

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
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**BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
OF THE DEPARTMENT OF COMMERCE
OF THE STATE OF UTAH**

IN THE MATTER OF THE LICENSES OF
EDWARD JOSEPH EYRING, MD . **NOTICE OF AGENCY ACTION**
TO PRACTICE AS A PHYSICIAN/SURGEON .
AND TO ADMINISTER AND PRESCRIBE :
CONTROLLED SUBSTANCES :
IN THE STATE OF UTAH Case No. DOPL-2010-13

THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING TO
Edward Joseph Eyring ("Respondent"),
Murray UT 84107

The Division of Occupational and Professional Licensing ("the Division") hereby files this Notice of Agency Action. Said action is based upon the Verified Petition of Irene Woodford, Investigator, State of Utah, a copy of which is attached hereto and incorporated herein by reference.

The adjudicative proceeding designated herein is to be conducted on a formal basis. **Within thirty (30) days of the mailing date of this Notice, you are required to file a written response with this Division.** The response you file may be helpful in clarifying, refining or narrowing the facts and violations alleged in the Verified Petition. Your written response should be mailed to the following address: Division of Occupational and Professional Licensing, Attn Disciplinary Files, 160 East 300 South, PO Box 146741, Salt Lake City UT 84114-6741

You may represent yourself or be represented by legal counsel, at your own expense, at all times while this action is pending. Your legal counsel shall file with the Division an Entry of Appearance and until that Entry of Appearance is filed, the presiding officer will deal directly with you.

You are entitled by law to an evidentiary hearing to determine whether your licenses to practice as a physician/surgeon and to administer and prescribe controlled

substances in the State of Utah should be subject to a disciplinary action. Unless otherwise specified by the Director of the Division, the Physicians Licensing Board will serve as fact finder in the evidentiary hearing. You will be notified by separate notice of the date, time, and place of that evidentiary hearing and of any other hearings

During the evidentiary hearing, you will have the opportunity to present evidence, argue, respond, conduct cross-examination and submit rebuttal evidence to the fact finder. After the hearing, unless otherwise specified by the Director of the Division, the fact finder will issue findings of fact, conclusions of law and a recommended order to the Director of the Division of Occupational and Professional Licensing for his review and action

The presiding officer for purposes of conducting hearings will be J Steven Eklund, Administrative Law Judge, Department of Commerce, who will preside over any evidentiary issues and matters of law or procedure. If you or your attorney have any questions as to the procedures relative to the hearing, Judge Eklund can be contacted at P O Box 146701, Salt Lake City, UT 84114-6701. His telephone number is (801) 530-6648

Counsel for the Division in this case is Judith Jensen, Assistant Attorney General at (801) 366-0310 or P O Box 140872, Salt Lake City, UT 84114-0872. Within ten (10) days after the filing of your response, Ms Jensen will request the scheduling of a prehearing conference.

You, or if you have an attorney, your attorney, may attempt to negotiate a settlement of the case without proceeding to a hearing by contacting Ms. Jensen

Should you fail to timely file a response, as set forth above, or fail to attend or participate in any scheduled hearing in this case, including prehearing conference(s), you may be held in default without further notice to you. If you are held in default, the maximum administrative sanction consistent with the terms of the Verified Petition may be imposed against you. The maximum administrative sanction in this case is revocation of licensure and an administrative fine.

Please conduct yourself accordingly

Dated this 14th day of January, 2010.

W. Ray Walker
W Ray Walker
Regulatory & Compliance
Officer

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**BEFORE THE DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING
OF THE DEPARTMENT OF COMMERCE
OF THE STATE OF UTAH**

IN THE MATTER OF THE LICENSES OF
EDWARD JOSEPH EYRING, M.D.,
TO PRACTICE AS A
PHYSICIAN AND SURGEON AND TO
ADMINISTER AND PRESCRIBE
CONTROLLED SUBSTANCES
IN THE STATE OF UTAH

PETITION

Case No DOPL 2010 - 13

PRELIMINARY STATEMENT

These claims were investigated by the Utah Division of Occupational and Professional Licensing (the "Division") upon complaint that Edward Joseph Eyring, M D , ("Respondent") has engaged in acts, practices, and omissions which constitute violations of the Division of Occupational and Professional Licensing Act, Utah Code Ann § 58-1-101 to 58-1-504 (West Supp 2009), and the Utah Medical Practice Act, Utah Code Ann § 58-67-101 to 58-67-803 (West Supp 2009)

The allegations against Respondent are based upon information and belief arising out of an investigation conducted by the Division under its authority as set forth in Utah Code Ann § 58-1-106 (West Supp 2009)

Each count in this Petition shall be deemed to incorporate by reference the allegations set forth in the other paragraphs of the Petition

PARTIES

1 The Division is a division of the Department of Commerce of the State of Utah as established by Utah Code Ann § 13-1-2(2) (West Supp 2009)

2 Respondent is licensed by the Division to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah Respondent was so licensed at all times material to the allegations contained herein

