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. 07-07-3338**
DARRELL ARNOLD SEELIG, M.D. LICENSE NO. 6539	)	
Defendant.	)	

VOLUNTARY SURRENDER OF LICENSE IN LIEU OF PROSECUTION

State of Oklahoma)
)
County)

I, Darrell Arnold Seelig, M.D., being of lawful age and after first being duly sworn, depose and state as follows:

1. I hereby voluntarily surrender my Oklahoma medical license no. 6539.

2. The surrender of my license is freely and voluntarily made. I have not been subject to any coercion or duress, and I am fully aware of the consequences of the surrender of my license.

3. I am the subject of an investigation and Complaint before the Oklahoma State Board of Medical Licensure and Supervision involving allegations that if proven, would constitute grounds for disciplinary action by the Board.

4. The allegations to which I have plead guilty are as follows:

a. Defendant, Darrell Arnold Seelig, M.D., holds Oklahoma license no. 6539.

b. On or about February 12, 1975, a Complaint was filed against Defendant upon his alleged failure to keep complete and accurate records of the purchase and disposal of controlled drugs or of narcotic drugs. A review of Defendant's public file with the Board reflects that the Board considered the Complaint on March 15, 1975, at which time it sent him a letter cautioning him from writing prescriptions to his family.

c. On or about May 29, 1998, Defendant was **REPRIMANDED** by the Board based upon a finding that he had confessed to a crime involving the anti-narcotic laws, that he had prescribed drugs without sufficient examination and establishment of a valid physician patient relationship, and that he had aided and abetted the unlicensed practice of medicine. The Board further ordered that he not be allowed to supervise physician assistants for five (5) years.

d. From November 4, 2003 until June 25, 2007, Defendant wrote or authorized one-hundred sixty-nine (169) prescriptions for **13,740 dosage units** of controlled dangerous drugs to Patient KDW for alleged left shoulder pain. These prescriptions include forty-one (41) prescriptions for Ritalin, a Schedule II controlled dangerous drug, for a total of **2,280 dosage units**, forty-four (44) prescriptions for Lortab and Lorcet, Schedule III controlled dangerous drugs, for a total of **4,950 dosage units,** and eighty-five (85) prescriptions for Restoril and Xanax, Schedule IV controlled dangerous drugs, for a total of **6,510 dosage units**, for an **average of 10.34 dosage units per day** of controlled dangerous drugs over a three and one half year period of time. Defendant's chart on this patient reveals that he failed to perform a sufficient physical examination and in many instances failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, including labs and x-rays, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any physical findings. Additionally, on November 5, 2004, Defendant began prescribing Ritalin to Patient KDW without any physical examination or complaints necessitating the use of this drug.

e. From January 28, 2005 until June 12, 2007, Defendant wrote or authorized fifty-nine (59) prescriptions for **8,139 dosage units** of controlled dangerous drugs to Patient PMW for alleged wrist pain, left shoulder pain and tendonitis. These prescriptions include twenty-nine (29) prescriptions for Methadone, a Schedule II controlled dangerous drug, for a total of **4,686 dosage units,** one (1) prescription for Lortab, a Schedule III controlled dangerous drug, for a total of **50 dosage units**, and twenty-nine (29) prescriptions for Restoril and Soma, Schedule IV controlled dangerous drugs, for a total of **3,403 dosage units**, for an **average of 9.41 dosage units per day** of controlled dangerous drugs. Defendant's chart on this patient reveals that he failed to perform an initial physical examination on this

patient prior to prescribing the controlled dangerous drugs, that any subsequent physical examinations were rare and insufficient, that he failed to order appropriate tests, including labs and x-rays, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any physical findings.

