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

In the Matter of the Accusation Against: Craig Richard Thayer, M.D. Physician's and Surgeon's Certificate No. G 62641 Respondent.	Case No. 800-2021-078500

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 October 20, 2023.

IT IS SO ORDERED September 21, 2023.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

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

In the Matter of the Accusation Against: **CRAIG RICHARD THAYER, M.D.** **4321 Cleveland Hwy** **Cohutta, GA 30710-9157** **Physician's and Surgeon's Certificate No. G 62641** Respondent.	Case No. 800-2021-078500 OAH No. 2022120646 **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. Reji Varghese (Complainant) is the Interim 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 Kalev Kaseoru, Deputy Attorney General.

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2. Respondent Craig Richard Thayer, M.D. (Respondent) is represented in this proceeding by attorney M. Bradley Wishek, Esq., whose address is: 756 University Avenue, Sacramento, CA, 95825.

3. On or about April 11, 1988, the Board issued Physician's and Surgeon's Certificate No. G 62641 to Craig Richard Thayer (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-078500, and will expire on August 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-078500 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 September 29, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-078500 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. 800-2021-078500. 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. Having had the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2021-078500, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. 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. 800-2021-078500, 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 62641 to disciplinary action.

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

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

14. 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.

ADDITIONAL PROVISIONS

15. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-listed matter.

16. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

17. 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

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 62641 issued to Respondent Craig Richard Thayer, M.D., shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code, section 2227, subdivision (a) (4). This public reprimand, which is issued in connection Respondent's care and treatment of Patients A, B, C and D, as set forth in Accusation No. 800-2021-078500 , is as follows:

"On October 3, 2020, through March 14, 2021, while treating Patients A, B, C, and D, you engaged in a series of repeated negligent acts and failed to maintain adequate and accurate records as set forth in Accusation No. 800-2021-078500. Thereafter, your credentialing was subject to review by the Medical Executive Committee (MEC) at the hospital where these acts occurred, and you successfully completed proctored cases and a medical record keeping course and the review was terminated with recommendations. You passed a comprehensive University of California at San Diego Physician Assessment and Clinical Education Program Physician Competency Assessment in 2022, which included minor recommendations for completion of continuing medical education which Respondent timely completed."

B. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, legal reviews, and investigation and other costs, in the amount of $25,652.40 (Twenty five thousand six hundred fifty two dollars and forty cents). This amount reflects a reduction of costs by the Board. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered unprofessional conduct and may serve as the grounds for further disciplinary action.

Payment must be made in full within 365 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered unprofessional conduct and may serve as the grounds for further disciplinary action.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, M. Bradley Wishek, Esq. 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: 5/24/2023

CRAIG RICHARD THAYER, M.D.
Respondent

I have read and fully discussed with Respondent Craig Richard Thayer, 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: 5/24/2023

M. BRADLEY WISHEK, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: May 30, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

KALEV KASEORU
Deputy Attorney General
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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: **CRAIG RICHARD THAYER, M.D.** **4321 Cleveland Hwy.** **Cohutta, GA 30710-9157** **Physician's and Surgeon's Certificate No. G 62641,** Respondent.	Case No. 800-2021-078500 **ACCUSATION**

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 April 11, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number G 62641 to Craig Richard Thayer, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2023, unless renewed.

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JURISDICTION

3. This 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 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

STATUTORY PROVISIONS

5. 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.
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> (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.

6. 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

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

8. On or about May 21, 2021, the Medical Board of California (MBC) received an 805 report from Marshall Medical Center (MMC) on behalf of Respondent. The report indicated that restrictions had been imposed on Respondent's staff privileges in response to concerns regarding his surgical practice and medical record keeping. Respondent agreed to voluntarily accept using a surgical assistant on certain types of surgeries while the facility's Medical Executive Committee (MEC) conducted a review of Respondent's practice. After an external review, the MEC imposed additional restrictions on Respondent's next twenty cases in that they were required to be proctored as a condition of performing surgery, along with monitoring and educational requirements. Respondent's practice was to be evaluated by July 31, 2021, resulting in either continued evaluation, modification of these restrictions, or termination.

9. Respondent is a physician and surgeon Board Certified in General Surgery, who at all times alleged herein worked at Marshall Medical Center, Placerville, CA.

Patient A[1]

10. On or about January 22, 2021, Respondent performed a right hemicolectomy on Patient A, a 64-year-old male with a history of colonic polyps, who had been referred to

[1] Patient names have been redacted to protect patient privacy.

