

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended
Accusation Against:

Anna Pawlikowska-Haddal, M.D.

Physician's and Surgeon's
Certificate No. A 82389

Respondent.

Case No. 800-2018-050802

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 24, 2022.

IT IS SO ORDERED June 17, 2022.

MEDICAL BOARD OF CALIFORNIA



William Prasifka
Executive Director

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 REBECCA L. SMITH
Deputy Attorney General
4 State Bar No. 179733
300 South Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 269-6475
6 Facsimile: (916) 731-2117
Attorneys for Complainant
7

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation
12 Against:

13 ANNA PAWLIKOWSKA-HADDAL, M.D.
669 Highway 52, Box 8
14 Cuchillo, New Mexico 87901-9026

15 Physician's and Surgeon's Certificate
No. A 82389,

16 Respondent.
17

Case No. 800-2018-050802

OAH No. 2022010279

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
23 California (Board). He brought this action solely in his official capacity and is represented in this
24 matter by Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith, Deputy
25 Attorney General.

26 2. Anna Pawlikowska-Haddal, M.D. (Respondent) is representing herself in this
27 proceeding and has chosen not to exercise her right to be represented by counsel.

28 ///

1 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
2 of Respondent's license history with the Board.

3 2. Respondent shall lose all rights and privileges as a physician and surgeon in
4 California as of the effective date of the Board's Decision and Order.

5 3. Respondent shall cause to be delivered to the Board her pocket license and, if one was
6 issued, her wall certificate on or before the effective date of the Decision and Order.

7 4. If Respondent ever files an application for licensure or a petition for reinstatement in
8 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
9 comply with all the laws, regulations and procedures for reinstatement of a revoked or
10 surrendered license in effect at the time the petition is filed, and all of the charges and allegations
11 contained in First Amended Accusation No. 800-2018-050802 shall be deemed to be true, correct
12 and admitted by Respondent when the Board determines whether to grant or deny the petition.

13 5. Respondent shall pay the agency its costs of investigation and enforcement in the
14 amount of \$12,848.75 (Twelve Thousand Eight Hundred Forty-Eight Dollars and Seventy-Five
15 Cents) prior to issuance of a new or reinstated license.

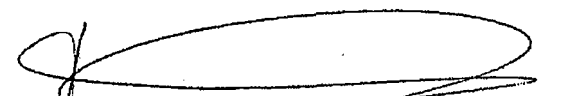
16 6. If Respondent should ever apply or reapply for a new license or certification, or
17 petition for reinstatement of a license, by any other health care licensing agency in the State of
18 California, all of the charges and allegations contained in First Amended Accusation, No. 800-
19 2018-050802 shall be deemed to be true, correct, and admitted by Respondent for the purpose of
20 any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

21 ACCEPTANCE

22 I have carefully read the Stipulated Surrender of License and Order. I understand the
23 stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this

24 stipulation Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to
25 be bound by the Decision and Order of the Medical Board of California.

26 _____
27 06-11-2022

28 
ANNA PAWLIKOWSKA-HADDAL, M.D.
Respondent

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19 2018-050802 shall be deemed to be true, correct, and admitted by Respondent for the purpose of
20 any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

21 **ACCEPTANCE**

22 I have carefully read the Stipulated Surrender of License and Order. I understand the
23 stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this
24 Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to
25 be bound by the Decision and Order of the Medical Board of California.

26
27 DATED: _____

28 _____
ANNA PAWLIKOWSKA-HADDAL, M.D.
Respondent

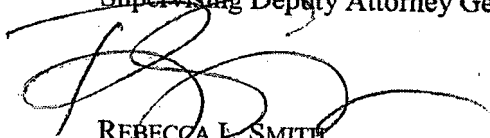
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ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 0/13/2022

Respectfully submitted,
ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General



REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2018-050802

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 REBECCA L. SMITH
Deputy Attorney General
4 State Bar No. 179733
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8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
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11 **STATE OF CALIFORNIA**

12 In the Matter of the First Amended Accusation
Against:

Case No. 800-2018-050802

13 **ANNA PAWLIKOWSKA-HADDAL, M.D.**
14 **669 Highway 52, Box 8**
Cuchillo, New Mexico 87901-9026

FIRST AMENDED ACCUSATION

15 **Physician's and Surgeon's Certificate**
16 **No. A 82389,**

17 Respondent.

18
19 **PARTIES**

20 1. William Prasifka (Complainant) brings this First Amended Accusation solely in his
21 official capacity as the Executive Director of the Medical Board of California, Department of
22 Consumer Affairs (Board).

23 2. On or about March 21, 2003, the Board issued Physician's and Surgeon's Certificate
24 Number A 82389 to Anna Pawlikowaska-Haddal, M.D. (Respondent). That license was in full
25 force and effect at all times relevant to the charges brought herein and will expire on November
26 30, 2022.

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1 **JURISDICTION**

2 3. This First Amended Accusation is brought before the Board, under the authority of
3 the following laws. All section references are to the Business and Professions Code (Code)
4 unless otherwise indicated.