STATEMENT OF ALLEGATIONS

3 On January 18, 2006, Respondent performed elective abdominal surgery on E E (name withheld to protect confidentiality), a male thirty-seven years of age diagnosed with chronic ulcerative colitis, at St Mark's Hospital in Salt Lake City, Utah E E had a history of treatment including, but not limited to, administration of large doses of steroids Respondent recommended E E undergo a laparoscopic total proctocolectomy with ileal pouch anal anastomosis and recommended that the surgery be performed in two stages due to E E 's illness Respondent, in the course of providing surgical and medical services to E E , engaged in acts, practices, and omissions including the following

- a On January 18, 2006, Respondent, as attending physician and operating surgeon, commenced surgery on E E to perform a total proctocolectomy with ileal pouch anal anastomosis and diverting ileostomy, using a laparoscopic approach
- b Respondent failed to perform the proctocolectomy in accordance with the standards of practice, failed to operate in the tissue plane appropriate for the planned surgical procedures, and/or failed to perform the surgical procedures in a manner to avoid injury to vascular structures, resulting in the laceration or tear of E E 's inferior vena cava ("IVC") and additional adverse effects to E E including the loss of blood, hypotension, and tachycardia

- c During Respondent's performance of the proctocolectomy, significant bleeding was observed. Respondent emergently converted to an open procedure and identified the source of the bleeding as a hole in the anterior aspect of the IVC. Pressure was applied to the IVC. Surgical and anesthesiology staff administered emergency procedures to stabilize E E 's condition including immediate transfusion with packed red blood cells and summoned a cardiovascular surgeon to the operating room to perform an emergency repair of the injured IVC.
- d After the cardiovascular surgeon completed the repair of the IVC, Respondent resumed the planned abdominal surgery on E E and, having converted from a laparoscopic to open abdominal procedure, completed mobilization of the transverse colon, and performed additional procedures on E E including, but not limited to, mobilization of the descending colon, total mesorectal excision of the rectum, formation of an ileal J-pouch, ileal pouch anal anastomosis, and construction of a diverting ileostomy.
- e On January 18, 2006, on completion of surgery, Respondent directed that E E be placed on a general medical floor.
- f On the morning of January 19, 2006, Respondent assigned E E 's care jointly to two covering physicians and traveled out of the State of Utah. Respondent transferred E E 's care and absented himself from the State without dictating an operative report for the January 18, 2006, surgery. Respondent submitted a handwritten operative note to St. Mark's Hospital, dated January 19, 2006, in which Respondent reported the size of the injury to E E 's IVC, to be smaller than it, in fact, was, reported the amount of blood transfused to be less than it, in fact, was, and failed to report that the patient suffered hypotension and tachycardia subsequent to injury to the IVC. Respondent returned to St. Mark's Hospital in the evening of January 20, 2006.
- g Beginning on January 19, 2006, after E E 's placement on the general medical floor, E E developed medical problems that prompted his relocation to the hospital's pulmonary care unit and, subsequently, to the intensive care unit. Symptoms included, among others, tachycardia, chest pain, renal insufficiency, elevated white count, and cardiopulmonary insufficiency.
- h On January 21, 2006, subsequent to E E 's resuscitation from respiratory arrest, Respondent commenced a second abdominal surgery on E E , during which Respondent evacuated approximately 4.5 liters of fluid from E E 's abdomen.
- i On January 21, 2006, Respondent dictated the patient history and physical, and, after Respondent completed Respondent's second surgery on E E , Respondent dictated the operative report of

Respondent's first surgery performed on January 18, 2006. In the operative report for the January 18, 2006, surgery, Respondent reported the size of the injury to E E 's IVC, to be smaller than it, in fact, was, reported the size of the ileal J-pouch created to be smaller than it, in fact, was, and reported that E E tolerated the January 18, 2006, surgical procedure well, with no complications other than the rent in the IVC. Respondent failed to report that the patient suffered hypotension and tachycardia subsequent to injury to the IVC. On February 11, 2006, Respondent signed the history and physical and the January 18, 2006, operative report for submission to St. Mark's Hospital.

- j On January 22, 2006, clinical impressions reported in progress notes for E E included critical illness, septic shock, ischemic bowel and gallbladder, ulcerative colitis, metabolic acidosis, respiratory failure, hyperglycemia, hypocalcemia, refractory hypotension, and atrial fibrillation with rapid ventricular response.
- k On January 22, 2006, Respondent performed a third abdominal surgery on E E and, on finding the J-Pouch and gallbladder necrotic, performed a small bowel resection with end ileostomy and cholecystectomy.
- l On January 22, 2006, E E 's medical condition continued to deteriorate, and E E died subsequent to the withdrawal of life support.
- m On February 11, 2006, Respondent dictated the discharge summary for E E , and, on March 13, 2009, Respondent signed the discharge summary and submitted it to St. Mark's Hospital for inclusion in E E 's hospital medical chart. In the discharge summary, Respondent reported that the vascular injury to E E during the January 18, 2006, surgery was repaired with no other sequelae.
- n On July 22, 2009, during the course of an investigative interview conducted by the Division into Respondent's medical and surgical treatment of Patient E E , Respondent falsely reported to the Division the vein injured during the January 18, 2006, surgery on Patient E E was the splenic vein and falsely reported the size of the vascular injury to be smaller than it, in fact, was.

