Board, Dr. Firth shall provide a copy of this Order to all employers or entities with which she is under contract to provide health-care services (including but not limited to third-party payors) or is receiving training, and the Chief of Staff at each hospital or health-care center where she has privileges or appointments.

   Further, Dr. Firth shall provide a copy of this Order to all employers or entities with which she contracts in the future to provide health-care services, or applies for or receives training, and the Chief of Staff at each hospital or health-care center where she applies for or obtains privileges or appointments. This requirement shall continue until Dr. Firth receives from the Board written notification of her successful completion of probation as set forth in section B above.

2. **Required Reporting To Emergency Medical Services Organization or Provider**:
   In the event that Dr. Firth provides any health-care services or health-care direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, Dr. Firth shall provide, within 30 days or as otherwise determined by the Board, a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

3. **Required Reporting To Other Licensing Authorities**: Within 30 days of the effective date of this Order, or as otherwise determined by the Board, Dr. Firth shall provide a copy of this Order to the proper licensing authority of any State or jurisdiction in which she currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which she currently holds any license or certificate.

   When Dr. Firth applies for any professional license or reinstatement/restoration of any professional license in any State or jurisdiction, she shall provide a copy of this Order to the proper licensing authority of that State or jurisdiction at the time of application. This requirement shall continue until Dr. Firth receives from the Board written notification of her successful completion of probation as set forth in section B, above.

4. **Documentation that the Required Reporting Has Been Performed**: Further, Dr. Firth shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each notification required above: (1) the return receipt of certified mail within 30 days of

receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.

This Order is hereby entered upon the Journal of the State Medical Board of Ohio for the 8th day of July 2009 and the original thereof shall be kept with said Journal.

Lance A. Talmage, M.D.
Secretary

(SEAL)

July 8, 2009
Date

AFFIDAVIT

The State of Ohio
Franklin County, SS

I, Debra L. Jones, being duly cautioned and sworn, do hereby depose and say that:

1) I am employed by the State Medical Board of Ohio (hereinafter, "The Board")

2) I serve the Board in the position of Continuing Medical Education and Renewal Officer.

3) In such position I am the responsible custodian of all public licensee records maintained by the Board pertaining to individuals who have received certificates issued pursuant to Chapter 4731., Ohio Revised Code;

4) I have this day carefully examined the records of the Board pertaining to Patsy Nerissa Firth, M.D.

5) Based on my examination, I have found the last known address of record of Dr. Firth to be:

104 Driftwood Court
Joppa, MD 21085

6) Further, Affiant Sayeth Naught.

Debra L. Jones
Continuing Medical Education and Renewal Officer

Sworn to and signed before me, Barbara A. Jacobs, Notary Public, this 18th day of June, 2009.

Notary Public

BARBARA ANN JACOBS, ATTORNEY AT LAW
NOTARY PUBLIC, STATE OF OHIO
My commission has no expiration date.
Section 147.03 R.C.

AFFIDAVIT

The State of Ohio
Franklin County, SS

I, Barbara A. Jacobs, being duly cautioned and sworn, do hereby depose and state that the following is true based upon my first-hand knowledge:

1) I am employed by the State Medical Board of Ohio (hereinafter, "The Board").

2) I serve the Board in the position of Public Services Administrator.

3) In the course of my regular duties, I am responsible for seeing that all procedural requirements of Chapter 119., Ohio Revised Code, regarding service of any notice issued by the Board are met.

4) According to the Board's records, the Board issued a Notice of Opportunity for Hearing to Patsy Nerissa Firth, M.D., on May 13, 2009. Such notice was mailed by certified mail, return receipt requested, to Dr. Firth's address of record.

5) A certified mail receipt was received by the Board, documenting service of the May 13, 2009, notice upon Dr. Firth.

6) Pursuant to Section 119.07, Ohio Revised Code, Dr. Firth had until the close of business on June 15, 2009, to submit a written hearing request to the Board.

7) On June 17, 2009, the Board received a written hearing requested from Dr. Firth. Such request was not timely pursuant to Section 119.07, Ohio Revised Code.