5 4. Section 2004 of the Code states:

6 The board shall have the responsibility for the following:

7 (a) The enforcement of the disciplinary and criminal provisions of the Medical
8 Practice Act.

9 (b) The administration and hearing of disciplinary actions.

10 (c) Carrying out disciplinary actions appropriate to findings made by a panel or
an administrative law judge.

11 (d) Suspending, revoking, or otherwise limiting certificates after the conclusion
12 of disciplinary actions.

13 (e) Reviewing the quality of medical practice carried out by physician and
surgeon certificate holders under the jurisdiction of the board.

14 (f) Approving undergraduate and graduate medical education programs.

15 (g) Approving clinical clerkship and special programs and hospitals for the
16 programs in subdivision (f).

17 (h) Issuing licenses and certificates under the board's jurisdiction.

18 (i) Administering the board's continuing medical education program.

19 5. Section 2227 of the Code states:

20 (a) A licensee whose matter has been heard by an administrative law judge of
the Medical Quality Hearing Panel as designated in Section 11371 of the Government
21 Code, or whose default has been entered, and who is found guilty, or who has entered
into a stipulation for disciplinary action with the board, may, in accordance with the
22 provisions of this chapter:

23 (1) Have his or her license revoked upon order of the board.

24 (2) Have his or her right to practice suspended for a period not to exceed one
year upon order of the board.

25 (3) Be placed on probation and be required to pay the costs of probation
26 monitoring upon order of the board.

27 (4) Be publicly reprimanded by the board. The public reprimand may include a
28 requirement that the licensee complete relevant educational courses approved by the
board.

1 (5) Have any other action taken in relation to discipline as part of an order of
2 probation, as the board or an administrative law judge may deem proper.

3 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
4 medical review or advisory conferences, professional competency examinations,
5 continuing education activities, and cost reimbursement associated therewith that are
6 agreed to with the board and successfully completed by the licensee, or other matters
7 made confidential or privileged by existing law, is deemed public, and shall be made
8 available to the public by the board pursuant to Section 803.1.

9 6. Section 2234 of the Code, states:

10 The board shall take action against any licensee who is charged with
11 unprofessional conduct. In addition to other provisions of this article, unprofessional
12 conduct includes, but is not limited to, the following:

13 (a) Violating or attempting to violate, directly or indirectly, assisting in or
14 abetting the violation of, or conspiring to violate any provision of this chapter.

15 (b) Gross negligence.

16 (c) Repeated negligent acts. To be repeated, there must be two or more
17 negligent acts or omissions. An initial negligent act or omission followed by a
18 separate and distinct departure from the applicable standard of care shall constitute
19 repeated negligent acts.

20 (1) An initial negligent diagnosis followed by an act or omission medically
21 appropriate for that negligent diagnosis of the patient shall constitute a single
22 negligent act.

23 (2) When the standard of care requires a change in the diagnosis, act, or
24 omission that constitutes the negligent act described in paragraph (1), including, but
25 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
26 licensee's conduct departs from the applicable standard of care, each departure
27 constitutes a separate and distinct breach of the standard of care.

28 (d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is
substantially related to the qualifications, functions, or duties of a physician and
surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend
and participate in an interview by the board. This subdivision shall only apply to a
certificate holder who is the subject of an investigation by the board.

7. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate
records relating to the provision of services to their patients constitutes unprofessional
conduct.

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1 COST RECOVERY

2 8. Section 125.3 of the Code states:

3 (a) Except as otherwise provided by law, in any order issued in resolution of a
4 disciplinary proceeding before any board within the department or before the
5 Osteopathic Medical Board, upon request of the entity bringing the proceeding, the
6 administrative law judge may direct a licensee found to have committed a violation or
7 violations of the licensing act to pay a sum not to exceed the reasonable costs of the
8 investigation and enforcement of the case.

9 (b) In the case of a disciplined licensee that is a corporation or a partnership, the
10 order may be made against the licensed corporate entity or licensed partnership.

11 (c) A certified copy of the actual costs, or a good faith estimate of costs where
12 actual costs are not available, signed by the entity bringing the proceeding or its
13 designated representative shall be prima facie evidence of reasonable costs of
14 investigation and prosecution of the case. The costs shall include the amount of
15 investigative and enforcement costs up to the date of the hearing, including, but not
16 limited to, charges imposed by the Attorney General.

17 (d) The administrative law judge shall make a proposed finding of the amount
18 of reasonable costs of investigation and prosecution of the case when requested
19 pursuant to subdivision (a). The finding of the administrative law judge with regard
20 to costs shall not be reviewable by the board to increase the cost award. The board
21 may reduce or eliminate the cost award, or remand to the administrative law judge if
22 the proposed decision fails to make a finding on costs requested pursuant to
23 subdivision (a).

24 (e) If an order for recovery of costs is made and timely payment is not made as
25 directed in the board's decision, the board may enforce the order for repayment in any
26 appropriate court. This right of enforcement shall be in addition to any other rights
27 the board may have as to any licensee to pay costs.