4 On September 26, 2006, Respondent performed elective abdominal surgery on A C (name withheld to protect confidentiality), a female twenty-seven years of age diagnosed with colonic inertia and chronic constipation, at St. Mark's Hospital in Salt Lake City, Utah. Respondent, in the course of providing surgical and medical

services to A C , engaged in acts, practices, and omissions including the following

- a Respondent, during an August 30, 2006, office consultation, recommended that A C undergo a laparoscopic total colectomy with ileorectostomy, as an elective surgical procedure for the treatment of colonic inertia and chronic constipation Respondent reported in Respondent's office medical file for A C that on August 30, 2006, he recommended to A C that she not undergo surgery
- b A C agreed to undergo said surgery, and, on September 26, 2006, Respondent, as attending physician and operating surgeon, performed the total colectomy with ileorectostomy on A C using a laparoscopic approach
- c Respondent, in the course of performing the laparoscopic surgery on A C , failed to perform the total colectomy in accordance with the standards of practice, failed to operate in the tissue plane appropriate for the planned surgical procedures, and/or failed to perform the surgical procedures in a manner to avoid injury to duct structures, resulting in injury to the patient's common bile duct ("CBD") Said injury resulted in the subsequent stricture and occlusion of the CBD On October 26, 2006, Respondent signed his operative report and submitted it to St Mark's Hospital for inclusion in A C 's hospital medical chart
- d After surgery, A C suffered continuing and severe back pain A C reported the on-going back pain both to Respondent's office staff and, on or about October 24, 2006, to Respondent directly during her follow-up office appointment
- e Respondent falsely reported in A C 's office medical record for October 24, 2006, "good" and that back pain was now gone
- f After the October 24, 2006, follow-up appointment with Respondent, A C experienced continuing back pain and additional medical concerns including, but not limited to, fatigue, weakness, mid-thoracic pain, jaundice, diarrhea, nausea, and vomiting In 2006 and 2007, A C sought medical evaluation and treatment of her symptoms from other physicians
- g On or about January 9, 2007, A C was admitted in a jaundiced condition to the Timpanogos Regional Hospital, Orem, Utah, and then transferred to the University of Utah Hospital, Salt Lake City, Utah, where she was diagnosed with CBD stricture and occlusion On January 25, 2007, A C underwent hepaticojejunostomy surgery at the University of Utah to reconstruct her biliary system
- h A C , in 2007 after her release from the University of Utah Hospital, went to Respondent's medical office to obtain a copy of her medical records When A C arrived at Respondent's office, Respondent

took A C into an empty room and examined the scars sustained by A C consequent to the surgery to repair her biliary system. While in the room, Respondent pressed A C to make a statement to him regarding her interests in the matter, advised A C. that she did not need to contact anyone, and advised A C of the course of action to take in the matter. Respondent's medical office failed to provide A C with a copy of her medical records during this meeting and failed thereafter to provide said records to A C in a timely manner.

5 In 2004, physician and surgeon J G (name withheld to protect confidentiality) provided treatment to Patient P S (name withheld to protect confidentiality), a female fifty-nine years of age diagnosed with lupus disease and symptoms similar to Crohn's disease. On May 7, 2004, J G performed a colonoscopy with ablation polypectomy and colon biopsies on P S at St. Mark's Hospital, Salt Lake City, Utah. In the days subsequent to the procedure, P S suffered conditions and symptoms including extreme weakness, inadequate nutrition, diarrhea, bloating, and abdominal pain. J G recommended P S undergo a hemicolectomy to remove a bowel stricture, and, on May 21, 2004, P S underwent laboratory work-up at St. Mark's Hospital in preparation for the surgery. The May 21, 2004, result for white blood cell count was 3.7. On May 25, 2004, P S was admitted to St. Mark's Hospital for a bowel preparation with surgery scheduled for May 26, 2004. On admission, P S was non-ambulatory with symptoms of extreme weakness, distended abdomen, and abdominal pain. On May 25, 2004, Respondent assumed the care of P S as the physician "on call." A chest x-ray taken on May 25, 2004, revealed "a large amount of free intraperitoneal air" and laboratory data obtained on May 25, 2004 showed, among other abnormal results, "Panic Level" values for white blood count (1.0) and for platelets (24). J M (name withheld to protect confidentiality), a staff nurse, contacted Respondent by telephone and informed Respondent that P S had critical results for white blood count (1.0) and platelets (24) and other laboratory data including, but not limited to, sodium (128) and phosphorus (5.4). J M also reported to Respondent INR (1.96) and pro time

(16 7) Respondent issued an order by telephone changing P S 's IV solution to D5NS with 20 K at 125. No other order was issued to address the x-ray or laboratory results. P S was found unresponsive in her bed at 5 00 a m on May 26, 2004. A code was called and P S was pronounced dead. An autopsy reported findings of sepsis and bowel perforation.

A civil action for claims arising from the care and treatment of P S was brought in Smith vs Northern Utah Healthcare Corp et al, Third District Court, Salt Lake County, State of Utah, Case No 060913976. On March 8, 2007, Respondent, under oath during deposition in Case No 060913976, stated, in the afternoon of May 25, 2004, a staff nurse called Respondent and informed Respondent of the laboratory result showing a white blood cell count of 1 0, and the nurse reported no other laboratory data for P S. Respondent further stated, during the nurse's call, Respondent ordered P S 's IV fluid be changed to D5NS with 20 K at 125.