8) Attached hereto and incorporated herein are certified copies of the May 13, 2009, Notice of Opportunity for Hearing, with certified mail receipts.

9) Further, Affiant Sayeth Naught.

Barbara A. Jacobs
Public Services Administrator

Sworn to and signed before me, Angela D. Fields, Notary Public, this 18th day of June, 2009.

NOTARIAL SEAL STATE OF OHIO

ANGELA D. FIELDS
NOTARY PUBLIC, STATE OF OHIO
MY COMMISSION EXPIRES 05/16/11

Notary Public

Track & Confirm

Search Results

Label/Receipt Number: 9171 0821 3339 3631 2541 68
Class: First-Class Mail®
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Your item was delivered at 10:23 AM on May 18, 2009 in JOPPA, MD 21085.

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Detailed Results:

- Delivered, May 18, 2009, 10:23 am, JOPPA, MD 21085
- Arrival at Pick-Up-Point, May 16, 2009, 5:25 pm, JOPPA, MD 21085
- Notice Left, May 16, 2009, 3:20 pm, JOPPA, MD 21085
- Arrival at Unit, May 16, 2009, 8:21 am, JOPPA, MD 21085
- Electronic Shipping Info Received, May 14, 2009

Notification Options

CITE- FIRTH

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UNITED STATES POSTAL SERVICE.

Date: 05/18/2009

Jackie Moore:

The following is in response to your 05/15/2009 request for delivery information on your Certified Mail(TM) item number 7108 2133 3936 3125 4168. The delivery record shows that this item was delivered on 05/18/2009 at 10:23 AM in JOPPA, MD 21085. The scanned image of the recipient information is provided below.

Signature of Recipient:

Delivery Section

JOHN FIRTH

Address of Recipient:

104 DRIFTWOOD CT

Thank you for selecting the Postal Service for your mailing needs. If you require additional assistance, please contact your local Post Office or postal representative.

Sincerely,

United States Postal Service

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

May 13, 2009

Case number: 09-CRF-057

Patsy Nerissa Firth, M.D.
104 Driftwood Court
Joppa, MD 21085

Dear Doctor Firth:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) On or about October 22, 2008, the Maryland Board of Physicians [Maryland Board] issued a Consent Order [Maryland Consent Order], whereby you were reprimanded, placed on probation for two years, and required to be subjected to chart review and/or peer review, after the Maryland Board concluded that you failed to meet the standard of quality medical care and failed to maintain adequate medical records as required under the Maryland Medical Practice Act.

A copy of the Maryland Consent Order is attached hereto and incorporated herein.

The Maryland Consent Order as alleged in paragraph (1) above, constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must

Mailed 5.14.09

be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Lance A. Talmage, M.D.
Secretary

LAT/DSZ/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3936 3125 4168
RETURN RECEIPT REQUESTED

IN THE MATTER OF	*	**BEFORE THE**
PATSY FIRTH, M.D.	*	**MARYLAND BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D39836		**Case Number: 2006-0016**

STATE MEDICAL BOARD
2008 DEC -1 A 11:02

* * * * * * * * * * * *

CONSENT ORDER

On May 8, 2008, the Maryland Board of Physicians (the "Board") charged Patsy Firth, M.D. (the "Respondent") (D.O.B. [redacted]), License Number D39836, with violating the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2005 Repl. Vol. & 2007 Supp.).

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds**
>
> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (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;
>
> (40) Fails to maintain adequate medical records as determined by appropriate peer review.

On August 6, 2008, a conference with regard to this matter was held before the Case Resolution Conference ("CRC"). As a result of negotiations entered into after the CRC, the Respondent agreed to enter into this Consent

Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Respondent was originally licensed to practice medicine in the State of Maryland on April 11, 1990. The Respondent is board-certified in general psychiatry and, as of May 2006, in child and adolescent psychiatry.