f. From January 14, 2005 until June 12, 2007, Defendant wrote or authorized sixty-two (62) prescriptions for **9,920 dosage units** of controlled dangerous drugs to Patient KMW, the husband of Patient PMW in paragraph 6 above, for alleged back pain. These prescriptions include twenty-three (23) prescriptions for Methadone and Morphine, Schedule II controlled dangerous drugs, for a total of **4,720 dosage units**, nine (9) prescriptions for Lortab, a Schedule III controlled dangerous drug, for a total of **1,620 dosage units,** and thirty (30) prescriptions for Soma, a Schedule IV controlled dangerous drug, for a total of **3,580 dosage units**, for an **average of 11.29 dosage units per day** of controlled dangerous drugs over a two and one half year period of time. Defendant's chart on this patient reveals that he failed to perform a physical examination on this patient prior to prescribing the controlled dangerous drugs, that any subsequent physical examinations were rare and insufficient, that he failed to order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any physical findings.

g. From June 7, 2004 through July 6, 2007, Defendant wrote or authorized forty-five (45) prescriptions for **6,760 dosage units** of controlled dangerous drugs to Patient PEBW for alleged leg pain, headaches, lupus, and poor circulation. These prescriptions include thirteen (13) prescriptions for Methadone and Percocet, Schedule II controlled dangerous drugs for a total of **1,560 dosage units**, thirty-one (31) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug for a total of **5,100 dosage units,** and one (1) prescription for Soma, a Schedule IV controlled dangerous drug, for a total of **100 dosage units**, for an **average of 6.01 dosage units per day** of controlled dangerous drugs. Defendant's chart on this patient reveals that while she claimed to have been diagnosed with lupus, there were no records from other physicians to support this diagnosis. Additionally, tests performed at the OMRF Clinical Immunology Lab were not consistent with her alleged illnesses, yet Defendant continued to prescribe controlled dangerous drugs to her. Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that any subsequent physical examinations were rare and insufficient, that when he did order appropriate tests, he ignored test results, that he did not establish a legitimate medical need for the

medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any physical findings.

h. From August 6, 2004 through June 29, 2007, Defendant wrote or authorized one-hundred twenty-eight (128) prescriptions for a total of **12,690 dosage units** of controlled dangerous drugs to Patient RBFW for alleged bipolar disorder, major depression, post traumatic stress disorder, polysubstance dependence in remission, and anxiety. These prescriptions include nine (9) prescriptions for Ritalin, a Schedule II controlled dangerous drug, for a total of **900 dosage units**, fifty-two (52) prescriptions for Hydrocodone and Didrex, Schedule III controlled dangerous drugs, for a total of **5,000 dosage units**, and sixty-seven (67) prescriptions for Ambien, Valium, Phentermine, Xanax and Soma, Schedule IV controlled dangerous drugs, for a total of **6,790 dosage units**, for an **average of 12.01 dosage units per day** of controlled dangerous drugs. Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that any subsequent physical examinations were rare and insufficient, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague illnesses without any physical findings. Additionally, on August 6, 2004, Defendant's chart reflects that the patient reported that she had been told that she had cancer cells in her lungs, but he never ordered a chest x-ray or other test, nor did he ever obtain medical records to support this account from the patient.

i. From January 14, 2004 through July 9, 2007, Defendant wrote or authorized one-hundred thirty-six (136) prescriptions for a total of **11,690 dosage units** of controlled dangerous drugs and other dangerous drugs to Patient WBW for diabetes, hypogonadism, gout, carpal tunnel, and osteoarthritis. These prescriptions include five (5) prescriptions for Percocet, a Schedule II controlled dangerous drug, for a total of **300 dosage units**, sixty-four (64) prescriptions for Lortab, a Schedule III controlled dangerous drug, for a total of **6,720 dosage units,** and sixty-seven (67) prescriptions for Xanax, Phentermine and Soma, Schedule IV controlled dangerous drugs, for a total of **4,670 dosage units**, for an **average of 9.19 dosage units per day** of controlled dangerous drugs. Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that any subsequent physical examinations were rare and insufficient, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