6 On July 25, 2007, Respondent performed a colonoscopy on D H (name withheld to protect confidentiality), a male sixty-one years of age, at Cottonwood Hospital in Murray, Utah. D H had not experienced any bowel-related problems and requested Respondent perform the colonoscopy as a part of a routine well-check examination. Respondent scheduled the screening colonoscopy on D H as a thirty-minute surgical procedure. Respondent, in the course of his practice as a physician and surgeon, engaged in acts, practices, and omissions including the following:

- a On July 25, 2007, Respondent performed a screening colonoscopy on D H and reported in Respondent's endoscopy report filed with Cottonwood Hospital that polyps were noted in the rectum, transverse colon, hepatic flexure, and at 50 centimeters.
- b Respondent, in his endoscopy report, stated that the masses at the hepatic flexure and at 50 centimeters were quite large and could not be resected. Respondent further reported that he removed the

remaining polyps by snare polypectomy. The surgical specimens submitted to pathology were negative for cancer.

- c On or about August 2, 2007, Respondent conducted a follow-up office appointment with D H and his spouse. During the appointment, Respondent engaged in conduct including, but not limited to, the following:
- (1) Respondent stated that Respondent discovered two "tumors" during the colonoscopy that were too large to be removed by colonoscopy, one tumor in the top of the colon and one in the rectum.
 - (2) Respondent stated that D H had "a mean colon" and the tumors would require that "a couple of feet" of D H 's colon be removed. D H and his spouse asked Respondent to explain what he meant by "a couple of feet." In response, Respondent stated it would be necessary to remove approximately one-half of D H 's colon. Respondent did not identify the part of the colon he intended to remove.
 - (3) D H and his spouse asked Respondent to explain why it would be necessary to remove half of the colon. In response, Respondent stated the area of colon to be removed contained "all kinds of bad things" in addition to the tumor. Respondent did not explain the meaning of "all kinds of bad things."
 - (4) Respondent recommended to D H that Respondent perform two separate surgeries on D H to remove the tumors: (1) a Transanal Endoscopic Microsurgery ("TEMS") to remove the rectal tumor and (2) a second operation, to be performed one week after the TEMS, to remove approximately one-half of D H 's colon,
 - (5) Respondent stated to D H that he was the only physician in the State of Utah who would be able to remove the rectal tumor using TEMS,
 - (6) Respondent, through his office staff, scheduled the two surgeries for August 23 and August 30, 2007,
 - (a) without advising D H of the surgical options for treating the polyps and the potential impact, risks, and benefits of each option, and
 - (b) without providing D H with adequate opportunity to address his questions regarding the proposed surgeries

- d After the August 2, 2007, appointment with Respondent, D H decided to obtain a second opinion from another colorectal surgeon and cancelled the two surgery dates scheduled by Respondent
- e On or about August 13, 2007, Respondent personally contacted D H by telephone. D H informed Respondent that D H intended to obtain a second opinion by a colorectal surgeon practicing at the University of Utah Hospital in Salt Lake City, Utah. During the conversation, Respondent engaged in communications with D H including the following
 - (1) Respondent stated that he and his business partner were the only colorectal surgeons in the State of Utah who were trained to perform the TEMS that would be required to remove D H 's rectal tumor,
 - (2) Respondent stated that D H should not obtain medical services from the named University of Utah colorectal surgeon or from any other person practicing at the University of Utah Hospital, and
 - (3) Respondent stated that Respondent was a better surgeon than the University of Utah colorectal surgeon and D H would be better off with Respondent than with the other surgeon
- f In August 2007, D H consulted with the University of Utah colorectal surgeon to obtain a second opinion. The colorectal surgeon recommended that D H undergo a repeat colonoscopy with polypectomy of the remaining polyps and, if necessary, a laparoscopic resection of the mass reported at 50 cm 2 days later
- g On September 20, 2007, the University of Utah colorectal surgeon performed the repeat colonoscopy on D H and removed one 4 mm polyp from the cecum, one 15 mm polyp in the descending colon at 60 cm, and two 2 to 3 mm polyps in the rectum. Resection and retrieval were complete for all polyps and no additional surgery was recommended. The pathology on all specimens was negative for cancer

APPLICABLE LAW

7 At all times material hereto, the Division of Occupational and Professional Licensing Act, Utah Code Ann § 58-1-401, has provided in relevant part as follows

- (2) The division may refuse to issue a license to an applicant and may refuse to renew or may revoke, suspend, restrict, place on probation, issue a public or private reprimand to, or otherwise act upon the license of any licensee in any of the following cases

- (a) the applicant or licensee has engaged in unprofessional conduct, as defined by statute or rule under this title,
- (b) the applicant or licensee has engaged in unlawful conduct as defined by statute under this title,

8 At all times material hereto, the Division of Occupational and Professional Licensing Act, Utah Code Ann § 58-1-501 has provided as follows