2. From October 2002 until June 2005, the Respondent was the Medical Director at the Chesapeake Youth Center ("CYC") in Cambridge, Maryland, during which time CYC was a for-profit residential treatment center ("RTC") providing in-patient and acute out-patient services to adolescents. In or around June 2005, the Respondent resigned her position at CYC. She currently practices psychiatry at Psychiatry Associates, a private practice located in Bel Air, Maryland.

3. On or about July 1, 2005, the Board received a complaint from the grandmother of a former CYC patient of the Respondent, (hereinafter "Patient F."[1] The Complainant alleged that during Patient F's treatment at CYC from February 2003 through December 2003, Patient F had been, *inter alia,* inappropriately secluded, physically restrained and over-medicated. The Complainant stated that she had removed Patient F from CYC because she felt Patient F was being harmed. On August 2, 2005, the Board received written notice from the Director of the Maryland Office

[1] The patients' names are confidential. The Respondent may obtain the names from the Administrative Prosecutor.

of Health Care Quality ("OHCQ") that OHCQ had received a series of complaints about CYC and had conducted on-site investigations there. Appended to the OHCQ notice was a Statement of Deficiencies that detailed violations found during the investigations.[2] Among the deficiencies were those relevant to the Respondent, whom the OHCQ surveyors found was the designated team leader in the treatment team process. The general deficiencies pertaining to the Respondent included:

1. Failure to consistently document residents' treatment plans;
2. Failure to consistently update treatment plans;
3. Failure to consistently document progress notes, even for patients on medications or who manifested severe behavioral symptoms;
4. Failure to sign verbal orders promptly; and
5. Failure to assess patients' medications in a timely manner.

4. The OHCQ surveyors reviewed CYC's documentation policy. The policy requires as the minimum standard that all disciplines must document weekly for the first 2 months of the resident's stay and monthly thereafter. The OHCQ surveyors concluded: "A review of the medical records...revealed that these residents while in a RTC for the purpose of requiring residential psychiatric services are not receiving psychiatric services that meets even the most basic standards for psychiatric care."

[2] Pursuant to Health General Article § 19-308(b)(4), when conducting an inspection of an accredited RTC, OHCQ shall use the current standards of the Joint Commission for Accreditation of Health Care Organizations ("JCAHO").

5. The Board thereafter initiated an investigation and referred 10 resident records, including Patient F's, to the Maryland Psychiatric Society for peer review of the Respondent's care and treatment. Because of the volume of the records, 2 teams each consisting of 1 board-certified psychiatrist and 1 board-certified child psychiatrist, reviewed 5 resident records, for a total of 10 records. The results of the peer review are set forth in the Patient-Specific Allegations section.

6. On June 23, 2006, the Respondent, accompanied by counsel, was interviewed by Board staff. The Respondent stated that in her capacity as Medical Director, she was responsible for supervising CYC therapists and social workers, running the girls' residential center and covering the acute unit. The Respondent reported that because of staffing shortages, she was often the only psychiatrist serving the entire 59-bed residential facility. The Respondent stated that her duties included reviewing resident admission packets, ordering medications and attending interdisciplinary meetings. The Respondent told Board staff that she tried to write progress notes when she saw a resident, but that "because there were so many crises and ...so much going on, there were times when I ran – literally ran from one crisis to the next..." The Respondent acknowledged that, "while it is true that there were a lot of entries that were not in the progress notes, I actually saw these patients. I have kept an entire stack of notebooks where I had all my information about the...residential patient."

7. On December 4 and December 20, 2006, the Respondent, accompanied by counsel, was interviewed by each of the peer review teams. The Respondent's statements were consistent with those she had provided to Board staff. The Respondent described a chaotic anti-therapeutic environment at CYC in which she was constantly dealing with crises. The Respondent reiterated that she had not documented patient charts consistently, but had kept notes for each patient that she did not have time to enter in the patient's chart.

8. On March 21, 2007, the Respondent's husband appeared in person at the offices of OHCQ and spoke to the Assistant Director. During the course of the conversation, the Respondent's husband stated that the Respondent was "innocent" and that she kept extensive notes of all of her patients in notebooks that were then located at their home. He provided to the OHCQ Assistant Director a photograph of what he represented were the Respondent's notebooks of patient notes. The photograph shows a stack of composition notebooks, approximately 1 foot in height (as indicated by the ruler that is placed next to the stack).

