IN THE MATTER OF	*	**BEFORE THE MARYLAND**
LAWRENCE D. EGBERT, M.D.	*	**STATE BOARD OF PHYSICIANS**
Respondent.	*	**Case Number: 2011-0870**
License No. D16049	*	

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FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Lawrence D. Egbert, M.D. is a board-certified anesthesiologist, who has been licensed by the Maryland State Board of Physicians ("Board") since 1952. In November, 2012, the Board charged Dr. Egbert with unprofessional conduct in the practice of medicine, *see* Health Occ. § 14-404(a)(3)(ii), based on his actions as the Medical Director for Final Exit Network ("FEN"), a national right-to-die organization, and his participation in the assisted suicides of six FEN members.

Dr. Egbert requested and received an evidentiary hearing on September 26, 2013, at the Office of Administrative Hearings. At that hearing, the State presented expert witness testimony from Henry Silverman, M.D., who testified as an expert in internal medicine and medical ethics. Dr. Egbert did not testify or present any witnesses. In a Proposed Decision issued on December 23, 2013, Administrative Law Judge ("ALJ") Jennifer M. Carter Jones found that Dr. Egbert engaged in unprofessional conduct in the practice of medicine based on Dr. Egbert's review of FEN applicants' medical records, his determinations on applicants' suffering, and his determinations on whether applicants' conditions could or could not benefit from additional medical treatment. The ALJ further found that Dr. Egbert held himself out as a treating physician to other physicians so they would provide patients' medical documents to him as part

of the FEN screening process. The ALJ did not deem Dr. Egbert's presence or his assistance in the suicides to be "in the practice of medicine." The ALJ recommended that Dr. Egbert's medical license be revoked.

On January 8, 2014, Dr. Egbert filed exceptions (dated January 7, 2014) to the ALJ's Proposed Decision. The State also filed exceptions and a response to Dr. Egbert's exceptions on January 16, 2014. Both parties appeared before Disciplinary Panel B (the "Panel") of the Board for an oral exceptions hearing on March 26, 2014.

FINDINGS OF FACT

The Panel adopts the findings of fact numbered 1-33 proposed by the ALJ (Attached as Exhibit 1).[1] The facts, as described by the ALJ, and summarized below, are largely undisputed. Dr. Egbert was the Medical Director for FEN, an organization dedicated to supporting and aiding non-terminally ill persons to hasten their deaths. Individuals who wanted the organization's help to commit suicide would submit to FEN an application with their medical records and a statement explaining why they wished to end their lives.

As the Medical Director of FEN, Dr. Egbert received each applicant's medical record and determined whether the applicant's request for an assisted suicide would be accepted.[2] Dr. Egbert explained that he reviewed the medical records to determine: (1) whether the applicant accurately identified the source of his or her suffering, (2) whether the applicant's suffering was "horrible," and (3) whether the medical treatment that the applicant was receiving was adequate. In at least one circumstance, Dr. Egbert rejected an application because the applicant's pain was

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[1] The ALJ's Findings of Fact incorporated twenty stipulated facts (numbered 1-20) agreed to by the parties and thirteen additional factual findings (numbered 21-33).

[2] The applications were reviewed by the "medical evaluation committee." That committee consisted of professionals in various disciplines, each needing to be licensed in their discipline, and at least one layperson. As the medical director, Dr. Egbert made the final decision for each applicant.

not being properly treated and he advised the applicant to seek further pain management from her physician. Dr. Egbert also noted that FEN accepted applicants with exclusively psychological/psychiatric issues. For psychological and psychiatric cases, Dr. Egbert could refer the applicant to a mental health specialist, if he believed that his own determination would be inadequate.

After FEN accepted the applicant as a member to FEN, that member would receive a copy of the Final Exit book, which detailed how to commit suicide using helium gas to hasten death by releasing helium into an airtight bag/hood over the member's head. FEN assigned each member one or two "Exit Guides" to aid the member's suicide. The Exit Guide talks with the member, rehearses the suicide with the member, ensures all the paperwork is completed, attends the member's suicide, and holds the member's hands to comfort the member and to prevent the member from involuntarily displacing the bag during the suicide. After the member's death, the Exit Guide removes the helium tanks and bag, leaves, and disposes of the suicide paraphernalia. The suicide paraphernalia is immediately removed from the suicide location to prevent the cause of death from being determined and listed on the death certificate and to hinder police investigations into the circumstances of the death. Each member plans in advance the person who will "discover" the body and that person either calls 911 or the family physician. After the suicide, the Exit Guide contacts the "discoverer" to find out what occurred after the death was reported.