Respondent for this procedure. Postoperatively, per nursing records, Patient A started having emesis[2] three days after the operation on January 25, 2021, and was diagnosed with an ileus[3]. By January 27, 2021, Patient A had 1 liter of emesis and was noted by Respondent to be "not distended".

11. On or about January 27, 2021, Respondent was called in the evening to add an anti-emetic to Patient A's diet, but claims he was not notified about the large volume emisis. Respondent was aware that Patient A had continued nausea which required anti-emetics and diet downgrade. Respondent did not conduct further interrogation or examination of Patient A's bowel function with labs or imaging.

12. On or about January 28, 2021, Patient A had three liters of emisis and was made NPO[4] by Respondent. On January 28, 2021, Patient A had a witnessed fall while walking and became unresponsive. CPR was initiated and after twenty-five minutes of resuscitative efforts Patient A expired. Patient A was known to be of moderate risk of pulmonary embolism but Respondent did not administer chemical prophylaxis at Patient's A's request after a claimed full, informed consent, but no documentation of such. Respondent admitted to not documenting the informed consent nor patients' refusal for chemical DVT prophylaxis[5].

Patient B

13. On or about December 15, 2020, Patient B, an 80-year-old female with a history of congestive heart failure (ejection fraction 20-25%), respiratory failure on 2 liters oxygen, stroke, chronic kidney disease, and chronic atrial fibrillation[6] on anticoagulation, was admitted for abdominal pain, nausea and vomiting. She was found positive for COVID. During her hospitalization Patient B developed multi-system organ failure requiring pressors[7]. Respondent

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[2] Emesis is the action or process of vomiting.
[3] Ileus is the temporary lack of the normal muscle contractions of the intestines.
[4] NPO is a medical designation meaning an order that patient be given "nothing by mouth".
[5] DVT, or Deep Vein Thrombosis is the formation or presence of a thrombus (blood clot) in the deep veins. Prophylaxis (treatment) of DVT is primarily the use of medications and mechanical methods to prevent the condition from developing.
[6] A type of heart disorder marked by an irregular or rapid heartbeat.
[7] A group of medications that are used primarily for their ability to vaso-constrict (narrow) blood vessels.

was consulted for placement of a central venous catheter. After placement of the catheter, Patient B had a PEA arrest[8] which led to her exipiring. Respondent mispositioned the catheter in Patient B, but while aware of the mispositioning, did not document or note this fact. Respondent admitted to the lack of documentation, stating that, "because she didn't live, I didn't...feel the need to document that I knew the catheter was in the wrong position and that...I can reposition this later down the roads [sic] if she lives."

Patient C

14. On or about October of 2020, Patient C, a 65-year-old male, was admitted for recurrent diverticulitis[9]. Patient C had been previously hospitalized in 2018 for similar complaints and Respondent followed Patient C in the out-patient setting after the October hospitalization, and in January of 2021 noted Patient C had "cooled off and is ready for op".

15. Patient C underwent sigmoid colectomy[10] on January 22, 2021 by Respondent. Patient C's postoperative condition was complicated by renal failure which required hemodialysis[11].

16. On or about March 14, 2021, Respondent placed a central venous catheter in Patient C. Regarding the placement of the catheter, Respondent noted, "the wire would not go distally. He needs just IV access for heparin and possibly TPN, and it is most likely located in the IJ[12] which is fine for its [sic] need." Respondent ordered a follow-up chest x-ray which confirmed "[a]pparent malposition of right IJ catheter with tip projecting over the lateral aspect of the upper chest wall..." Respondent documented Patient C's malpositioned catheter but did not remove or reposition it.

17. On or about March 1, 2021, a follow-up CT chest scan showed the malpositioned catheter. Another physician removed the central line on April 2, 2021.

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[8] Pulseless electrical activity (PEA) refers to cardiac arrest in which the electrodiagram shows a heart rhythm that should produce a pulse, but does not.

[9] Diverticulosis occurs when small, bulging pouches (diverticula) develop in the digestive tract.

[10] Procedure where the last section of the colon (sigmoid) is surgically removed.

[11] A treatment to filter wastes and water from the blood, replicating healthy kidney function.

[12] Medical abbreviation for "internal jugular" (vein).

