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

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff	)	
v.	)	**Case No. 10-04-3966**
MICKEY RAY TYRRELL, M.D., LICENSE NO. 22897,	)	
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, Mickey Ray Tyrrell, M.D., Oklahoma license no. 22897, 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, Mickey Ray Tyrrell, M.D., holds Oklahoma license no. 22897 and practices family medicine in Vinita, Oklahoma.

3. Beginning in or around March 2007 and continuing until September 1, 2009, Defendant treated Patient TDD, a 35 year old female, and acted as her personal physician. During this same period of time, Patient TDD was also being treated by John Forest, M.D., a urologist in Tulsa, Oklahoma for interstitial cystitis. Dr. Forest was managing Patient TDD's pain due to her interstitial cystitis.

4. On or about June 2, 2009, Patient TDD approached Defendant and asked him to take over her pain management. Defendant agreed. Patient TDD advised Defendant that her urologist was giving her Demerol and requested that Defendant prescribe Demerol to her. Defendant did not obtain Patient TDD's medical records from her urologist to confirm what he was prescribing to her, but instead, immediately began prescribing Demerol and Oxycontin to Patient TDD. In fact, Defendant's urologist had **not** prescribed Demerol to her for over three (3) years.

5. A review of pharmacy records reflects that for the three (3) month period of June 2, 2009 through September 2, 2009, Defendant prescribed **990** Demerol 50 mg and **120** Oxycontin 20 mg to Patient TDD as follows:

06/02/09	**120 Demerol/Promethazine 50 mg/25 mg**	
06/22/09	**90 Demerol 50 mg**	
06/29/09	**120 Demerol 50 mg**	
07/12/09	**120 Demerol 50 mg**	**60 Oxycontin 20 mg**
07/29/09	**120 Demerol 50 mg**	
08/10/09	**90 Demerol 50 mg**	
08/17/09	**120 Demerol 50 mg**	
08/25/09	**120 Demerol 50 mg**	
09/02/09	**180 Demerol 50 mg**	**60 Oxycontin 20 mg**
Total:	**990 Demerol 50 mg**	**120 Oxycontin 20 mg**

6. A review of Patient TDD's medical record reflects that although nine (9) prescriptions for Demerol were written by Defendant, only two (2) prescriptions for Demerol were noted in the chart, the first being on July 29, 2009, by which time Defendant had already written four (4) prescriptions for Demerol. The only other reference in the patient chart reflecting Demerol prescriptions was on August 25, 2009. The remaining seven (7) Demerol prescriptions are not reflected anywhere in the patient chart.

7. Defendant has admitted to Board investigators that all nine (9) of the Demerol prescriptions to Patient TDD were authorized by him. He also admitted that he has no explanation as to why he documented only two (2) of the nine (9) prescriptions for Demerol.

8. During the thirty-four (34) days between July 29, 2009 and September 2, 2009, Patient TDD received **630** Demerol 50 mg and **60** Oxycontin 20 mg from Defendant, for an average of **18.5 dosage units per day of Demerol.**

9. On or about September 5, 2009, three (3) days after receiving her last prescription for Demerol from Defendant, **Patient TDD was found dead** in her home. Vinita police officers who first arrived at her home found that Patient TDD had been injecting Demerol that she had crushed and had accidentally overdosed.

10. An investigation was subsequently conducted by the State Medical Examiner's Office. The cause of Patient TDD's death was ruled to be "Acute combined drug toxicity. Due to: Meperidine, Normeperidine." At the time of her death, the patient's body had multiple visible injection sites all over her body where the patient had previously injected the Demerol.

11. Defendant was subsequently interviewed by Board investigators. At that time, he admitted that the prescriptions for Demerol were given to the patient so frequently because he did not know what he had already prescribed to the patient and when he had prescribed it. This was due to the fact that he had failed to document the prescriptions in the patient chart.

12. 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. Engaged in gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15).

C. 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).

D. 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).

E. Violated any state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27).

F. 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).

G. Confessed to a crime involving violation of the antinarcotics laws and regulations of the federal government and the laws of this state in violation of 59 O.S. §509(7).

H. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. §509(16) and OAC 435:10-7-4(2) and (6).

I. Engaged in indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

Conclusion

WHEREFORE, plaintiff 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 the revocation or suspension of the Defendant's license to practice as a physician and surgeon in the State of Oklahoma, the assessment of costs and fees incurred in this action, and any other appropriate action with respect to Defendant's license to practice as a physician and surgeon in the State of Oklahoma.

Dated this 13th day of August, 2010 at 8:00 a.m.

Respectfully submitted,

Elizabeth A. Scott

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