- a UTAH CODE ANN § 58-1-501(1), has defined "Unlawful Conduct" in relevant part as follows
 - (e) obtaining a passing score on a licensure examination, applying for or obtaining a license, or otherwise dealing with the division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission,
- b Utah Code Ann § 58-1-501(2), has defined "Unprofessional Conduct" in relevant part as follows
 - (a) violating, or aiding or abetting any other person to violate, any statute, rule, or order regulating an occupation or profession under this title,
 - (b) violating, or aiding or abetting any other person to violate, any generally accepted professional or ethical standard applicable to an occupation or profession regulated under this title,
 - (g) practicing or attempting to practice an occupation or profession regulated under this title through gross incompetence, gross negligence, or a pattern of incompetency or negligence,
 - (h) practicing or attempting to practice an occupation or profession requiring licensure under this title by any form of action or communication which is false, misleading, deceptive, or fraudulent
 - (i) practicing or attempting to practice an occupation or profession regulated under this title beyond the scope of the licensee's competency, abilities, or education,

9 At all times material hereto, the Utah Medical Practice Act, Utah Code Ann § 58-67-402 (West 2004)¹ has provided in relevant part as follows

- (1) After proceeding pursuant to Title 63, Chapter 46b, Administrative Procedures Act, and Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, the division may impose administrative penalties of up to \$10,000 for acts of unprofessional conduct under this chapter

10 At all times material hereto the Utah Medical Practice Act, UTAH CODE ANN § 58-67-502, has defined "Unprofessional Conduct" to include the definition in Section 58-1-501

11 At all times material hereto, the Utah Medical Practice Act, UTAH CODE ANN § 58-67-803, has provided in relevant part as follows

- (1) Medical records maintained by a licensee shall
 - (a) meet the standards and ethics of the profession,

12 At all times material hereto, the Utah Medical Practice Act Rules, UTAH ADMIN CODE R156-67-502, has defined "Unprofessional Conduct" in relevant part as follows

- (7) failing as an operating surgeon to perform adequate pre-operative and primary post-operative care of the surgical condition for a patient in accordance with the standards and ethics of the profession or to arrange for competent primary post-operative care of the surgical condition by a licensed physician and surgeon who is equally qualified to provide that care,

13 At all times material hereto, the Code of Medical Ethics of the American Medical Association, Opinion 8 08 Informed Consent, issued March 1981 in accordance with Principles of Medical Ethics I, II, III, IV, and V, provides, among other matters, the patient's right of self-decision can be effectively exercised only if the patient possesses

¹ Effective May 2008, the Utah Medical Practice Act, Utah Code Ann § 58-67-402 was amended to effect a nonsubstantive change amending the prior statutory citation "Title 63, Chapter 46b, Administrative Procedures Act," to "Title 63G, Chapter 4, Administrative Procedures Act "

enough information to enable an intelligent choice. Further, the physician's obligation is to present the medical facts accurately to the patient, to make recommendations for management in accordance with good medical practice, and to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.

14 At all times material hereto, the Code of Medical Ethics of the American Medical Association, Opinion 8.12 Patient Information, issued March 1981 and updated June 1994 in accordance with Principles of Medical Ethics I, II, III, and IV, provides, among other matters, it is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Further, patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care. Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.

15 At all times material hereto, the Code of Medical Ethics of the American Medical Association, Opinion 9.07 Medical Testimony, issued December 2004 based upon the report "Medical Testimony," adopted June 2004, provides, among other matters, medical evidence is critical in various legal and administrative proceedings. Physicians, as citizens and as professionals with specialized knowledge and experience, have an obligation to assist in the administration of justice. Physicians who serve as fact witnesses must deliver honest testimony.

16 At all times material hereto, the Code of Medical Ethics of the American

Medical Association, Opinion 10 01 Fundamental Elements of the Patient-Physician Relationship, issued June 1992 and updated 1993 in accordance with Principles of Medical Ethics I, IV, V, VIII, and IX) provides, among other matters, physicians can best contribute to the collaborative effort between physician and patient to secure the health and well-being of the patient by fostering patient rights including the following

- (a) to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives,
- (b) to receive guidance from their physicians as to the optimal course of action,
- (c) to obtain copies or summaries of the patient's medical records,
- (d) to have the patient's questions answered,
- (e) to be advised of potential conflicts of interest that the physician might have,
- (f) to receive independent professional opinions,
- (g) to make decisions regarding the health care that is recommended by his or her physician Accordingly, patients may accept or refuse any recommended medical treatment, and
- (h) to courtesy, respect, dignity, responsiveness, and timely attention to the patient's needs

Count 1

Gross incompetence, gross negligence, or a pattern of incompetency or negligence.

17 In 2006, Respondent, in the course of performing a total proctocolectomy with ileal pouch anal anastomosis and diverting ileostomy on Patient E E , as referenced in Paragraph 3 herein, engaged in the following acts, practices, and omissions

- a Respondent failed to perform the surgical procedures in a manner to avoid injury to vascular structures,
- b Respondent failed to operate in the tissue plane appropriate for the planned surgical procedures, and/or

- c Respondent failed to perform the surgical procedures in accordance with the standards of practice

18 In 2006, Respondent, in the course of performing a total colectomy with ileorectostomy on Patient A C , as referenced in Paragraph 4 herein, engaged in the following acts, practices, and omissions

- a Respondent failed to perform the surgical procedures in a manner to avoid injury to duct structures,
- b Respondent failed to operate in the tissue plane appropriate for the planned surgical procedures, and/or
- c Respondent failed to perform the surgical procedures in accordance with the standards of practice