j. From September 12, 2006 through June 20, 2007, Defendant wrote or authorized thirty-two (32) prescriptions for **3,520 dosage units** of controlled dangerous drugs to Patient PABW for alleged neck and lower back pain and depression. These prescriptions include fourteen (14) prescriptions for Lortab, a Schedule III controlled dangerous drug, for a total of **1,720 dosage units**, and eighteen (18) prescriptions for Valium and Soma, Schedule IV controlled dangerous drugs, for a total of **1,800 dosage units**, for an **average of 12.53 dosage units per day** of controlled dangerous drugs. Defendant's chart on this patient reveals that MRIs performed in 2002 and 2005 revealed nothing significant, yet Defendant continued to prescribe controlled dangerous drugs to the patient. Defendant's chart additionally reveals that all physical examinations were within normal limits, yet Defendant continued to prescribe controlled dangerous drugs, he did not order appropriate tests, he did not establish a legitimate medical need for the medications, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague illnesses without any physical findings.

k. From January 6, 2004 through June 29, 2007, Defendant wrote or authorized one-hundred sixty-two (162) prescriptions for **14,570 dosage units** of controlled dangerous drugs to Patient RBMW for alleged depression, COPD and poor circulation. These prescriptions include one-hundred one (101) prescriptions for Duragesic Patch, Tylox and Dilaudid, Schedule II controlled dangerous drugs, for a total of **8,840 dosage units**, and sixty-one (61) prescriptions for Flurazepam, Xanax and Dalmane, Schedule IV controlled dangerous drugs, for a total of **5,730 dosage units**, for an **average of 11.47 dosage units per day** of controlled dangerous drugs. Defendant's chart reveals that all physical examinations were within normal limits, yet Defendant continued to prescribe controlled dangerous drugs, he did not order appropriate tests, he did not establish a legitimate medical need for the medications, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits without any physical findings of pain. Additionally, on May 30, 2007, Defendant prescribed Nitrolingual Pump Spray at the same time he prescribed Viagra to the patient.

l. From December 31, 2004 through June 22, 2007, Defendant wrote or authorized one-hundred five (105) prescriptions for **13,630 dosage units** of controlled dangerous drugs to Patient DLW for alleged depression, anxiety and back pain. These prescriptions include thirty (30) prescriptions for Hydrocodone and Dilantin, Schedule III controlled dangerous drugs, for a total of **6,070 dosage units**, seventy-one (71) prescriptions for Soma, Restoril and Xanax, Schedule IV controlled dangerous drugs, for a total of **7,080 dosage units,** and four (4) prescriptions for Lomotil, a Schedule V controlled dangerous drug, for a total of **480 dosage units**, for an **average of 15.63 dosage units per day** of controlled dangerous drugs. Defendant's chart on this patient reveals that he failed to

perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that any subsequent physical examinations were rare and insufficient, that he did not order appropriate tests, including x-rays, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague illnesses without any physical findings. Additionally, Defendant prescribed Depotestosterone without any documented medical need or physical examination.

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

i. 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).

ii. Engaged in practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery in violation of OAC 435:10-7-4(18).

iii. 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).

iv. 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).

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

vi. 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).

vii. Prescribed, dispensed or administered a controlled substance 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).

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

ix. 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 standard in violation of OAC 435:10-7-4(2) and (6).

5. I will submit my wallet card and wall certificate as evidence of my intent to surrender my license upon locating them.

6. I hereby agree that I will not apply for reinstatement of my Oklahoma medical license for a minimum of one year from the entry of the Order Accepting Voluntary Surrender in Lieu of Prosecution, and that if the Board ever reinstates my Oklahoma medical license, it will be under terms of probation to be set by the Board at the time of reinstatement.

7. As a condition to accepting my surrender of license in lieu of prosecution, I acknowledge that the Board may require me to pay all costs expended by the Board for any legal fees and costs, and any investigation, probation and monitoring fees, including but not limited to staff time, salary and travel expense, witness fees and attorney fees.

DATED this 21 day of Aug, 2007.

Darrell Arnold Seelig, M.D.

Subscribed and sworn before me this 21 day of Aug., 2007.

Notary Public

My commission expires on 1/29/08

NOTARY PUBLIC SEAL
JOYCE SEELIG
Lincoln County
Notary Public in and for
State of Oklahoma
Commission # 99020462 Expires 1/29/08

ACCEPTED:

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

Date: 8-2-07