28 (f) In any action for recovery of costs, proof of the board's decision shall be
conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or
reinstate the license of any licensee who has failed to pay all of the costs ordered
under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion,
conditionally renew or reinstate for a maximum of one year the license of any
licensee who demonstrates financial hardship and who enters into a formal agreement
with the board to reimburse the board within that one-year period for the unpaid
costs.

(h) All costs recovered under this section shall be considered a reimbursement
for costs incurred and shall be deposited in the fund of the board recovering the costs
to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of
the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in

1 that board's licensing act provides for recovery of costs in an administrative
2 disciplinary proceeding.

3 FACTUAL ALLEGATIONS

4 9. Respondent was a pediatric endocrinologist in the pediatric endocrinology clinic at
5 the UCLA Medical Group (the clinic) during the timeframe that she provided care and treatment
6 to Patients 1 through 6.¹

7 Patient 1

8 10. Patient 1, a full-term male infant, was born on October 25, 2017, with congenital
9 hypothyroidism. His mother had a history of hypothyroidism² treated with levothyroxine.³ On
10 October 26, 2017, Patient 1's newborn screening laboratory tests revealed an elevated thyroid
11 stimulating hormone (TSH) value of 558.03 milli-international units per liter (mIU/L) with a
12 repeat value of 680.1 mIU/L, suggesting congenital hypothyroidism.⁴ On October 29, 2017, the
13 California Newborn Screening Program⁵ reported the test result to the clinic. Patient 1's parents
14 were contacted by the clinic and instructed to bring Patient 1 in for repeat laboratory studies and
15 to start levothyroxine 50 micrograms (mcg) daily. Respondent called Patient 1's mother on
16 October 30, 2017 to confirm that laboratory studies were done, medication was given, and that
17 Patient 1 would be seen the following day.

18 11. On October 31, 2017, Patient 1 was seen by Respondent. At that time, Respondent
19 noted that Patient 1's laboratory values may reflect congenital hypothyroidism or transient
20 hypothyroidism. Respondent stopped the levothyroxine therapy and ordered laboratory testing

21 ¹ For privacy purposes, the patients in this First Amended Accusation are referred to as Patients 1
22 through 6, with their respective identities disclosed to Respondent in discovery.

23 ² Hypothyroidism is a condition where the thyroid does not create and release enough thyroid
24 hormone into the bloodstream.

25 ³ Levothyroxine is a thyroid medicine that replaces the hormone normally produced by the thyroid
26 gland to regulate the body's energy and metabolism.

27 ⁴ Congenital hypothyroidism occurs when a newborn infant is born without the ability to produce
28 normal amounts of thyroid hormone.

⁵ The California Newborn Screening Program is a state public health service that ensures that
babies are tested for certain serious genetic conditions at birth. UCLA Medical Group provides follow-up
for newborns needing additional testing and/or a referral to pediatric specialists if indicated for diagnostic
evaluation and initiation of treatment.

1 for TSH, free T4,⁶ thyroid peroxidase (TPO)⁷ and thyroglobulin antibody.⁸ She instructed the
2 patient's mother to return the patient to the clinic in two weeks. Following the October 31, 2017
3 visit, Patient 1 was removed from Respondent's care and levothyroxine therapy was restarted.

4 12. At the time of her interview with the Board on June 3, 2021, Respondent stated that
5 she stopped the levothyroxine therapy because she thought that the patient had macro-TSH⁹ due
6 to material antibodies. She stated that if the TSH was high and free T4 was low, she would restart
7 the levothyroxine therapy.

8 **Patient 2**

9 13. On August 30, 2016, at 4 days of age, Patient 2 was seen by Respondent at the clinic
10 for an evaluation of possible hypocalcemia.¹⁰ Both of Patient 2's siblings had hypercalciuric
11 hypocalcemia¹¹ caused by the Calcium-sensing receptor (CaSR) mutation.¹² Patient 2 was
12 asymptomatic at that time and reportedly had a normal calcium level measured sometime after
13 birth. Respondent ordered laboratory testing, including calcium, phosphorus, parathyroid
14 hormone (PTH) levels as well as a CaSR genetic analysis. That same day, Patient 2's calcium
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17 ⁶ T4, also known as thyroxine, is a type of thyroid hormone. T4 test measures the blood level of
the hormone T4.

18 ⁷ TPO is an enzyme produced by the thyroid gland.

19 ⁸ Thyroglobulin is a protein produced and used by the thyroid gland to make the hormones T3 and
20 T4. Thyroglobulin antibodies test is used in diagnosing autoimmune conditions involving the thyroid
gland.

21 ⁹ Macro-TSH is a rare condition that is usually diagnosed in adults. In patients with macro-TSH,
22 binding of TSH to other plasma proteins, generally immunoglobulins, results in elevated TSH
measurements.

23 ¹⁰ Hypocalcemia occurs when there is too little calcium in the blood. Causes of hypocalcemia
24 include hypoparathyroidism, pseudo hypoparathyroidism, vitamin D deficiency, and renal failure.