Patient D

18. On or about October 3, 2020, Patient D, a 32-year-old male with a history of alcoholism and pancreatitis, presented with epigastric[13] abdominal pain. Imaging revealed pancreatitis and elevated bilirubin[14] (3.1). Patient D was discharged but then readmitted after sustaining a mechanical fall on October 6, 2020. Patient D was noted to have hypotension[15] and lactic acidosis[16]. Patient D's labs were notable for a marked decrease in hematocrit[17] (44.0 on October 3, 2020 versus 23.9 on October 6, 2020) and elevated lipase[18] of 197. A CT scan revealed "moderate abdominal ascites[19] with hyperdense fluid underneath the left hemidiaphragm, consistent with hemorrhage". Additionally, there was evidence of pancreatitis[20] with moderate peripancreatic inflammation along the tail of the pancreas and possible pseudocyst[21]. Patient D was resuscitated in the emergency room and then evaluated by Respondent who admitted him to the ICU for observation and repeated blood draws.

19. Over the course of October 6, 2020, Patient D received multiple units of blood and crystalloid[22]. On the morning of October 7, 2020, Patient D was noted to have a hemoglobin of 6.6. and tachycardic[23] to 147. His condition continued to deteriorate during the early morning hours. He required intubation[24] given decreased oxygen saturations and also became anuric[25]. Distension was noted on his physical exam.

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[13] Lying upon or over the stomach.

[14] Bilirubin is a yellowish pigment that is created during the normal breakdown of red blood cells.

[15] Low blood pressure.

[16] A condition which occurs when the body produces too much lactic acid and is unable to metabolize it quickly enough. Onset can be rapid or gradual. Condition can be a medical emergency.

[17] The percentage of red cells in your blood.

[18] A type of protein made by the pancreas.

[19] A condition in which fluid collects in spaces in the abdomen.

[20] Redness, swelling, inflammation of the pancreas.

[21] Pseudocysts form when the cells of the pancreas become inflamed or are injured and pancreatic enzymes start to leak.

[22] A solution which contains water-soluble electrolytes including sodium and chloride.

[23] Medical term for a heart rate over 100 beats a minute.

[24] A tube inserted through patient's mouth or nose and down into their trachea (windpipe) to keep the trachea open so air can get through. The tube is normally connected to a machine that delivers air or oxygen.

[25] Anuria is the failure of the kidneys to produce urine.

20. Medical documentation records that Respondent was aware of Patient D's deteriorating condition beginning the night of October 6, 2020 and continuing through the early morning hours of October 7, 2020, with Respondent being called and advised of Patient D's decline. Respondent undertook an exploratory laparotomy on Patient D at, or around, 10:15 a.m., and intraoperative findings noted 4.2 liters of old blood in the abdomen and that his spleen had "already been partially avulsed[26] at the hilum[27]". Patient D's medical records prior to the operation document that his urine output had only been 400ml despite having received over four liters of intravenous fluid. Patient D had also received two units of packed red cells[28] and complained of diffuse abdominal pain. Patient D recovered after the operation, but required percutaneous drainage[29].

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligence)

21. Respondent Craig Richard Thayer, M.D. is subject to disciplinary action under section 2234, subdivision (c), as he committed repeated acts, individually and collectively, in the care and treatment of Patients A, B, C and D. The circumstances are as follows:

22. Paragraphs 8 through 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

A. Respondent mismanaged Patient A's post-operative ileus because there was a documented persistent lack of gut motility without any diagnostic or therapeutic interventions by Respondent.

B. Respondent failed to document his discussions with Patient A regarding his refusal for chemical DVT prophylaxis.

C. Respondent failed to document his mispositioning of the central venous catheter in Patient B.

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[26] Pulled or torn away.

[27] Alternative medical term for "hilus", which is an indentation in the surface of the spleen in this case.

[28] Abbreviated as PRBC and one unit is typically 350ml in volume of which red blood cells make up 200 to 250ml in volume.

[29] Drained by a needle through the skin.

D. Respondent failed to replace or reposition his mispositioned central venous catheter in Patient C.

E. Respondent delayed surgical care for Patient D despite clinical findings that necessitated operative intervention in a more timely fashion.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

23. Respondent is further subject to discipline under sections 2227 and 2334, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate medical records in the care and treatment of Patients A and B, as more particularly alleged hereinafter:

24. Paragraphs 8 through 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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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 62641, issued to Craig Richard Thayer, M.D.;

2. Revoking, suspending or denying approval of Craig Richard Thayer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Craig Richard Thayer, 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;

4. Ordering Respondent Craig Richard Thayer, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: SEP 29 2022

WILLIAM PRASIEKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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