General Deficiencies

9. The peer reviewers noted in all 10 records deficiencies that constituted violations of the standard of care for the delivery of quality medical services. The general deficiencies include, but are not limited, to the following:

   a. The Respondent failed to document her patient assessments at

appropriate regular intervals, based on the clinical condition of the patient;

b. The Respondent failed to document appropriate assessments of the patients' mental status and of response to and side effects of medications prescribed; and

c. The Respondent failed to enter documentation in patients' charts in a timely manner.

Patient-Specific Allegations

Patient A

10. Patient A, a female born in 1989, was admitted to CYC in March 2005 with diagnoses of Bipolar Disorder, Alcohol Abuse, Cannabis Abuse and Learning Disabilities. She had a long history of early childhood trauma, multiple hospitalizations and placements and had been previously treated with anti-psychotics, mood stabilizers and anxiolytics.

11. On Patient A's March 2005 CYC Initial/Master Treatment Plan, the Respondent, who is listed as "Medical Director," is designated to perform Patient A's psychopharmacological management.

12. The Respondent's name appears on treatment plan reviews from March 2005 through May 2005. The treatment plan reviews describe Patient A's assaults on staff, a suicide attempt, severe oppositional behaviors and intrusive behaviors.

13. On April 27, 2005, the Respondent met with Patient A to review the events of the previous day when Patient A had written a suicide note. The

Respondent wrote a lengthy progress note regarding this meeting in which she documented her mental status examination of Patient A, Patient A's difficulties with behavioral controls and the current status of her suicidal ideation. The Respondent noted that Patient A would be closely monitored and p.r.n. ("as needed") medications were to be administered. The Respondent did not note the specific medications to be used.

14. On May 6, 2005, the Respondent wrote a lengthy progress note in which she described Patient A's continued uncontrollable, highly agitated behavior. The Respondent documented that a change of specific medications was discussed.

15. On June 20, 2005, the Respondent wrote "late entry" notes for the following dates: "March 2005," "week of 3/15/05," "Treatment team 3/22/05," 4/5/05, 4/12/05 and 5/3/05. The "late entry" notes summarize Patient A's progress and behavioral issues; however, unlike previous notes written by the Respondent, the "late entry" notes do not state that Patient A was seen by the Respondent. The Respondent listed Patient A's medications on the "late entry" notes, but failed to document the presence or absence of Patient A's side effects.

16. The Respondent failed to meet the standard of quality medical care in her treatment of Patient A for reasons including, but not limited to, the following:

    a. The Respondent failed to enter notes in Patient A's chart in a timely manner; her "late entry" notes were posted to Patient A's chart 6 to 8 weeks after the events described in the note; and

b. The Respondent failed to document Patient A's side effects to the medications the Respondent prescribed to her.

Patient B

17. Patient B, a male born in 1990, was admitted to CYC in July 2003 with diagnoses of Mood Disorder Not Otherwise Specified ("NOS") and Attention Deficit Hyperactivity Disorder NOS, borderline IQ, obesity, hypertension and hypercholesterolemia.

18. Patient B was transferred to the Respondent's care effective March 26, 2004.

19. From March 2004 through June 2004, the Respondent is listed on Patient B's monthly Reviews of Treatment Plans as "Psychiatrist."[3]

20. From March 2004 through June 2004, the Respondent signed several Physician Orders including the reviews of medication regimens and authorizations for Patient B to be placed in the Quiet Room for specified time periods to address his agitation and disruptive behavior.

21. During the above period, the Respondent wrote only 1 note in Patient B's chart. The note, dated June 6, 2004, is a brief narrative of an incident on that date during which Patient B attempted to assault staff. The note states that Patient B was taken to the Quiet Room at 8:30 p.m. and was given Benadryl and Ativan p.r.n.. The note does not indicate that the Respondent saw Patient B during or after this incident.