25 ¹¹ Familial hypercalciuric hypercalcemia (FHH) is a rare condition inherited in an autosomal
26 dominant pattern equally distributed between the sexes. Patients with FHH have abnormally high levels of
calcium in the blood and low to moderate levels of calcium in urine.

27 ¹² The CaSR mutation can cause autosomal dominant hypocalcemia type 1, which is characterized
28 by low levels of calcium in the blood (hypocalcemia). Some affected individuals also have a shortage of
parathyroid hormone (hypoparathyroidism).

1 level was reported as low at 6.8 to 7.0¹³ and her phosphorus level was reported high at 7.9.¹⁴ The
2 PTH level and genetic testing remained pending. Respondent noted that Patient 2 likely had the
3 CaSR mutation like her siblings and started Patient 2 on calcitriol and a calcium supplement.
4 Patient 2's father was advised to return Patient 2 to see Respondent in follow-up in one month.

5 14. Patient 2 was next seen by Respondent on September 22, 2016. There are no
6 progress notes for the visit. Patient 2's laboratory studies reflected that a repeat calcium level was
7 normal at 9.4, PTH was low at 7,¹⁵ and phosphorus level was elevated at 10. Her medications
8 were continued.

9 15. Patient 2's CaSR genetic test returned as negative on October 7, 2016.

10 16. Patient 2 was next seen by Respondent on November 1, 2016. At that time,
11 Respondent noted that Patient 2's genetic testing was negative, but that given the possibility of a
12 mutation not detected by available genetic tests, management would continue based on [her]
13 clinical diagnosis and the patient's calcium and phosphorous levels would be monitored closely.
14 Respondent also noted that transient hypoparathyroidism should be considered given the patient's
15 low PTH. Respondent's plan was to continue monitoring and adjust the patient's medications as
16 indicated. That same day, Patient 2's calcium level was noted to have normalized at 10.0.
17 Respondent discontinued Patient 2's calcitriol and noted that the patient's laboratory values
18 would be checked at her next visit.

19 17. On January 9, 2017, Patient 2's parents were called by the clinic regarding follow-up
20 laboratory results. As of January 5, 2017, Patient 2's calcium and phosphorous levels were
21 normal at 9.0 and 6.7, respectively. The patient's low phosphorus infant formula was
22 discontinued.

23 18. Patient 2 was next seen by Respondent on March 14, 2017, at which time laboratory
24 testing was performed. Respondent noted that if the patient's calcium remained normal, the
25 supplemental calcium would be discontinued. On March 17, 2017, Patient 2's mother was called

26 ¹³ Normal reference range for calcium at Patient 2's age is 8.6 to 10.3.

27 ¹⁴ Normal reference range for phosphorus at Patient 2's age is 3.9 to 6.9.

28 ¹⁵ Normal reference range for PTH at Patient 2's age is 11 to 51.

1 with the updated laboratory results. The patient's calcium level was again low at 7.6. Patient 2's
2 mother was advised to increase the patient's calcium supplement.

3 19. Patient 2 was next seen by Respondent on June 20, 2017 for follow-up. No follow-up
4 laboratory testing was performed between March 14, 2017 and June 20, 2017. Laboratory studies
5 performed on June 20, 2017 reflected that the patient's calcium level continued to be low, now at
6 7.4 and she had a high phosphorus level of 9.2. Patient 2's father was contacted on June 29, 2017
7 and instructed to further increase the patient's calcium supplement. There was no documented
8 plan for follow-up testing.

9 **Patient 3**

10 20. On August 26, 2014, Patient 3, a 10-year-old female, presented to the clinic with a
11 diagnosis of late onset congenital adrenal hyperplasia (CAH)¹⁶ that was being treated with
12 hydrocortisone and fludrocortisone. She was also noted to have duplex ectopic ureters and
13 clitoromegaly. At that time, laboratory studies reflected that her 17-OH progesterone¹⁷ level was
14 elevated at 1150 nanograms per deciliter (ng/dL).¹⁸ Patient 3's mother reported some issues with
15 adherence to medication. Respondent evaluated the patient and noted that they would continue
16 twice-a-day dosing to improve compliance. Her plan was for the patient to continue her
17 medications, undergo laboratory testing, and return in three to four months.

18 21. Patient 3 next presented to the clinic on June 30, 2015, at which time it was noted that
19 she was doing well on her maintenance medication. Laboratory testing reflected that her 17-OH
20 progesterone level was elevated at 3650. There was no notation of discussions regarding
21 medication adherence. The patient was instructed to return in four months.

22 ///

23
24 ¹⁶ CAH is a genetic disorder in which the two adrenal glands do not function properly because of
25 mutations in the gene for encoding adrenal steroid 21-hydroxylase enzyme. Without this enzyme, the
adrenal glands may produce too little cortisol and/or aldosterone and too much androgen.

26 ¹⁷ 17-OH progesterone is the hormone 17-hydroxyprogesterone and is produced by the adrenal
27 glands. 17-OH progesterone is converted to cortisol, which is important in regulating metabolism and the
immune system.

28 ¹⁸ Normal 17-OH progesterone level for children before puberty is in the range of 100 ng/dL and
for adults, less than 200 ng/dL.