19 In 2006, Respondent, in the course of performing a total proctocolectomy with ileal pouch anal anastomosis and diverting ileostomy on Patient E E , as referenced in Paragraph 3 herein, engaged in the following acts, practices, and omissions

- a Respondent failed to terminate surgery subsequent to injury to the IVC and adverse events and conditions including the loss of blood, hypotension, and tachycardia
- b Respondent, subsequent to injury to the IVC and adverse events and conditions including the loss of blood, hypotension, and tachycardia, resumed the planned abdominal surgery on E E and, having converted from a laparoscopic to open abdominal procedure, completed mobilization of the transverse colon, and performed additional procedures on E E including, but not limited to, mobilization of the descending colon, total mesorectal excision of the rectum, formation of an ileal J-pouch, ileal pouch anal anastomosis, and construction of a diverting ileostomy
- c Respondent, subsequent to performing the January 18, 2006, surgery, engaged in the following acts, practices, and omissions
 - (1) Respondent placed E E on a general medical floor,
 - (2) Respondent failed to admit E E to an intensive care unit for heightened post-operative monitoring,
 - (3) Respondent failed to document, accurately and in timely manner, the injury to the IVC and the loss of blood,

hypotension, and tachycardia observed subsequent to the injury,

- (4) Respondent failed to provide and document sufficient information for other practitioners to assume continuity of the patient's care,
- (5) Respondent failed to dictate and submit to the hospital in timely manner an accurate operative report of Respondent's January 18, 2006, surgery,
- (6) Respondent failed to submit to the hospital an operative note immediately after surgery describing the findings and providing accurate and pertinent information for individuals required after surgery to attend to the patient,
- (7) Respondent transferred care of E E to covering physicians and traveled out of state without documenting accurate and pertinent information for individuals required after surgery to attend to the patient,
- (8) Respondent failed to dictate and submit to the hospital a timely, comprehensive history and physical, and
- (9) Respondent failed to dictate and submit to the hospital a timely, accurate discharge summary

20 On July 25, 2007, Respondent performed a screening colonoscopy on Patient D H , as referenced in Paragraph 6 herein, and engaged in the following acts, practices and omissions

- a Respondent, during the screening colonoscopy, failed to remove polyps that could be removed by colonoscopy,
- b Respondent, subsequent to the screening colonoscopy, failed to report to the patient and to document in patient records that the polyps remaining could be removed by colonoscopy,
- c Respondent failed to recommend D H undergo a second colonoscopy to remove the remaining polyps, and
- d Respondent recommended that D H undergo two separate surgeries, TEMS and a hemicolectomy, to remove polyps remaining after performance of the screening colonoscopy when the recommended surgeries were unnecessary for removal of the polyps and posed heightened risks to the patient of complications, life-long physical impairment, diminished quality of life, and unnecessary expense

21 Based upon the foregoing, Respondent practiced as a physician and surgeon through gross incompetence, gross negligence, or a pattern of incompetency or negligence and engaged in "Unprofessional Conduct," as defined by Utah Code Ann § 58-1-501(2)(a) and (g) and Utah Code Ann § 58-67-502

22 In accordance with UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against the licenses of Edward J Eyring, M D , to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah

23 In accordance with Utah Code Ann § 58-67-402(1), sufficient bases exist for imposing administrative penalties for each act of "Unprofessional Conduct "

Count 2
**Practicing as a physician and surgeon
beyond the scope of the licensee's competency, abilities, or education**

24 Respondent engaged in the acts, practices, and omissions referenced in Count 1 herein

25 Based upon the foregoing, Respondent practiced as a physician and surgeon beyond the scope of Respondent's competency, abilities, or education and engaged in "Unprofessional Conduct," as defined by Utah Code Ann § 58-1-501(2)(a) and (i) and Utah Code Ann § 58-67-502

26 In accordance with UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against the licenses of Edward J Eyring, M D , to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah

27 In accordance with Utah Code Ann § 58-67-402(1), sufficient bases exist for imposing administrative penalties for each act of "Unprofessional Conduct "

Count 3
**Practicing as a physician and surgeon
in violation of generally accepted professional standards**

28 Respondent engaged in the acts, practices, and omissions, referenced in Count 1 herein

29 Based upon the foregoing, Respondent violated generally accepted professional standards applicable to the profession of the physician and surgeon and engaged in "Unprofessional Conduct," as defined by Utah Code Ann § 58-1-501(2)(a) and (b) and Utah Code Ann § 58-67-502

30 In accordance with UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against the licenses of Edward J Eyring, M D , to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah

31 In accordance with Utah Code Ann § 58-67-402(1), sufficient bases exist for imposing administrative penalties for each act of "Unprofessional Conduct "

Count 4
**Failing as an operative surgeon to perform
adequate pre-operative and primary post-operative care or
to arrange for competent primary post-operative care of the surgical condition**

32 In 2006, Respondent, in the course of providing medical and surgical services to Patient E E , engaged in the acts, practices, and omissions referenced in Count 1, Paragraph 19(c), herein