22. The Respondent failed to meet the standard of quality medical care in her treatment of Patient B for reasons including, but not limited to, the

[3] The Respondent is one of several psychiatrists who treated Patient B during his stay at CYC.

following:

a. The Respondent failed to document that she monitored Patient B's medications for efficacy and side effects;

b. The Respondent failed to document that she evaluated Patient B for suicidal or homicidal risk; and

c. The Respondent failed to document that she treated Patient B's medical conditions.

Patient C

23. Patient C, a male born in 1987, was admitted to CYC on December 7, 2004 after a brief stay in the CYC Acute Unit.

24. Patient C's diagnoses upon admission were: Conduct Disorder, Attention Deficit Hyperactivity Disorder and Polysubstance Abuse.

25. The Respondent is listed as the psychiatrist on Patient C's Initial/Master Treatment Plan. Patient C's medications are noted to be: Lithium, Prozac, Risperdal and Vistaril (p.r.n. for anxiety), all at reasonable levels.

26.

27. On December 14, 2004, the Respondent wrote a progress note in Patient C's chart that is unsigned and appears to be incomplete.

28. On December 27, 2004, the Respondent wrote a progress note in Patient C's chart that documents his medications and mental status in an appropriate manner.

29. The Respondent's subsequent progress notes dated January 6, January 21, February 8 and February 21, 2005, document Patient C's Lithium levels and further treatment plans. The Respondent failed, however, to document a mental status examination in these progress notes and failed

to document that she had actually seen Patient C prior to writing these notes.

30. The Respondent is listed as Patient C's psychiatrist on subsequent Review of Treatment Plans dated March 9, 2005, April 6, 2005 and May 4, 2005. On the June 1, 2005 Review of Treatment Plan, the Respondent is listed as Patient C's attending physician; however, she did not sign the Plan.

31. The Respondent failed to meet the standard of quality medical care in her treatment of Patient C for reasons including, but not limited to, her failure to document Patient C's mental status in her progress notes for January and February, 2005.

Patient D

32. Patient D, a male born in 1991, was admitted to CYC on May 11, 2004.

33. Patient D's diagnoses upon admission were: Major Depressive Disorder, ADHD, Oppositional Defiant Disorder and Post-Traumatic Stress Disorder.

34. The Respondent is listed in Patient D's May 11, 2004 Initial/Master Treatment Plan as responsible for his "Medication therapy." The Respondent signed the May 11 Treatment Plan as "Medical Director, Psychiatry;" no other physician signed the Treatment Plan.

35. The Respondent is listed as Patient D's medication manager on the May 26, 2004 Treatment Plan; however, she did not sign the Plan. Instead, another physician signed as "psychiatrist."

36. The Respondent failed to meet the standard of quality medical care in her

treatment of Patient D for reasons including, but not limited to, her failure to document that she had seen Patient D or had reviewed his admission laboratory results from the date of his admission until June 24, 2004, although she is the only physician listed on Patient D's Treatment Plan Reviews.

Patient E

37. Patient E, a male born in 1987, was admitted to CYC on October 5, 2004 with diagnoses of Major Depressive Disorder, Alcohol Abuse and Cannabis Abuse.

38. The Respondent signed Patient E's October 12, 1004 Initial Treatment Plan; however, she failed to document that she conducted a face-to-face psychiatric assessment upon admission.

39. The Respondent did not write a progress note until December 27, 2004 (another psychiatrist entered progress notes on November 23, December 6 and December 7, 2004).

40. In the December 27, 2004 progress note the Respondent failed to document Patient E's mental status or the presence or absence of medication side effects, nor did she document that she had assessed Patient E's depressive symptoms, including suicidal ideation.

41. The Respondent was designated as Patient E's Medication Manager and signed Patient E's Treatment Plan Reviews in January, March, April and May, 2005; however, she failed to enter timely progress notes during these months.

42. The next physician note in Patient E's chart is entered by another physician on June 18, 2005.

43. On September 18, 2005, the Respondent entered a "late entry for the months of March, April and May 2005" in Patient E's chart. These late entries were entered approximately 3 months after both Patient E and the Respondent had left CYC. The notes are summaries of treatment provided by the various treatment team members during those months.