1 22. Patient 3 next presented to the clinic on November 10, 2015, at which time laboratory
2 studies were ordered. Her 17-OH progesterone level was noted to be elevated at 3170 ng/dL.
3 The clinic fellow working with Respondent, Dr. F.R., noted that the elevated 17-OH progesterone
4 level may be due to medication non-compliance. He left a message for the patient's mother
5 requesting a return call to discuss medication compliance. He noted that if Patient 3 was not
6 missing any doses, she may benefit from higher doses of hydrocortisone in the morning and at
7 nighttime. There are no notes documenting any reply from Patient 3's mother.

8 23. Patient 3 next presented to the clinic on March 29, 2016. It was noted that she had
9 been on a higher hydrocortisone dosage but that it was decreased to the previous dosage due to an
10 increase in weight. Her 17-OH progesterone level was 1882 ng/dL.

11 24. On August 2, 2016, Patient 3 was seen by Respondent. Patient 3's mother reported
12 no missed doses of medication. Her 17-OH progesterone level of 1849 ng/dL, was similar to the
13 previously recorded result. She was to continue her medications and return in four months.

14 25. Patient 3 was next seen by Respondent on January 10, 2017. There was no
15 documentation regarding medication adherence nor were there any notes addressing symptoms
16 other than noting that the patient had menarche. Patient 3's 17-OH progesterone level was
17 documented to be markedly elevated at 11,767 ng/dL. There was no follow-up, assessment, or
18 plan of treatment of the elevated 17-OH progesterone level.

19 26. Patient 3 was next seen in the clinic on October 17, 2017. Respondent noted that the
20 patient had menarche 6 months ago with regular menses but also noted in her "impression"
21 section of her note that the patient had no menarche yet. The patient's 17-OH progesterone level
22 was documented to be very high again at 12,200 ng/dL. There was no follow-up of the elevated
23 17-OH progesterone level.

24 27. At the time of her interview with the Board on June 3, 2021, Respondent stated that
25 she called Patient 3's mother regarding the very high 17-OH progesterone levels and to discuss
26 compliance; however, there is no documentation of this telephone call.

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28 ///

1 **Patient 4**

2 28. On October 9, 2006, Patient 4, at six years of age, was seen in the clinic for
3 evaluation of short stature and endocrine late-effects.¹⁹ He had a history of pharyngeal
4 rhabdomyosarcoma²⁰ for which he had received radiation therapy. Laboratory studies revealed a
5 low Insulin-Like Growth Factor-1 (IGF-1) and normal Insuline-Like Growth Factor Binding
6 Protein-3 (IGFBP-3). Pituitary evaluation was noted to be normal other than IGF-1. Patient 4's
7 bone-age was read as 5 years. Respondent ordered a growth hormone (GH) stimulation test²¹ and
8 an adrenocorticotropic hormone (ACTH) stimulation test.²² Peak GH was 20 and peak cortisol
9 was 32, indicating normal results.

10 29. On May 24, 2010, at 10 years of age, a repeat IGF-1 was performed and the results
11 were slightly below normal. At that time, Patient 4's Free T4 and TSH were normal and his
12 cortisol level was low at 2.0. While the laboratory results were recorded in the medical record,
13 there was no discussion regarding the results. A GH stimulation test was repeated on June 17,
14 2010, and reported as normal with peak at 13. There was no repeat of the ACTH stimulation test.

15 30. On September 18, 2012, Patient 4's IGF-1 level was noted to be low for his age. No
16 treatment recommendations or follow-up was noted.

17 31. On September 26, 2013, Patient 4 was noted to have had a peak GH of 4.9 on
18 stimulation test; consistent with GH deficiency and his cortisol level was low. GH treatment of
19 1.1 mg daily was initiated. It was noted that he did not keep his visits for ACTH stimulation tests
20 but that ACTH stimulation testing would be deferred for now as clinically, the patient had no
21 signs of adrenal insufficiency.

22 _____
23 ¹⁹ Endocrine late-effects includes impairments of the hypothalamus/pituitary, thyroid and gonads,
24 as well as decreased bone mineral density and metabolic derangements common in childhood cancer
survivors.

25 ²⁰ Rhabdomyosarcoma is a rare type of cancer that forms in skeletal muscle tissue, mostly in
children and adolescents.

26 ²¹ GH stimulation test is done to determine whether the pituitary gland is properly releasing
27 growth hormone into the bloodstream.

28 ²² ACTH stimulation test measures the ability of the adrenal cortex to respond to ACTH by
producing cortisol appropriately.

1 32. Respondent saw Patient 4 on July 6, 2014, at which time she noted that he had
2 excellent interval growth with annualized growth velocity at 90% on his current dose of GH of
3 1.1 mg daily. She further noted that he was at risk for pituitary hormone deficiencies because of
4 his history of radiation. Her plan was to obtain pituitary assessment and obtain IFG-1 level for
5 GH dose adjustment. She recommended that he return in 4 months.