33 Based upon the foregoing, Respondent failed as an operative surgeon to perform adequate pre-operative and primary post-operative care of the surgical condition of Patient E E in accordance with the standards and ethics of the profession or to arrange for competent primary post-operative care of the surgical condition by a licensed physician and surgeon who is equally qualified to provide that care

34 Therefore, Respondent engaged in "Unprofessional Conduct" as defined by Utah Code Ann § 58-1-501(2)(a), UTAH ADMIN CODE R156-67-502, and Utah Code Ann § 58-67-502

35 In accordance with UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against the licenses of Edward J Eyring, M D , to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah

36 In accordance with Utah Code Ann § 58-67-402(1), sufficient bases exist for imposing administrative penalties for each act of "Unprofessional Conduct "

Count 5
Practicing as a physician and surgeon through
any form of action or communication which is
false, misleading, deceptive, or fraudulent

37 In 2006, Respondent, in the course of providing surgical and medical services to Patient E E , engaged in false, misleading, and/or deceptive forms of action or communication including the following, as referenced in Paragraph 3 herein

- a Respondent dictated, signed, and submitted to St Mark's Hospital an operative report of Respondent's January 18, 2006, surgery in which Respondent falsely reported the size of the injury to E E 's IVC to be smaller than it, in fact, was, and Respondent falsely reported that E E tolerated the January 18, 2006, surgical procedure well, with no complications other than the rent in the IVC Respondent failed to report that the patient suffered hypotension and tachycardia subsequent to injury to the IVC
- b Respondent wrote and submitted to St Mark's Hospital an operative note of Respondent's January 18, 2006, surgery on Patient E E in which Respondent falsely reported the size of the injury to E E 's IVC to be smaller than it, in fact, was and falsely reported the amount of blood transfused to be less than it, in fact, was Respondent failed to report that the patient suffered hypotension and tachycardia subsequent to injury to the IVC
- c Respondent dictated, signed, and submitted to St Mark's Hospital a discharge summary in which Respondent stated the vascular injury during the January 18, 2006, surgery was repaired with no

other sequelae and said statement was false, misleading, and/or deceptive

38 In 2006, Respondent, in the course of providing surgical and medical services to Patient A C , engaged in false, misleading, and/or deceptive forms of action or communication including the following, as referenced in Paragraph 4 herein

- a Respondent falsely reported in A C 's office medical record that on August 30, 2006 , Respondent recommended to A C that she not undergo surgery
- b Respondent falsely reported in A C 's office medical record for October 24, 2006, "good" and that back pain was now gone

39 In 2007, Respondent, in the course of providing surgical and medical services to Patient D H , engaged in false, misleading, and/or deceptive forms of action or communication including the following, as referenced in Paragraph 6 herein

- a Respondent dictated, signed, and submitted an endoscopy report to Cottonwood Hospital in which Respondent falsely stated that two masses, located at 50 cm and at the hepatic flexure, were quite large and could not be resected
- b In August 2007, subsequent to performing the July 25, 2007, screening colonoscopy on Patient D H , Respondent conducted an office consultation with D H and personally engaged D H in a follow-up conversation by telephone During said consultation and follow-up conversation, Respondent engaged in false, misleading, and/or deceptive forms of action or communication including the following
 - (1) Respondent falsely reported to D H that during the screening colonoscopy he discovered two tumors, located in the top of the colon and in the rectum, that were too large to be removed by colonoscopy
 - (2) Respondent falsely reported to D H two separate surgeries were needed to remove the two tumors remaining after the screening colonoscopy– a TEMS and a hemicolectomy
 - (3) Respondent falsely reported to D H that the tumors remaining after the screening colonoscopy would require a couple of feet of D H 's colon be removed
 - (4) Respondent, through false, misleading, and/or deceptive statements, reported to D H that Respondent was the only

physician in the State of Utah who would be able to remove the rectal tumor using TEMS

- (5) Respondent, through false, misleading, and/or deceptive statements, reported to D H that Respondent and his business partner were the only colorectal surgeons in the State of Utah who were trained to perform the TEMS that would be required to remove D H 's rectal tumor
- (6) Respondent, through false, misleading, and/or deceptive statements, reported to D H that D H should not obtain medical services from the University of Utah colorectal surgeon from whom D H planned to obtain a second opinion and that D H should not obtain medical services from any other person practicing at the University of Utah Hospital
- (7) Respondent, through false, misleading, and/or deceptive statements, reported to D H that Respondent was a better surgeon than the University of Utah colorectal surgeon and that D H would be better off with Respondent than with the University of Utah surgeon

40 On March 8, 2007, Respondent, in the course of his practice as a physician and surgeon, provided false sworn testimony by deposition in Smith vs Northern Utah Healthcare Corp et al , Third District Court, Salt Lake County, State of Utah, Case No 060913976, in which Respondent falsely testified the staff nurse reported to him, of available laboratory results for Patient P S , only the white blood cell count of "1," as referenced in Paragraph 5 herein

41 Based upon the foregoing, Respondent practiced as a physician and surgeon by any form of action or communication which is false, misleading, deceptive, or fraudulent and engaged in "Unprofessional Conduct," as defined by Utah Code Ann § 58-1-501(2)(a) and (h) and Utah Code Ann § 58-67-502

42 In accordance with UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against the licenses of Edward J Eyring, M D , to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah

43 In accordance with Utah Code Ann § 58-67-402(1), sufficient bases exist for imposing administrative penalties for each act of "Unprofessional Conduct "

Count 6
Practicing as a physician and surgeon
in violation of generally accepted ethical standards

44 Respondent engaged in the acts, practices, and omissions, referenced in Counts 1, 4, and 5 herein

45 Based upon the foregoing, Respondent, in the course of his practice as a physician and surgeon, engaged in acts, practices, and omissions in violation of the Principles of Medical Ethics, I, II, III, IV, V, VIII, and IX of the Code of Medical Ethics of the American Medical Association, in that Respondent

- a failed to be honest in Respondent's professional interactions,
- b failed to deal honestly and openly with and failed to present medical facts accurately to Respondent's patient,
- c failed to make relevant information available to Respondent's patient and to colleagues,
- d failed to respect and foster the patient's rights of self-decision and informed consent in determining the patient's course of medical management,
- e failed to make recommendations to Respondent's patient for medical management in accordance with good medical practice,
- f failed to help Respondent's patient make choices from among the therapeutic alternatives consistent with good medical practice,
- g failed to respect and foster the rights of Respondent's patient as follows
 - (1) to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives,
 - (2) to receive guidance as to the optimal course of action,
 - (3) to obtain copies of the patient's medical records,

- (4) to have the patient's questions answered, and
- (5) to receive independent professional opinions,
- h failed to advise Respondent's patient of potential conflicts of interest that Respondent might have,
- i failed to respect and foster the patient's right to courtesy, respect, dignity, responsiveness, and timely attention to the patient's needs,
- j failed to inform Respondent's patient of all the facts necessary to ensure understanding of what has occurred when the patient has suffered significant medical complications that may have resulted from Respondent's mistake or judgment, and
- k failed to deliver truthful testimony during deposition in a civil legal action filed in a Utah State District Court and failed to assist in the administration of justice

46 Based upon the foregoing, Respondent violated generally accepted ethical standards applicable to the profession of the physician and surgeon and engaged in "Unprofessional Conduct," as defined by Utah Code Ann § 58-1-501(2)(a) and (b) and Utah Code Ann § 58-67-502

47 In accordance with UTAH CODE ANN § 58-1-401(2)(a), sufficient bases exist for imposing disciplinary sanctions against the licenses of Edward J Eyring, M D , to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah

48 In accordance with Utah Code Ann § 58-67-402(1), sufficient bases exist for imposing administrative penalties for each act of "Unprofessional Conduct "

Count 7
Dealing with the Division of Occupational and Professional Licensing through the use of intentional deception, misrepresentation, misstatement, or omission

49 On July 22, 2009, and during the course of an investigative interview conducted by the Division into Respondent's medical and surgical treatment of Patient E E , Respondent falsely reported to the Division the vein injured during the January 18,

2006, surgery on Patient E E was the splenic vein, and falsely reported the size of the vascular injury to be smaller than it, in fact, was, as referenced in Paragraph 3

50 Based upon the foregoing, Respondent dealt with the Division of Occupational and Professional Licensing through the use of intentional deception, misrepresentation, misstatement, or omission and engaged in "Unlawful Conduct," as defined by Utah Code Ann § 58-1-501(1)(e)

51 In accordance with UTAH CODE ANN § 58-1-401(2)(b), a sufficient basis exists for imposing disciplinary sanctions against the licenses of Edward J Eyring, M D , to practice as a physician and surgeon and to administer and prescribe controlled substances in the State of Utah

WHEREFORE, the Division requests an order granting the following relief

1 Determining that Respondent engaged in the acts, practices, and omissions alleged herein,

2 Determining that, by engaging in the above acts, practices, and omissions, Respondent violated the terms of the provisions of the Division of Occupational and Professional Licensing Act and the rules promulgated thereunder, the Utah Medical Practice Act and the rules promulgated thereunder, and the professional and ethical standards applicable to the profession of the physician and surgeon, which are particularly referenced above,

3 Imposing administrative penalties of up to \$10,000 for each act of "Unprofessional Conduct" in accordance with Utah Code Ann § 58-67-402, and

4 Imposing appropriate sanctions on the licenses of Respondent to practice as a physician and surgeon and to administer and prescribe controlled

substances in the State of Utah in accordance with UTAH CODE ANN § 58-1-401(2)(a) and (b)

DATED this 14th day of January, 2010

MARK L SHURTLEFF
ATTORNEY GENERAL

Judith A Jensen
JUDITH A JENSEN
Assistant Attorney General

VERIFICATION

STATE OF UTAH)
) ss
COUNTY OF SALT LAKE)

Irene Woodford, being first duly sworn, states as follows

1 I am an Investigator for the Bureau of Investigation, Division of Occupational and Professional Licensing, Department of Commerce, State of Utah, and have been assigned to investigate this case

2 I have read the foregoing Petition and am familiar with the contents thereof All of the factual allegations in the Petition are true to the best of my knowledge, information, and belief

Irene Woodford

IRENE WOODFORD
Investigator
Division of Occupational &
Professional Licensing

SWORN TO AND SUBSCRIBED before me this 14 day of

January, 2010

[Signature]
NOTARY PUBLIC