It is undisputed that Dr. Egbert participated in six suicides in the State of Maryland as either a Senior Exit Guide or as the members' only Exit Guide. Dr. Egbert reviewed their applications and medical records and recommended accepting them as members. Dr. Egbert attended their suicide rehearsals. He held each member's hands and talked to him or her. Each

of the members died from asphyxiation due to helium inhalation. After each member died, Dr. Egbert removed the hoods and helium tanks and disposed of the helium tanks. In each of these suicides, the death certificates did not list asphyxiation, helium inhalation, or suicide as the cause of death. Dr. Egbert stipulated that in each of these suicides, the FEN member was not terminally ill, that is, would not have died within six months. The six FEN members for whom Dr. Egbert acted as an Exit Guide are as follows:

1. Patient A was a 68-year-old man with Parkinson's disease who suffered from gait disturbances and mental fogginess. He died on May 25, 2008. His death certificate states Coronary artery disease due to Parkinson's disease as the cause of death.

2. Patient B was a 71-year-old woman suffering from progressive Multiple Sclerosis for 45 years complicated by axonal polyneuropathy. She died on November 20, 2008. Her death certificate states acute myocardial infarction and multiple sclerosis as the cause of death.

3. Patient C was an 85-year-old woman with a medical history of significant peripheral vascular disease, diabetes mellitus, hypertension, coronary artery disease, atrial fibrillation s/p pacemaker placement, anemia, and depression with significant functional impairment. She stated that her reason for suicide was to leave enough money to establish a trust to care for her son with Asperger syndrome. She died on October 15, 2008. Her death certificate states that she died from heart failure and aortic valvular disease.

4. Patient D was an 82-year-old woman with chronic obstructive pulmonary disease with increasing difficulty in breathing. She died on July 16, 2008. Her death certificate states that she died from right heart failure, emphysema, and smoking.

5. Patient F was an 87-year-old woman with worsening monopolar depression. She died on August 5, 2006. Her death certificate lists atherosclerosis, cardiovascular disease as the causes of death.

6. Patient G was a 76-year-old woman with degenerative ataxia not amenable to treatment, progressive symptoms and was diagnosed with depression. She died on May 27, 2004. Her death certificate states that she died from degenerative cerebeller disorder.

ANALYSIS

The issue in this case is whether Dr. Egbert's actions as Medical Director of FEN and his assistance to the suicide of six members of FEN constitutes unprofessional conduct in the practice of medicine under Health Occ. § 14-404(a)(3)(ii). In the Board's analysis, the Board first discusses whether Dr. Egbert's conduct was "in the practice of medicine," second, whether his conduct was "unprofessional," and finally addresses miscellaneous exceptions filed by Dr. Egbert.

I. PRACTICE OF MEDICINE

A. ALJ's Proposed Decision and Exceptions

In her proposed decision, the ALJ found that Dr. Egbert engaged in the practice of medicine based on his review and evaluation of applicants' medical records. The ALJ, however, found that Dr. Egbert's presence and assistance in the members' suicides was not in the practice of medicine.

Dr. Egbert filed exceptions to the ALJ's proposed decision's conclusion that Dr. Egbert's review of the medical records was in the practice of medicine. He claims that the review of the medical records was not within the practice of medicine. He also claimed that he had not received notice in the charges that his review of medical records was in the practice of medicine.

The State filed exceptions to the ALJ's proposed decision's conclusions that aiding patients in committing suicide was not the practice of medicine, arguing that the continuum of Dr. Egbert's conduct including reviewing the medical records, his participation in the suicide rehearsal, his conduct during the suicides, and his conduct after the suicides, such as removing the helium tanks and suicide paraphernalia, should be considered the practice of medicine.