6 33. Patient 4 was seen by Respondent on November 30, 2014 in follow-up. At that time,
7 Respondent noted that the Patient 4's current dose of growth hormone was meeting clinical
8 expectations and he was to return in 4 months.

9 34. Patient 4 was seen by Respondent on September 14, 2015 in follow-up. At that time,
10 Respondent noted that Patient 4 was to continue on growth hormone therapy of 1.2 mg daily. No
11 tests were ordered. Patient 4 was instructed to return in 3 months.

12 35. Patient 4 was seen by Respondent on January 5, 2016, at which time he was 15 years,
13 4 months of age. She noted that he was taking growth hormone therapy of 1.4 mg daily and
14 misses 1 to 2 doses every week due to forgetting or not being present at home.²³ He was noted to
15 have had minimal growth since his last visit. Respondent's plan was to continue the growth
16 hormone therapy and order a bone-age x-ray to determine whether his growth plates were still
17 open. Patient 4 was instructed to return in 6 months.

18 36. Patient 4 was seen by Respondent on July 5, 2016. His height velocity was noted to
19 be at 95% for his age. Growth hormone therapy was continued and he was instructed to return in
20 4 months.

21 37. On March 7, 2017, Patient 4 was seen by Respondent. She noted that the patient's
22 height velocity was still at 95% for age. She recommended the continuation of growth hormone
23 therapy. She ordered laboratory tests to adjust dosing. She noted that the patient was at risk of
24 other anterior pituitary deficiencies given his prior radiation exposure and that he was unlikely to
25 have posterior pituitary issues, and no history of symptoms to suggest issues. No pituitary
26 evaluation was ordered. Patient 4 was instructed to return in four months.

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28 ²³ There is no documentation reflecting the dose increase of growth hormone from 1.2 mg to 1.4
mg daily.

1 38. Patient 4 was seen by Respondent on July 11, 2017. He was noted to have no interval
2 issues, no headaches, no joint pains, no missed doses and that he self-administers his injections.
3 His growth hormone therapy was continued. It was again noted that he was at risk of other
4 pituitary deficiencies given prior radiation exposure and that he was unlikely to have posterior
5 pituitary issues, and no history of symptoms to suggest issues.

6 **Patient 5**

7 39. Patient 5, a 15-year-old male, first presented to the clinic on March 8, 2018, for a
8 pituitary function evaluation. He had been diagnosed as having a pituitary tumor versus
9 craniopharyngioma on MRI after two months of chronic headaches and decreased vision. An
10 MRI report reflected that Patient 5 had a lobulated solid and cystic sellar/suprasellar mass with
11 layering hemorrhagic contents. The mass was noted to have superiorly displaced the optic
12 chiasm. Differential considerations were noted to include craniopharyngioma; and less likely,
13 hemorrhagic pituitary macroadenoma. Laboratory studies from an outside hospital reflected a
14 substantially elevated prolactin level greater than 1500.²⁴ Respondent diagnosed Patient 5 with
15 pituitary macroprolactinoma.²⁵ She recommended an assessment of the entire pituitary function.
16 She ordered assessments of pituitary hormone levels, including TSH, free T4, ACTH, cortisol,
17 testosterone, luteinizing hormone (LH), and a basic metabolic panel. Respondent did not order a
18 repeat prolactin level and relied on the reported level from the outside hospital.

19 40. Following confirmation with Patient 5's neurosurgeon that he would be undergoing
20 pharmacologic therapy rather than surgery, Patient 5 was started on cabergoline, a medication
21 used to lower prolactin level and reduce tumor size.

22 41. Patient 5 was next seen on April 10, 2018, at which time it was noted that he was
23 responding very well to treatment with cabergoline with improvement in energy and vision.
24 Respondent ordered prolactin, TSH, and free T4 studies. Patient 5's prolactin level was noted to
25 have decreased to 107.

26 ²⁴ The reference range for prolactin is 3.8 to 18.9.

27 ²⁵ Prolactinomas is a type of pituitary tumor that produces an excessive amount of the hormone
28 prolactin. If the tumor size is greater or equal to one centimeter, it is referred to as a macroprolactinoma.

1 42. Patient 5 was seen on June 12, 2018, at which time it was noted that he continued to
2 respond very well to treatment with cabergoline. Respondent ordered prolactin, testosterone,
3 and hemoglobin A1C studies as well as a follow-up MRI. Patient 5's laboratory results reflected
4 that his prolactin level normalized at 17.1 and the MRI showed a decrease in the size of the
5 tumor.

6 43. By October 9, 2018, Respondent noted that Patient 5's macroprolactinoma responded
7 very well to treatment with cabergoline. His vision was restored 100%, his lethargy had resolved,
8 and his appetite had significantly improved. He was noted to have an excessive weight gain and
9 was at risk for Type 2 diabetes. Respondent ordered prolactin, testosterone, LH, IGF-1, cortisol,
10 hemoglobin A1C and a metabolic panel as well as a further MRI of the brain.

