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

In the Matter of the Accusation Against: Raymond Israel Poliakin, M.D. Physician's & Surgeon's Certificate No G 42576 Respondent	Case No. 800-2018-040916

DECISION

The attached Stipulated Settlement and Disciplinary 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 November 10, 2021.

IT IS SO ORDERED October 12, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
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Attorneys for Complainant

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

In the Matter of the Accusation Against: RAYMOND ISRAEL POLIAKIN, M.D. 227 West Janss Road, Suite 300 Thousand Oaks, CA 91360-1885 Physician's and Surgeon's Certificate No. G 42576, Respondent.	Case No. 800-2018-040916 OAH No. 2021030214 **STIPULATED SETTLEMENT AND DISCIPLINARY 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. Raymond Israel Poliakin, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, whose address is 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071-1562.

3. On or about July 14, 1980, the Board issued Physician's and Surgeon's Certificate No. G 42576 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-040916, and will expire on September 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-040916 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 25, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-040916 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-040916. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his 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.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-040916, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2018-040916, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 42576 to disciplinary action.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the imposition of discipline by the Board as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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 Settlement 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.

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

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 42576 issued to Respondent Raymond Israel Poliakin, M.D. is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4), with the following

attendant terms and conditions.

A. PUBLIC REPRIMAND.

This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient 1 as set forth in Accusation No. 800-2018-040916, is as follows:

> In 2014, you committed acts constituting negligence and a failure to maintain adequate and accurate medical records in violation of Business and Professions Code sections 2234, subdivision (c), and 2266, in your care and treatment of Patient 1, by failing to address and document Patient 1's noncompliance with the perinatologist's recommendations with respect to fetal assessment.

B. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the medical record keeping course within the designated time period, Respondent shall receive a notification from

the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the medical record keeping course has been completed. Failure to successfully complete the medical record keeping course outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/30/21

RAYMOND ISRAEL POLIAKIN, M.D.
Respondent

I have read and fully discussed with Respondent Raymond Israel Poliakin, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/2/21

PETER R. OSINOFF
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: Sept 3, 2021

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

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Attorneys for Complainant

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

In the Matter of the Accusation Against: RAYMOND ISRAEL POLIAKIN, M.D. 227 West Janss Road, Suite 300 Thousand Oaks, California 91360-1885 Physician's and Surgeon's Certificate No. G 42576, Respondent.	Case No. 800-2018-040916 **A C C U S A T I O N**

PARTIES

1. William Prasifka ("Complainant") brings this 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 July 14, 1980, the Medical Board issued Physician's and Surgeon's Certificate Number G 42576 to Raymond Israel Poliakin, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2021, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California 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.

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FACTUAL SUMMARY

8. On May 13, 2014, Patient 1,[1] a 34-year-old gravida 4, para 2 patient, presented to Respondent for prenatal care. Patient 1 was at 12 weeks' gestation and sought to transfer her care to Respondent from another obstetrical provider. She gave a past medical history of a cardiomyopathy[2] from birth that had been followed regularly with no treatment required. Respondent performed a review of systems, physical examination and transvaginal obstetrical ultrasound to calculate the patient's estimated date of confinement. Respondent referred Patient 1 to a perinatologist and cardiologist and instructed her to return to see him in 4 weeks.

9. On May 15, 2014, Patient 1 was seen in consultation by perinatologist, Dr. R.M. At that time, Patient 1 reported her history, as well as her family history of cardiomyopathy, including her sister and cousin. An ultrasound performed by Dr. R.M. was interpreted as normal; however, cardiac evaluation was limited due to the early gestational age. The risk of cardiac defect was noted to have been discussed with the patient. Patient 1 was instructed to return in 2 weeks for a complete cardiac assessment. Dr. R.M. also recommended a genetic evaluation, with fragile X screening, as well as a second trimester ultrasound with a follow-up genetic fetal ultrasound, fetal cardiac evaluation, and 3-dimensional imaging. Genetic counseling was noted to be offered as needed based on the results of the patient's Fully Integrated Screen, family history, and fetal structural evaluation.

10. On May 30, 2014, Patient 1 saw cardiologist Dr. J.E. An echocardiogram was performed and Dr. J.E. noted it to be a normal examination with no major changes when compared to Patient 1's March 13, 2009 study.

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[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1, with the identity of the patient disclosed to Respondent in discovery.

[2] Cardiomyopathy is a heart muscle disease in which the heart is abnormally enlarged, thickened, and/or stiffened. As a result, the heart muscle's ability to pump blood is less efficient, often causing heart failure and the backup of blood into the lungs or rest of the body. The disease can also cause abnormal heart rhythms.

11. On June 2, 2014, Patient 1 returned to see Dr. R.M. for a fetal heart assessment. On ultrasound, the fetal heart appeared normal except for a left echogenic foci.[3] A second trimester ultrasound was scheduled for July 7, 2014 with Dr. R.M.; however, the patient cancelled the appointment.

12. Respondent did not have a copy of the June 2, 2014 ultrasound results in the patient's chart at the time he provided prenatal care and treatment to Patient 1. Respondent testified in deposition that he obtained the June 2, 2014 ultrasound results in 2016 after the patient filed a malpractice action against him and that he does not recall if he was aware of the June 2, 2014 ultrasound results at the time he was providing care and treatment to the patient.

13. The patient cancelled her second trimester ultrasound appointment scheduled for July 7, 2014 with perinatologist, Dr. R.M. Respondent did not document that the patient cancelled the July 7, 2014 second trimester ultrasound appointment and Respondent testified that he does not recall if he was aware of the cancellation at the time he was providing care and treatment of Patient 1.

