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

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

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. 669 Highway 52, Box 8 Cuchillo, New Mexico 87901-9026 Physician's and Surgeon's Certificate No. A 82389, Respondent.	Case No. 800-2018-050802 OAH No. 2022010279 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

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

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

///

3. On or about March 21, 2003, the Board issued Physician's and Surgeon's Certificate No. A 82389 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-050802 and will expire on November 30, 2022, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-050802 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on January 1, 2022. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of First Amended Accusation No. 800-2018-050802 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2018-050802. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to be represented by counsel, at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in First Amended Accusation No. 800-2018-050802, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

///

9. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation and that those charges constitute cause for discipline. Respondent hereby gives up her right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 82389, issued to Respondent Anna Pawlikowska-Haddal, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline

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

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

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

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

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

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

ACCEPTANCE

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

DATED: 06-11-2022

ANNA PAWLIKOWSKA-HADDAL, M.D.
Respondent

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

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

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

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

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

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

ACCEPTANCE

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

DATED: _____ _____

ANNA PAWLIKOWSKA-HADDAL, M.D.
Respondent

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: 6/13/2022

Respectfully submitted,

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

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

LA2021604488
65171715.docx

Exhibit A

First Amended Accusation No. 800-2018-050802

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

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.** **669 Highway 52, Box 8** **Cuchillo, New Mexico 87901-9026** **Physician's and Surgeon's Certificate No. A 82389,** Respondent.	Case No. 800-2018-050802 **FIRST AMENDED ACCUSATION**

PARTIES

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

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

///

///

JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2227 of the Code states:

(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 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 provisions of this chapter:

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

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

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

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

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

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

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(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.

///

COST RECOVERY

8. Section 125.3 of the Code states:

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

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

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

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

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

(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

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

FACTUAL ALLEGATIONS

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

Patient 1

10. Patient 1, a full-term male infant, was born on October 25, 2017, with congenital hypothyroidism. His mother had a history of hypothyroidism[2] treated with levothyroxine.[3] On October 26, 2017, Patient 1's newborn screening laboratory tests revealed an elevated thyroid stimulating hormone (TSH) value of 558.03 milli-international units per liter (mIU/L) with a repeat value of 680.1 mIU/L, suggesting congenital hypothyroidism.[4] On October 29, 2017, the California Newborn Screening Program[5] reported the test result to the clinic. Patient 1's parents were contacted by the clinic and instructed to bring Patient 1 in for repeat laboratory studies and to start levothyroxine 50 micrograms (mcg) daily. Respondent called Patient 1's mother on October 30, 2017 to confirm that laboratory studies were done, medication was given, and that Patient 1 would be seen the following day.

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

---

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

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

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

[4] Congenital hypothyroidism occurs when a newborn infant is born without the ability to produce 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.

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

12. At the time of her interview with the Board on June 3, 2021, Respondent stated that she stopped the levothyroxine therapy because she thought that the patient had macro-TSH[9] due to material antibodies. She stated that if the TSH was high and free T4 was low, she would restart the levothyroxine therapy.

Patient 2

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

///

---

[6] T4, also known at thyroxine, is a type of thyroid hormone. T4 test measures the blood level of the hormone T4.

[7] TPO is an enzyme produced by the thyroid gland.

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

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

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

[11] Familial hypercalciuric hypercalcemia (FHH) is a rare condition inherited in an autosomal 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.

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

level was reported as low at 6.8 to 7.0[13] and her phosphorus level was reported high at 7.9.[14] The PTH level and genetic testing remained pending. Respondent noted that Patient 2 likely had the CaSR mutation like her siblings and started Patient 2 on calcitriol and a calcium supplement. Patient 2's father was advised to return Patient 2 to see Respondent in follow-up in one month.

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

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

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

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

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

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

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

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

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

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

Patient 3

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

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

///

---

[16] CAH is a genetic disorder in which the two adrenal glands do not function properly because of 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.

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

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

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

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

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

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

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

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

///

///

Patient 4

28. On October 9, 2006, Patient 4, at six years of age, was seen in the clinic for evaluation of short stature and endocrine late-effects.[19] He had a history of pharyngeal rhabdomyosarcoma[20] for which he had received radiation therapy. Laboratory studies revealed a low Insulin-Like Growth Factor-1 (IGF-1) and normal Insuline-Like Growth Factor Binding Protein-3 (IGFBP-3). Pituitary evaluation was noted to be normal other than IGF-1. Patient 4's bone-age was read as 5 years. Respondent ordered a growth hormone (GH) stimulation test[21] and an adrenocorticotropic hormone (ACTH) stimulation test.[22] Peak GH was 20 and peak cortisol was 32, indicating normal results.

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

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

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

---

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

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

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

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

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

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

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

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

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

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

---

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

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

Patient 5

39. Patient 5, a 15-year-old male, first presented to the clinic on March 8, 2018, for a pituitary function evaluation. He had been diagnosed as having a pituitary tumor versus craniopharyngioma on MRI after two months of chronic headaches and decreased vision. An MRI report reflected that Patient 5 had a lobulated solid and cystic sellar/suprasellar mass with layering hemorrhagic contents. The mass was noted to have superiorly displaced the optic chiasm. Differential considerations were noted to include craniopharyngioma; and less likely, hemorrhagic pituitary macroadenoma. Laboratory studies from an outside hospital reflected a substantially elevated prolactin level greater than 1500.[24] Respondent diagnosed Patient 5 with pituitary macroprolactinoma.[25] She recommended an assessment of the entire pituitary function. She ordered assessments of pituitary hormone levels, including TSH, free T4, ACTH, cortisol, testosterone, luteinizing hormone (LH), and a basic metabolic panel. Respondent did not order a repeat prolactin level and relied on the reported level from the outside hospital.

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

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

---

[24] The reference range for prolactin is 3.8 to 18.9.

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

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

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

Patient 6

44. On January 23, 2018, Patient 6, a four-year-old female with a complex past medical history, presented to the clinic in order to have hypothyroidism ruled out as a cause of macrocytic anemia. Laboratory studies performed on January 11, 2018 reflected an elevated TSH of 28.8.[26] and normal free T4 level. She also was noted to have had a low hemoglobin of 8.6 g/dL.[27] Respondent noted that though this was her first encounter with Patient 6, the patient's TSH and free T4 had been monitored by the clinic in the past. Respondent's plan was to obtain laboratory testing of TSH, free T4, and TPO antibody levels. Respondent noted that if Patient 6's TSH level continued to be elevated and her antibodies were positive, she would be started on levothyroxine therapy. In addition, Respondent ordered vitamin B-12 and folate levels, as well as IGG-1 and IGFBP-3 levels.

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

///

[26] The reference range for TSH is 0.3 to 4.7.

[27] The reference range for hemoglobin is 11.5 to 13.5.

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

Patient 1

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

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

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

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

Patient 2

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

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

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

Patient 3

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

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

---

[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.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

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

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

Patient 3

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

Patient 4

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

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

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

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

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' rising TSH level.

///

///

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

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

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

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 82389, issued to Respondent Anna Pawlikowaska-Haddal, M.D.;

2. Revoking, suspending or denying approval of Respondent Anna Pawlikowaska-Haddal, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Anna Pawlikowaska-Haddal, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: DEC 29 2021

Reji Varghese
Deputy Director

for: WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2021604488