11 **Patient 6**

12 44. On January 23, 2018, Patient 6, a four-year-old female with a complex past medical
13 history, presented to the clinic in order to have hypothyroidism ruled out as a cause of macrocytic
14 anemia. Laboratory studies performed on January 11, 2018 reflected an elevated TSH of 28.8.²⁶
15 and normal free T4 level. She also was noted to have had a low hemoglobin of 8.6 g/dL.²⁷
16 Respondent noted that though this was her first encounter with Patient 6, the patient's TSH and
17 free T4 had been monitored by the clinic in the past. Respondent's plan was to obtain laboratory
18 testing of TSH, free T4, and TPO antibody levels. Respondent noted that if Patient 6's TSH level
19 continued to be elevated and her antibodies were positive, she would be started on levothyroxine
20 therapy. In addition, Respondent ordered vitamin B-12 and folate levels, as well as IGG-1 and
21 IGFBP-3 levels.

22 45. On February 21, 2018, Respondent noted that Patient 6 continued to have an elevated
23 TSH level with a normal free T4 level. Respondent recommended a repeat of TSH, free T4, TPO
24 antibody, T3 and reverse T3 laboratory tests. She noted that normalization of TSH with
25 levothyroxine therapy was an option but would unlikely correct macrocytic anemia. She noted

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27 ²⁶ The reference range for TSH is 0.3 to 4.7.

28 ²⁷ The reference range for hemoglobin is 11.5 to 13.5.

1 that she would start levothyroxine therapy if the TSH level was still elevated and that
2 normalization of TSH was the goal of intervention.

3 46. Patient 6 was next seen by Respondent on March 6, 2018. At that time, Respondent
4 noted that Patient 6 had chronic TSH elevation, positive TPO antibodies titer,²⁸ and normal T4
5 and T3 levels. She noted that the elevated TSH and positive TPO levels may represent an assay
6 interference with very high B-12 level or a mild TSH resistance. She also noted that primary
7 autoimmune thyroiditis was unlikely. Respondent recommended levothyroxine therapy with the
8 goal to normalize the patient's TSH level.

9 47. On March 7, 2018, levothyroxine was started with the plan to repeat a complete blood
10 count (CBC) when on levothyroxine therapy to see if hemoglobin was improving with repletion.

11 **FIRST CAUSE FOR DISCIPLINE**

12 **(Gross Negligence)**

13 48. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),
14 in that she committed gross negligence in her care and treatment of Patients 1, 2, and 3.
15 Complainant refers to and, by this reference, incorporates herein, paragraphs 10 through 28,
16 above, as though fully set forth herein. Respondent committed the following acts of gross
17 negligence:

18 **Patient 1**

19 49. There is a critical period during which brain development requires normal levels of
20 thyroid hormone in newborns. When treating infants with congenital hypothyroidism, the
21 standard of care requires that physicians start thyroid replacement as soon as possible, typically
22 within the first three to five days of life following diagnosis via newborn screening. Once thyroid
23 replacement therapy is started, the dosage of thyroid hormone is adjusted to maintain normal
24 levels of TSH and free T4, but the medication is almost always continued until the patient is past
25 the critical period for brain development, which is two to three years of age.

26 50. In the event that the physician is concerned that the infant has macro-TSH, which is
27 an exceedingly rare condition, rather than congenital hypothyroidism and performs tests to rule in

28 ²⁸ Positive TPO antibodies is a marker for autoimmune thyroid disease.

1 or out macro-TSH, thyroid replacement therapy should be continued until laboratory results are
2 received. Further, measurements of thyroid antibodies are not very useful for diagnosis of macro-
3 TSH.²⁹ Respondent inappropriately discontinued Patient 1's thyroid replacement therapy while
4 performing tests to rule out macro-TSH.

5 **Patient 2**

6 51. Hypoparathyroidism is suspected when the PTH level is inappropriately low in
7 relation to calcium level. Elevated phosphorus levels are also characteristic of
8 hypoparathyroidism. Calcium supplements alone are insufficient to treat hypoparathyroidism.

9 52. When a patient continues to have low calcium levels despite treating with increased
10 calcium, the standard of care requires the prompt modification of treatment to normalize calcium
11 levels. Respondent failed to restart Patient 2's calcitriol to normalize her calcium levels, when
12 Patient 2 had persistently low calcium levels despite an increased calcium dosage.

13 53. Hypocalcemia is a metabolic abnormality with potentially serious, possibly life-
14 threatening consequences. When a patient has hypocalcemia, the standard of care requires
15 frequent repeat testing of calcium levels and adjustment of treatment until the patient's calcium
16 level is within normal range. Respondent failed to perform repeat testing of Patient 2's calcium
17 and document a plan for follow-up testing following the report of low calcium levels in March
18 2017.

19 **Patient 3**

20 54. When a minor patient is non-compliant with medication, the standard of care requires
21 that the physician notify the patient's parent/guardian promptly of poor medication adherence.

22 55. Lack of sufficient hydrocortisone replacement can lead to episodes of adrenal crisis.
23 Patient 3 had two markedly elevated 17-OH progesterone levels which indicated a substantial
24 change from multiple previous 17-OH progesterone levels, which is clear evidence of insufficient
25 administration of hydrocortisone. Respondent failed to contact Patient 3's parent/guardian after
26 the first substantially elevated 17-OH progesterone level on January 10, 2017.

