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. 05-11-3024**
HOWARD EDWARD HAGGLUND, M.D., LICENSE NO. 9798,	)	
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, Howard Edward Hagglund, 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, Howard Edward Hagglund, M.D., holds Oklahoma license no. 9798 and practices internal medicine in Norman, Oklahoma.

3. On or about November 8, 1995, Defendant began treating Patient RKM, a sixty-six (66) year old woman. The patient provided Defendant copies of prior medical records from the Oklahoma City Clinic showing normal TSH levels and instructions to remain on her existing dose of thyroid medication. At that time, Defendant changed her thyroid medication from Armour to Westhroid. On or about November 18, 1996, the patient and Defendant were advised by Morris Dees, M.D. of the Oklahoma City Clinic that the patient's thyroid medications were suppressing her thyroid function. On or about February 10, 1997, the patient's thyroid function was tested at Oklahoma City Clinic and was reported to be low, at a 0.03 level. Both she and Defendant were advised that she was taking too much thyroid medication, that heart failure could result, and that she should cut her dose in half. Defendant acknowledged this, but continued her on her regular dose as prescribed by him. On or about March 29, 1998, the patient and Defendant were again advised that she was taking too much thyroid supplement and that she should cut her dose in half. Despite being advised of this, on or about February 15, 2000,

Defendant advised the patient to raise her thyroid dosage up even more. On or about December 22, 2003, the patient's TSH level was tested by Peter Chan, D.O. and was found to be at a 0.01 level. The patient and Defendant were advised that the patient was taking too much thyroid medication and that it was not good for her heart and bones. When the patient questioned Defendant about this, Defendant advised her "it's all OK." The patient continued on her thyroid medication as prescribed by Defendant until June 19, 2005, at which time she as admitted to Kingfisher Regional Hospital with rapid atrial fibrillation. Her TSH level was tested and found to be at 0.00. Physicians at the hospital took her off all thyroid medication prescribed by Defendant. She was released from the hospital several days later. On or about August 15, 2005, Defendant nevertheless advised her that she "must take thyroid" and he continued to prescribe it to her.

4. On or about November 18, 2005, Defendant began treating Patient MCM, a fifty-six (56) year old female who resided in Dallas, Texas. No physical exam or vital signs are noted in the patient chart. Defendant's chart reflects that he diagnosed her with low thyroid and prescribed Westhroid. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing Westhroid, nor after prescribing the Westhroid. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform an adequate physical examination, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant continued to treat Patient MCM only through "phone visits" on December 5, 2005, January 31, 2006 and March 19, 2006. On both "phone visits" in 2006, Defendant continued to prescribe Westhroid to the patient without ever obtaining a valid thyroid test.

5. On or about September 1, 2005, Defendant conducted a "phone visit" with Patient LFM, a fifty-seven (57) year old male residing in Indiana. The patient told Defendant he was taking thyroid medications at that time. On or about October 10, 2005, the patient mailed the results of a Saliva Thyroid Test to Defendant. The Defendant conducted another "phone visit" on this date. On or about November 7, 2005, Defendant prescribed Westhroid to the patient. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing Westhroid, nor after prescribing the Westhroid. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform any physical examination, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

6. On or about August 15, 2005, Defendant began treating Patient MCRM, a forty-eight (48) year old female. The patient told Defendant she was taking Synthroid. At this time, Defendant prescribed Westhroid to the patient. On or about September 8, 2005, Defendant again treated the patient and prescribed Westhroid to her. Defendant treated the patient again on September 29, 2005. No physical exam or vital signs are noted for these dates. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing Westhroid, nor after prescribing the Westhroid. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform any physical

examination, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

7. On or about June 27, 2000, Defendant began treating Patient KBM, a forty-one (41) year old female. The patient told Defendant she was taking Synthroid because she had Hashimoto's Thyroiditis. At that time, Defendant prescribed Westhroid to the patient. Defendant continued to prescribe Westhroid to the patient through July 9, 2007. Only minimal vital signs were noted during this seven (7) year period. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing Westhroid, nor after prescribing the Westhroid for this seven (7) year period. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform an adequate physical examination, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

8. On or about November 19, 2001, Patient NRM, an eight (8) year old male, was treated in Defendant's office by a nurse practitioner. On the first office visit, the nurse practitioner diagnosed the patient with ADHD and hypothyroidism. The patient was treated by the nurse practitioner on seven (7) more occasions through June 20, 2002. On or around August 16, 2002, Defendant prescribed Westhroid to him. According to the patient chart, Patient NRM was never seen nor examined by Defendant prior to Defendant prescribing Westhroid to him. Defendant saw the patient for the first time on or about October 11, 2002. Defendant continued to prescribe Westhroid to the patient through at least August 9, 2004. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing the Westhroid, nor after prescribing the Westhroid. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform any physical examination, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

9. On or around February 17, 1999 and continuing through January 10, 2007, Defendant treated Patient REM, a fifty (50) year old female, for hypothyroidism. On February 17, 1999, he prescribed Westhroid to her. Defendant continued to prescribe Westhroid to the patient for approximately eight (8) years until January 10, 2007. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing the Westhroid, nor after prescribing the Westhroid. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform any physical examination or record any vital signs after 2001, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

10. On or about May 6, 1997 and continuing through October 18, 2006, Defendant treated Patient PSM, a forty-four (44) year old woman for hypothyroidism. At the first visit on May 6, 1997, the patient advised Defendant that two (2) previous doctors had advised her that

her thyroid was fine. Defendant nevertheless prescribed Westhroid to her and continued to prescribe Westhroid until October 18, 2006. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing the Westhroid, nor after prescribing the Westhroid for the entire nine (9) year period of treatment. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform any physical examination or record any vital signs after 2001, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

11. On or about January 22, 2003, and continuing through September 9, 2005, Defendant treated Patient BPM, a sixty-six (66) year old woman for low thyroid. Prior to her first visit, the patient provided Defendant with the results of a Saliva Thyroid Test. Defendant prescribed Westhroid to her on her first visit and continued prescribing Westhroid to her until September 9, 2005. Defendant did not obtain or perform any valid test to determine the patient's thyroid levels prior to prescribing the Westhroid, nor after prescribing the Westhroid. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform any physical examination or record any vital signs prior to prescribing the Westhroid, that he did not order appropriate tests, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

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

A. Engaged in conduct which is likely to deceive, defraud or harm the public in violation of OAC 435:10-7-4(11).

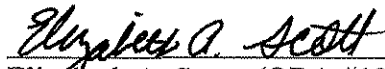
B. Prescribed a drug without sufficient examination and establishment of a valid physician patient relationship in violation of 59 O.S. §509(12).

C. 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 435:10-7-4(41).

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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