44. The Respondent failed to meet the standard of quality medical care in her treatment of Patient E for reasons including, but not limited to, the following:

    a. The Respondent failed to document adequately her progress note of December 27, 2004; specifically, she failed to note pertinent aspects of Patient E's mental status, as noted above; and

    b. The "late entry note" for March through May 2005 although containing pertinent aspects of Patient E's mental status, was entered by the Respondent 6 months after her assessment.

Patient F

45. Patient F, a female born in 1989, was admitted to CYC for her third admission to that facility on February 13, 2003.

46. The Respondent conducted an evaluation of Patient F upon her admission and noted her diagnoses as: Mood Disorder, NOS; Oppositional Defiant Disorder, r/o Conduct Disorder and Post-Traumatic Stress Disorder, r/o Complicated Bereavement.

47. The Respondent is listed on Patient F's treatment plans as her medication manager and is the only physician on the team. Patient F had been

prescribed Wellbutrin at the time of her admission. During the course of Patient F's treatment, the Respondent prescribed Wellbutrin, Topamax, Seroquel, Thorazine and Strattera.

48. The Respondent documented that she had face-to-face meetings with Patient F at fairly regular intervals through April 15, 2003; however, in the majority of the Respondent's notes after that date she either failed to indicate that she had actually met with the patient, or stated merely that Patient F was discussed at Treatment Team meetings.

49. In a note dated June 4, 2003, the Respondent documented that she saw Patient F on June 3, but failed to document Patient F's mental status on that date.

50. On July 23, 2003, the Respondent documented that she saw Patient F and noted an abbreviated mental status examination and Patient F's reaction to prescribed medication.

51. The Respondent did not document that she met with Patient F from July 24 until the week prior to August 29, 2003; and from the latter date until October 1, 2003.

52. On November 5, 2003, Patient F was discharged from CYC against medical advice to the care of her grandmother.

53. The Respondent failed to meet the standard of quality medical care in her treatment of Patient F for reasons including, but not limited to, the following:

    a. The Respondent failed to document that she had face-to-face contact with Patient F and conduct mental status

examinations for months at a time; and

b. The 'Respondent failed to document Patient F's response to and side effects from medication.

Patient G

54. Patient G, a female born in 1989, was admitted to CYC from CYC's "acute unit" on August 31, 2004 for aggressive behaviors at home and at school. Her diagnoses upon admission included: Mood Disorder, NOS; r/o Bipolar Disorder, NOS; Oppositional Defiant Disorder; Post-Traumatic Stress Disorder; Alcohol Abuse; Cannabis Abuse; Phenylcyclidine Abuse; Sexual Abuse. She had had a past psychiatric hospitalization for drinking hairspray and had been unable to be maintained in a number of group homes prior to admission at CYC.

55. The Respondent is listed on Patient G's treatment plans as her medication manager and is the only physician on the team.

56. The Respondent continued the psychotropic medications that Patient G had been prescribed prior to her admission. Although the Respondent signed monthly orders to renew Patient G's medications and was Patient G's attending physician, the Respondent wrote only 2 notes that indicated that she had face-to-face meetings with Patient G (September 24, 2004 and May 9, 2005).

57. In December 2005, after Patient G had been discharged (in August 2005) and after the Respondent had left CYC, the Respondent made several late entries to Patient G's chart for the months of October, November and December, 2004 and January and February, 2005 which summarize

monthly assessments of Patient G by other treatment team members. There is no indication in the Respondent's notes that she had face-to-face contact with Patient G during these months.

58. Patient G had a number of seclusion episodes for assaultive behavior to staff and self-injurious behavior. The Respondent did not consistently document her observations of the patient or the sequelae of these episodes.