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28 ²⁹ While a test for TSH receptor blocking antibodies is generally used to rule in or out macro-
TSH, tests for TPO and thyroglobulin antibodies are not useful for ruling in or out macro-TSH.

1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 56. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),
4 in that she committed repeated negligent acts with respect to her care and treatment of Patients 1,
5 2, 3, 4, 5, and 6. Complainant refers to and, by this reference, incorporates herein, paragraphs 10
6 through 55, above, as though fully set forth herein. The circumstances are as follows:

7 57. Each of the alleged acts of gross negligence set forth above in the First Cause for
8 Discipline is also a repeated negligent act.

9 58. In addition, Respondent committed the following repeated acts of negligence:

10 **Patient 3**

11 59. The standard of care requires that medication adherence and pertinent symptoms are
12 discussed at each visit and documented accurately in the medical record. Respondent failed to
13 document medication adherence at each of Patient 3's visits. Respondent failed to document the
14 presence or absence of pertinent symptoms at each of Patient 3's visits.

15 **Patient 4**

16 60. Patients with history of radiation exposure to the head for treatment of malignancy
17 are at risk for hypopituitarism. Screening tests for pituitary function should be performed on a
18 yearly basis, or more frequently when the patient has symptoms to suggest pituitary deficiencies.

19 61. Patient 4 developed GH deficiency which indicated an increased risk for other
20 pituitary hormone deficiencies. Respondent failed to order regular laboratory screening tests for
21 Patient 4 on annual basis.

22 62. The standard of care requires that the physician document the medical decision
23 making, including the interpretation of laboratory results, the rationale behind evaluation and
24 treatment decisions, as well as discussions of the risks and benefits of GH treatment with the
25 patient's parent/guardian. Respondent failed to document clinical decision-making and
26 laboratory interpretation in Patient 4's medical records.

27 63. Respondent failed to document discussions of the risks and benefits of GH treatment
28 with Patient 4's parent/guardian.

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Patient 5

64. The standard of care requires documentation of medical decision-making, including consideration of appropriate differential diagnosis, interpretation of laboratory results, and patient education concerning symptoms and possible side effects of medication. Respondent failed to document her medical decision-making in her care and treatment of Patient 5. She failed to document any discussion of the results of Patient 5's laboratory studies with his parent/guardian, failed to document a treatment plan for ongoing monitoring of Patient 5's pituitary function, and failed to document advising the patient and his parent/guardian of potential complications of the disease or adverse effects of medication.

65. The standard of care requires that laboratory-based diagnoses be confirmed prior to initiating treatment, so that diagnoses are not erroneously based on laboratory errors. This is particularly important when response to treatment will be based on repeat measurement of laboratory values. Upon Patient 5's initial presentation, Respondent noted that his prolactin level, which was measured at an outside hospital, was elevated. Respondent failed to order a repeat prolactin level to confirm her diagnosis before initiating therapy with cabergoline.

66. Development of hypopituitarism can occur in patients with a large pituitary gland or in those with suprasellar masses and in severe cases, it can be life-threatening. The standard of care requires ongoing monitoring of pituitary function for patients with a large pituitary gland or in those patients with suprasellar masses. Respondent failed to provide consistent laboratory testing to monitor Patient 5's pituitary function.

Patient 6

67. Elevated TSH in the setting of positive thyroid antibodies is generally diagnostic of autoimmune thyroiditis, particularly if the TSH level is rising over time. The standard of care requires that the physician initiate thyroid treatment as soon as the positive antibodies are found and consistently an elevated TSH level is documented. Respondent failed to promptly initiate levothyroxine therapy in response to Patient 6's rising TSH level.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Failure to Maintain Adequate and Accurate Medical Records)**

3 68. Respondent is subject to disciplinary action under section 2266 of the Code for failing
4 to maintain adequate and accurate records relating to her care and treatment of Patients 1, 2, 3, 4,
5 5, and 6. The circumstances are as follows:

6 69. The allegations in the First and Second Causes for Discipline above, are incorporated
7 herein by reference as if fully set forth.

8 **PRAYER**

9 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
10 and that following the hearing, the Medical Board of California issue a decision:

- 11 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 82389,
12 issued to Respondent Anna Pawlikowaska-Haddal, M.D.;
- 13 2. Revoking, suspending or denying approval of Respondent Anna Pawlikowaska-
14 Haddal, M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 15 3. Ordering Respondent Anna Pawlikowaska-Haddal, M.D., to pay the Board the costs
16 of the investigation and enforcement of this case, and if placed on probation, the costs of
17 probation monitoring; and
- 18 4. Taking such other and further action as deemed necessary and proper.

19
20 DATED: DEC 29 2021

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22 for: WILLIAM PRASIFKA
23 Executive Director
24 Medical Board of California
25 Department of Consumer Affairs
26 State of California
27 Complainant

Reji Varghese
Deputy Director

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