14. Respondent saw Patient 1 on a regular basis for prenatal visits throughout her prenatal course from May 13, 2014 through November 2014. Respondent did not document that he recommended that Patient 1 follow-up with the perinatologist given her history of cardiomyopathy. Respondent did not document that Patient 1 refused or declined to follow-up with the perinatologist for a second trimester ultrasound. No abnormalities or patient complaints were noted by Respondent during the prenatal course. Routine prenatal blood work and routine genetic blood testing was normal.

15. Respondent performed obstetrical ultrasounds in his office on July 14, 2014 and September 8, 2014. On both occasions, Respondent documented that the fetal heart was examined with normal findings. Specifically, he noted a normal four chamber, a normal left outflow tract, a normal right outflow tract three vessel, a normal aortic arch, a normal cardiac rhythm, and a normal ductal arch. There is no documentation reflecting that Respondent

[3] A left echogenic foci of the fetal heart represent papillary muscle mineralization within the left ventricle and is generally a normal variant in fetal development.

discussed the limitations of the ultrasounds he performed in his office or that he informed the patient that an ultrasound by a perinatologist would be more sensitive to structural defects with the formation of the heart.

16. On December 3, 2014, Patient 1 delivered a 7 pound, 13 ounce female infant by normal spontaneous vaginal delivery at Los Robles Hospital. Neonatologist, Dr. M.A., followed the infant. No cardiac evaluation of the infant took place. Patient 1 and her infant were discharged on post-partum day number 2.

17. Three weeks later, Patient 1's infant was taken to the emergency department at Los Robles Hospital with complaints of poor feeding and increasing lethargy. Patient 1 reported that the infant had appeared tachypneic[4] and cyanotic for two weeks and was taken to the pediatrician several times, at which time Patient 1 received repeated reassurances that the infant was fine. Upon arrival to the emergency department, the infant was tachypneic and lethargic. She was admitted to the Neonatal Intensive Care Unit ("NICU") and intubated. An echocardiogram revealed severe cardiomyopathy. She suffered a cardiac arrest, was resuscitated and upon stabilization, transferred to the Cardiac NICU at Children's Hospital Los Angeles where she was treated for multiple ventricular septal defects[5] and severe cardiomyopathy. As a result of hypoxic-ischemic encephalopathy,[6] the infant was placed on full medical support. On January 5, 2015, support was withdrawn and the infant expired.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the prenatal care and treatment of

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[4] Tachypneic is used to describe someone who has excessively rapid breathing.

[5] A ventricular septal defect ("VSD") is a congenital heart defect in which there is a hole in the septum that separates the two lower ventricles of the heart. A ventricular septal defect happens during pregnancy if the wall that forms between the two ventricles does not fully develop, leaving a hole.

[6] Hypoxic ischemic encephalopathy is a serious and life-threatening brain injury triggered by an interruption of oxygen circulation and blood flow restriction.

Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 17, above, as though fully set forth herein. The circumstances are as follows:

19. When providing prenatal care and treatment to a patient with a known medical condition, such as cardiomyopathy, the standard of care requires that the obstetrician refer the patient to a perinatologist for consultation. The obstetrician is responsible for ensuring that the patient follows the consultant's recommendations. Should the patient fail to follow the consultant's recommendations, the obstetrician must document the noncompliance as well as formulate an alternative treatment plan, taking into consideration the patient's noncompliance.

20. Respondent knew Patient 1's fetus was at risk for a cardiomyopathy and failed to ensure that Patient 1's fetus was properly evaluated. Respondent referred Patient 1 to Dr. R.M. for a perinatology consultation. Dr. R.M. recommended a second trimester ultrasound with a follow up genetic fetal ultrasound, fetal cardiac evaluation, and 3-dimensional imaging. The patient did not follow up with the recommendations enumerated by Dr. R.M. Respondent failed to address Patient 1's noncompliance with Dr. R.M.'s recommendations and failed to formulate an alternative plan to obtain the required assessment of the fetal heart. This is a simple departure from the standard of care.

21. When recommending treatment, the standard of care requires that an obstetrician discuss the risks and benefits of the proposed treatment, as well as possible alternative courses of treatment. Discussions regarding treatment and the associated risks, benefits and alternatives must be conducted in lay terms with the opportunity for the patient to ask questions and have those questions answered. These discussions should be documented in the patient's medical records.

22. Patient 1 declined to undergo a thorough fetal cardiac assessment during the second trimester of her prenatal course without an appropriate informed consent discussion with Respondent. Respondent failed to discuss the clinical significance of Patient 1's congenital cardiomyopathy with respect to her pregnancy, including the necessity of a thorough fetal cardiac assessment during the second trimester, as well as the associated risks should she decline the recommended treatment. This is a simple departure from the standard of care.

23. A standard obstetrical ultrasound examination requires that the obstetrician assess the four chambers, as well as the ventricular outflow tracts of the fetal heart. When performing obstetrical ultrasounds, the standard of care requires that the obstetrician obtain informed consent, including a discussion with the patient regarding the limitations of the ultrasound examination being performed, as well as the potential necessity of further testing.

24. Respondent performed obstetrical ultrasounds on July 14, 2014 and September 8, 2014. Respondent reported normal cardiac findings with no documentation of informed consent, patient admonitions regarding the limitations of the studies, or the necessity or recommendation of further studies. This is a simple departure from the standard of care.

25. Respondent's acts and/or omissions as set forth in 18 through 24, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

26. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records concerning the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates Paragraphs 18 through 25, above, as though set forth fully herein.

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 G 42576, issued to Raymond Israel Poliakin, M.D.;

2. Revoking, suspending or denying approval of Raymond Israel Poliakin, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Raymond Israel Poliakin, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JAN 25 2021

For: WILLIAM PRASIFKA REJI VARGHESE
Executive Director DEPUTY DIRECTOR
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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