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.	)	

FINAL ORDER OF PROBATION, REPRIMAND AND ADMINISTRATIVE FINE

This cause came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision (the "Board") on January 17, 2008, at the office of the Board, 5104 N. Francis, Suite C, 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, Tracy Zahl and Richard Mildren.

The Board *en banc* after hearing arguments of counsel, reviewing the exhibits admitted and the sworn testimony of witnesses, 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, Howard Edward Hagglund, M.D., holds Oklahoma license no. 9798.

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

B. 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).

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

B. 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).

3. The Board further found that the Defendant's license should be **REPRIMANDED,** subject to an **ADMINISTRATIVE FINE,** and placed on **PROBATION** for **ONE (1) YEAR** based upon any or all of the violations of the unprofessional conduct provisions of 59 O.S. §509 (12) and (18) and OAC 435: 10-7-4 (41).

Order

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

1. The license of Defendant, Howard Edward Hagglund, M.D., Oklahoma license no. 9798, is hereby **PUBLICLY REPRIMANDED.**

2. Defendant shall pay an **ADMINISTRATIVE FINE** in the amount of **$20,000.00**, to be paid on or before January 17, 2009.

3. Defendant shall be placed on **PROBATION** for a minimum period of **ONE (1) YEAR** under the following terms and conditions:

A. Defendant will conduct his practice in compliance with the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act as interpreted by the Oklahoma State Board of

Medical Licensure and Supervision. Any question of interpretation regarding said Act shall be submitted in writing to the Board and no action based on the subject of the question will be taken by Defendant until clarification of interpretation is received by Defendant from the Oklahoma State Board of Medical Licensure and Supervision.

B. Defendant will furnish to each and every state in which he holds licensure or applies for licensure and hospitals, clinics or other institutions in which he holds or anticipates holding any form of staff privilege or employment, a copy of the Board Order stipulating sanctions imposed by the Oklahoma State Board of Medical Licensure and Supervision.

C. Defendant will not supervise allied health professionals that require surveillance of a licensed physician.

D. Defendant will make the following changes in his treatment of patients:

1. Defendant will improve charting of his patients' medical records to accurately reflect the evaluation, treatment, and medical necessity of treatment of the patients.
2. Defendant will obtain serum levels of free triiodothyronine (T3) tests and use thyroid-stimulating hormone ("TSH") and thyroid antibodies on new thyroid cases.
3. Defendant will obtain and involve saliva and urine tests for thyroid T3 tests and thyroxine (T4) tests and use TSH to affirm his clinical diagnosis.
4. Defendant will blend the above changes in his practice with his clinical experience and knowledge to secure a diagnosis with better serves his patients.

E. Defendant shall allow the Compliance Consultant or his designee to periodically review his charts to determine his compliance with this Order.

F. Defendant will keep the Oklahoma State Board of Medical Licensure and Supervision informed of his current address.

G. Defendant will keep current payment of all assessments by the Oklahoma State Board of Medical Licensure and Supervision for prosecution, investigation and monitoring of his case, which

shall include but is not limited to a one hundred dollar ($100.00) per month fee during the term of probation, unless Defendant affirmatively obtains a deferment of all or part of said fees upon presentation of evidence that is acceptable to the Board Secretary.

H. Until such time as all indebtedness to the Oklahoma State Board of Medial Licensure and Supervision has been satisfied, Defendant will reaffirm said indebtedness in any and all bankruptcy proceedings.

I. Defendant shall make himself available for one or more personal appearances before the Board or its designee upon request.

J. Defendant shall submit any required reports and forms on a timely, accurate and prompt basis to the Compliance Coordinator or designee.

K. Failure to meet any of the terms of this Board Order will constitute cause for the Board to initiate additional proceedings to suspend, revoke or modify Defendant's license after due notice and hearing.

5. After one (1) year, Defendant shall appear before the Board so that the Board may review Defendant's practices and compliance with the probationary terms.

6. Promptly upon receipt of an invoice, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and costs, investigation costs, staff time, salary and travel expenses, witness fees and attorney's fees.

Dated this 18 day of January, 2008.

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 January, 2008, I mailed, via first class mail, postage prepaid, a true and correct copy of this Order to Richard Mildren and Tracy Zahl, Riggs, Abney, Neal, Turpen, Orbison and Lewis, 5801 N. Broadway, Suite 101, Oklahoma City, OK 73118.

Janet Swindle

Janet Swindle