B. Practice of Medicine in Statute and Caselaw

The Medical Practice Act, Health Occ. § 14-101(o) defines practicing medicine as follows:

> (1) "Practice medicine" means to engage, with or without compensation, in medical:
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> (i) Diagnosis;
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> (ii) Healing;
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> (iii) Treatment; or
>
> (iv) Surgery.
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> (2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following:
>
> (i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual:
>
> 1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or
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> 2. By appliance, test, drug, operation, or treatment;
>
> (ii) Ending of a human pregnancy; and
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> (iii) Performing acupuncture as provided under § 14–504 of this title.

Maryland courts have not strictly interpreted the statutory definition of practicing medicine, but rather have applied a broad interpretation of what is "in the practice of medicine" under Health Occ. § 14-404(a)(3)(ii). *See Kim v. Maryland State Board of Physicians*, 423 Md. 523, 527 (2011) (lying on a renewal application deemed in the practice of medicine); *Finucan v. Maryland Bd. of Physician Quality Assurance*, 380 Md. 577, 597 (2004) (sexual relationship with three patients deemed in the practice of medicine); *Board of Physician Quality Assurance v.*

Banks, 354 Md. 59, 66 (1999) (sexual harassment of administrative employees of a hospital deemed in the practice of medicine); *Cornfeld v. State Board of Physicians*, 174 Md. App. 456, 468 (2007) (lying to a hospital peer review deemed in the practice of medicine). In deciding whether Dr. Egbert's action is in the practice of medicine, the Board must consider whether his actions were "intertwined with patient care to pose a threat to the patients or the medical profession." *Cornfeld*, 174 Md. App. at 474.

C. Analysis

1. Physician-Patient Relationship

Before the Panel considers whether Dr. Egbert's actions can be considered intertwined with patient care, the Panel must determine whether these FEN applicants and members were patients. The Panel concludes that the FEN applicants and members were Dr. Egbert's patients.

First, Dr. Egbert considered the FEN members to be his patients. In his letter to Board staff and throughout his interview with Board staff, Dr. Egbert described the FEN members who committed suicide as "patients." In his letter to the Board, Dr. Egbert further stated that he believed that "if a person has the right to hasten death, a physician has the right to guide him or her in doing this in a painless and dignified manner."

Second, Dr. Egbert held himself out to the members as a physician and medical professional. Dr. Egbert was identified as the Medical Director of FEN and performed the duties, including deciding which individuals could be approved for membership based on the severity of their illnesses. In two publications for FEN members, Dr. Egbert was referred to by his title as an "M.D." In a document titled "Procedure for Hastened Death Using Inert Gas," Dr. Egbert was identified as an editor with his "M.D." and "M.P.H." degrees listed after his name. Additionally, the training manual suggested that if a physician refuses to provide a patient's

medical record, the patient could send the records to "Lawrence Egbert, MD MPH," and suggested the patient tell his doctor that "Dr. Egbert" is a pain management specialist. This training manual refers to the FEN members as patients as well. These documents indicate that Dr. Egbert and FEN identify their members as patients, and Dr. Egbert is identified to them as a physician. As discussed further below, the actions taken by Dr. Egbert were also the type of actions that a physician undertakes, such as reviewing and evaluating patient medical records and aiding the patients with their end of life decisions.

2. Review of Medical Records to Determine Diagnosis of Conditions, Severity of Suffering and Possible Treatment Options is "In the Practice of Medicine."

Next, the Panel finds that the continuum of Dr. Egbert's conduct was intertwined with patient care, that is, involved patient welfare, health, and the potential for patient harm. Dr. Egbert acted in his role as a physician both when he reviewed the medical records as part of his duty as medical director of FEN as well as the actions he took as an Exit Guide.

Dr. Egbert argues in his exceptions that lawyers, nurses, insurance adjusters, nutritionists and pharmacists all review patient records without engaging in the practice of medicine. While that is true, each professional reviews records for different purposes. The Panel concludes that Dr. Egbert cannot divest himself of his licensure or his medical training and expertise or his purpose in reviewing the medical records, in considering whether he has acted as a physician.

The State's expert, Dr. Silverman, opined that determinations based on medical records about what disease or illness the person was suffering from, whether the individual had intolerable suffering, and whether the care the individual was receiving was sufficient are medical determinations because he made medical assessments about patients conditions. *See*

Health Occ. § 14-101(o). Dr. Egbert presented no expert testimony to contradict this opinion. The Panel finds Dr. Silverman's testimony persuasive.