59. The Respondent failed to meet the standard of quality medical care in her treatment of Patient G for reasons including, but not limited to, the following:

    a. the Respondent failed to document that she had face-to-face contact with Patient G for months, even though she prescribed psychotropic medications to Patient G. She failed to assess Patient G's assaultive and self-injurious behavior, response to medications or side effects of medications; and

    b. the Respondent failed to enter documentation in Patient G's chart in a timely manner.

Patient H

60. Patient H, a male born in 1988, was admitted to CYC in January 2005 from a Department of Juvenile Services facility. His diagnoses upon admission included: Depressive Disorder, NOS; r/o Major Depressive Disorder, recurrent, severe with psychotic features; Cannabis Abuse, Alcohol Abuse and Conduct Disorder. Patient H reported ongoing command auditory hallucinations.

61. The Respondent was Patient H's attending psychiatrist from his admission through June 2005, when she left CYC.

62. The Respondent saw Patient H for his admission psychiatric evaluation and continued the psychotropic medications he had been previously prescribed.

63. On February 8, 2005, the Respondent documented that she saw Patient H along with several members of his treatment team. The Respondent reported, *inter alia,* the Patient H was "in overall tenuous control" with continuing auditory command hallucinations being prominent.

64. On February 10, 2005, the Respondent documented that Patient H remained highly psychotic with paranoid ideation.

65. The Respondent wrote her next note in Patient H's chart on May 25, 2005. She once again described Patient H as being in tenuous control and noted that his insight and judgment were severely compromised. The Respondent recommended a change in Patient H's medication.

66. Between February 10 and May 25, 2005, notes in Patient H's chart from other disciplines state he continued to suffer with visual and auditory command hallucinations, paranoia and self-injurious behavior. In April 2005, Patient H eloped from CYC with 3 other residents after assaulting 2 staff members, taking their keys and stealing a staff member's car.

67. The Respondent did not make any entries to Patient H's chart during the period from May 25, 2005 until July 25, 2005. On July 25, 2005, after she had left CYC, she made late entries for March 2, 10, 16, 23, 30 and April 2005. The late entry notes summarize information from interdisciplinary team meetings; none indicate that the Respondent had met personally

with Patient H.

68. The Respondent failed to meet the standard of quality medical care in her treatment of Patient H for reasons including, but not limited to, the following:

a. the Respondent failed to document that she had face-to-face contact with Patient H for months, even though she prescribed psychotropic medications to him. She failed to assess Patient H's assaultive and self-injurious behavior, response to medications or side effects of medications; and

b. the Respondent failed to enter documentation in Patient H's chart in a timely manner.

Patient I

69. Patient I, a female born in 1988, was admitted to CYC in January 2004. She had a history of oppositional and aggressive behaviors, suicidal and homicidal ideation towards family members, and illicit drug use.

70. The Respondent saw Patient I on her admission date and conducted a psychiatric evaluation.

71. The Respondent did not write a progress note in Patient I's chart until February 19, 2004, at which time she documented that she planned to taper Patient I's Risperdal at Patient I's mother's request and eventually discontinue that medication. The Respondent did not document that she actually saw Patient I on February 19, 2004.

72. The Respondent failed to document that she directly monitored Patient I for symptoms or side effects from the tapering of the Risperdal until March 22, 2004.

73. The Respondent's next note, written on April 12, 2004, documents that

Patient I had had multiple seclusions over the previous several days coinciding with the cessation of Risperdal. The Respondent further noted that Patient I appeared to be responding to internal stimuli, although the Respondent did not document that she had face-to-face contact with the patient.

74. On April 14, 2004, the Respondent noted that Patient I was discussed "at length" during the Treatment Team meeting on that date. The Respondent documented that Patient I was clinically unstable, that her condition has "deteriorated tremendously" and that she is "unable to be re-directed." The Respondent noted Patient I's medication regimen and further noted that she will continue to monitor Patient I's response and reassess. The Respondent did not document that she actually saw Patient I.

75. On May 2, 2004, the Respondent wrote a progress note that indicated that she had seen Patient I "earlier." The note included a mental status assessment.

