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

FILED

MAR 18 2011

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION

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.**	)	

FINAL ORDER OF SUSPENSION, RESTRICTION, ADMINISTRATIVE FINE AND COMMUNITY SERVICE

This cause came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision (the "Board") on March 10, 2011, at the office of the Oklahoma State Board of Medical Licensure and Supervision, 101 N.E. 51st Street, Oklahoma City, Oklahoma, pursuant to notice given as required by law and the rules of the Board.

Elizabeth A. Scott, Assistant Attorney General, appeared for the plaintiff and defendant appeared in person and through counsel, Robert Rush and Douglas A. Rice.

The Board *en banc* after hearing arguments of counsel, reviewing the pleadings filed, and being fully advised in the premises, found that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

Findings of Fact

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.* The Board has jurisdiction over this matter, and notice has been given in all respects in accordance with law and the rules of the Board.

2. Defendant, Mickey Ray Tyrrell, M.D., holds Oklahoma license no. 22897 and practices family medicine in Vinita, Oklahoma.

3. Beginning in or around October 2005 and continuing until September 2, 2009, Defendant treated Patient TDD, a 35 year old female, and acted as her personal physician. Beginning in or around mid-2008, 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 accurately noted in the chart, the first being on June 29, 2009, by which time Defendant had already written two (2) prescriptions for Demerol. The only other reference in the patient chart accurately reflecting a Demerol prescription was on August 25, 2009. The June 2, 2009, July 12, 2009 and the August 17, 2009 prescriptions are not referenced in any way in the patient chart.

The remaining four (4) Demerol prescriptions are inaccurately reflected or simply referred to without dosage amounts or even confirmation that a prescription was actually issued.

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 accurately documented only two (2) of the nine (9) prescriptions for Demerol.

8. During the thirty-six (36) 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 **17.5 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 believed 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. 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).

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

C. 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).

D. 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).

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

Conclusions of Law

1. The Board has jurisdiction and authority over the Defendant and subject matter herein pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act (the "Act") and its applicable regulations. The Board is authorized to enforce the Act as necessary to protect the public health, safety and welfare.

2. Defendant is guilty of unprofessional conduct in that he:

A. 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).

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

C. 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).

D. 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).

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

3. The Board further found that the Defendant's license should be **SUSPENDED** based upon any or all of the violations of the unprofessional conduct provisions of 59 O.S. §509(12), (16) and (18) and OAC 435:10-7-4 (1), (2), (6), (27) and (41).

Order

IT IS THEREFORE ORDERED by the Oklahoma State Board of Medical Licensure and Supervision as follows:

1. The license of Defendant, Mickey Ray Tyrrell, M.D., Oklahoma license no. 22897, is hereby **SUSPENDED** beginning March 10, 2102 and continuing for a period of **THIRTY (30) DAYS.**

2, At the conclusion of Defendant's suspension, Defendant's license shall be **RESTRICTED** for a period of **THIRTY (30) DAYS** during which time his practice shall be limited to obstetrics and prenatal care.

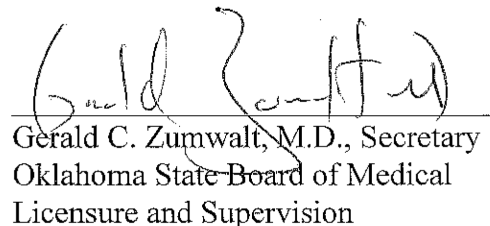
3. Defendant shall pay an **ADMINISTRATIVE FINE** in the amount of **$25,000.00** to be paid on or before April 9, 2011.

4. Within one (1) year of the date of this Order, Defendant shall complete **TWO-HUNDRED (200) HOURS** of **COMMUNITY SERVICE** at a facility to be approved in advance in writing by the Board Secretary.

5. Promptly upon receipt of an invoice, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and investigation costs.

6. Defendant's suspended license shall not be reinstated unless Defendant has reimbursed the Board for all taxed costs.

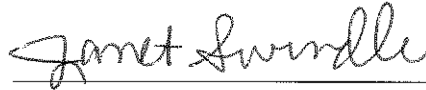
Dated this 18 day of March, 2011.



Gerald C. Zumwalt, M.D., Secretary
Oklahoma State Board of Medical
Licensure and Supervision

CERTIFICATE OF SERVICE

I certify that on the 18 day of March, 2011, I mailed, via first class mail, postage prepaid, a true and correct copy of this Order to Robert Rush, Logan & Lowery, LLP, 101 S. Wilson Street, P.O. Box 558, Vinita, OK 74301, Douglas A. Rice, Derryberry & Naifeh, LLP, 4800 N. Lincoln Blvd., Oklahoma City, OK 73105, and Mickey Ray Tyrrell, 624 W. Canadian, Vinita, OK 74301.



Janet Swindle