76. The Respondent's next entered a note in Patient I's chart on August 6, 2004. The note does not indicate that she actually saw Patient I on that date, nor is there indication in Patient I's chart that the Respondent or any other psychiatrist had seen her from May 2004 until August 6, 2004.

77. On August 19, 2004, the Respondent wrote a multi-page psychiatric update of Patient I's status in which she noted that Patient I needed to be transferred to a more secure facility for her own safety and that of others.

78. Patient I was later discharged from CYC to another psychiatric treatment facility.

79. The Respondent failed to meet the standard of quality medical care in her treatment of Patient I for reasons including, but not limited to, the following:

> a. the Respondent failed to document that she had face-to-face contact with Patient I for months or to document her mental status, even though she prescribed psychotropic medications to her; and
>
> b. the Respondent failed to directly monitor Patient I for symptoms or side effects during the 6-week period during which she ordered Patient I's Risperdal to be tapered.

Patient J

80. Patient J, a male born in 1989, was admitted to CYC in November 2003 for suicidal behavior.

81. Patient J's chart notes that his care was "transferred to [the Respondent]" effective March 26, 2004. As of July 2004, Patient J's care was transferred to another psychiatrist.

82. The Respondent was identified as Patient J's medication manager on his April, May and June 2004 Treatment Review Plans.

83. From March 26, 2004 through June 2004, the Respondent signed Physician Orders for Patient J that specified medication dosages and changes and authorized behavioral restrictions and restraints.

84. During the time that Patient J was assigned to the Respondent's care, she entered only 1 brief note, dated May 27, 2004, in his chart. The note documented that Patient J was referred to a local hospital emergency

room because of concerns regarding his suicidal ideation, gestures and attempts. The Respondent's note failed to indicate that she had face-to-face contact with Patient J.

85. The Respondent failed to meet the standard of quality care in her treatment of Patient J for reasons including but not limited to her failure to document her meetings with Patient J for the 2 month period from March 26, 2004 through May 26, 2004.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to meet the standard of quality medical care, in violation of H.O. § 14-404(a)(22) and failed to maintain adequate medical records, in violation of H.O. § 14-404(a)(40).

ORDER

Based on foregoing Findings of Fact and Conclusions of Law, it is this 22nd day of October, 2008, by a majority of the quorum of the Board considering this case:

ORDERED that the Respondent's license to practice medicine in the State of Maryland shall be **REPRIMANDED;** and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for 2 years from the effective date of the Consent Order and until she has satisfactorily completed the following term of probation:

> Within 1 year from the date of the Consent Order, the Respondent's practice shall be subject to a chart review and/or peer review at the discretion of the Board;

and it is further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a hearing, may impose any other disciplinary sanctions it deems appropriate, including but not limited to a reprimand, probation, suspension, revocation and/or a monetary fine; and it is further

ORDERED that the Respondent shall not petition the Board for early termination of the terms and conditions of this Consent Order; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of the Consent Order; and it is further

ORDERED that the Consent Order shall be a **PUBLIC** DOCUMENT pursuant to Md. State Gov't. Code Ann. § 10-611 *et seq.* (2004).

10/22/08
Date

C. Irving Pinder, Jr.
Executive Director
Maryland Board of Physicians

CONSENT

I, Patsy Firth, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

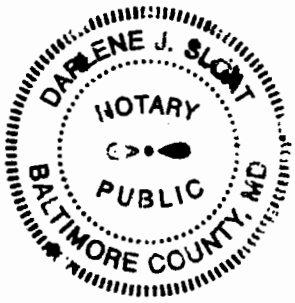
10 September 2008
Date

Patsy Firth, M.D.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 10th day of September 2008, before me, a Notary Public of the foregoing State and City/County personally appeared Patsy Firth, M.D., License Number D39836, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.



Darlene J. Sloat
Notary Public

I HEREBY ATTEST AND CERTIFY UNDER PENALTY OF PERJURY ON 11/25/08 THAT THE FORGOING DOCUMENT IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE IN MY OFFICE AND IN MY LEGAL CUSTODY.

DEPUTY DIRECTOR
MARYLAND BOARD OF PHYSICIANS