Further, Dr. Egbert stated in his letter to the Board Senior Compliance Analyst:

> My work for the Final Exit Network was to evaluate each person's request to hasten death. I received their medical records and a copy of their letters stating why life had become only suffering and was no longer bearable. *It was my job to evaluate the care they were receiving and occasionally there were suggestions made to improve their care.* I had several psychologists for consultation. No one has suggested that *our patients* were not suffering severely.

Evaluation of medical care for improved care is one example that demonstrates that his role in reviewing medical records was in the medical realm. Another example given by Dr. Egbert at his interview concerned an applicant who wanted to commit suicide because of her pain. After his review of the file, he determined that her pain was not being properly treated. He advised the patient that she tell her doctor that she needed more pain medicine, and "this doctor from Hopkins [Dr. Egbert], will be glad to tell him how to do it right." As a result of his medical advice, the applicant withdrew her application for FEN. Such evaluation and advice are illustrative of the way in which Dr. Egbert's review of patient files in this context was medical in nature and within the practice of medicine. Even if the review were not squarely under the definition of "practicing medicine," it was certainly "in the practice of medicine" under the broad interpretation the Court of Appeal applied in *Banks.* 354 Md. at 66.

Dr. Egbert noted that he sought additional information if he believed that the medical records were incomplete. Additionally, Dr. Egbert made referrals to psychologists when he was uncomfortable evaluating the psychology of the patients. Dr. Egbert explained that with regards to the psychology of patients "[t]he difficulty was that I am not a psychiatrist." In so doing, Dr. Egbert used his medical expertise, and when he did not have requisite medical expertise, he

would refer the patient to a specialist, rather than use his lay, non-medical opinion. Referring patients to specialists is also an element of what physicians do. This also indicates that in non-psychiatric cases he was using his expertise as a physician to diagnose the patient. Dr. Egbert's evaluations were, thus, in the practice of medicine, even in cases that Dr. Egbert approved without comment.

In sum, Dr. Egbert used his medical expertise to evaluate the medical records, diagnose the patients, and measure the severity of their conditions, and he gave medical advice about treatment, when appropriate. When he did not feel comfortable with his diagnosis or felt his medical knowledge was insufficient, such as the psychological matters, he would refer the patients to a specialist. The Board, thus, rejects Dr. Egbert's claim that he did not practice medicine.

3. Aiding Suicide Concerned Patient Well-being and is In the Practice of Medicine.

Dr. Egbert was also acting in the practice of medicine in his role as an Exit Guide because his conduct led to extreme threats to the patient's well-being by aiding their suicide. The Maryland Court of Appeals held that suicide is a type of harm to patients that may be evidence that the physician's conduct should be considered within the practice of medicine. *See Finucan*, 380 Md. at 599 (quoting *Finucan*, 151 Md. App. at 417) (considering the possibility that Dr. Finucan's sexual relationship with a patient caused her apparent suicide attempt as evidence that Dr. Finucan's conduct was in the practice of medicine).

4. Rehearsal and Procedure Aiding Suicide is In the Practice of Medicine.

Dr. Egbert's review of the patients' medical records cannot be separated from his conduct in rehearsing the process for suicide, including instructions on how to use the materials, walking patients through the steps of the suicide, and holding the patients' hands during the suicide.

The ALJ explained that "participation in assisted suicide is antithetical to the long-standing or prevailing purpose of medical practice to treat and heal patients and/or to make patients comfortable." ALJ Proposed Decision at 19. The ALJ stated that assisting suicide was not for the purpose of healing or relieving patients' symptoms of ailments, and, therefore, should not be considered in the practice of medicine.

The Panel disagrees with the ALJ's rationale on this point because the ALJ disregarded caselaw regarding the practice of medicine. Physicians are often found guilty of unprofessional conduct in the practice of medicine for acts that are not facially related to the practice of medicine or are antithetical to the practice of medicine. Specifically, Maryland courts have found the practice of medicine to include sexually harassing hospital co-workers (*Banks*, 354 Md. at 76-77), sexual liaisons with patients (*Finucan*, 380 Md. 601), lying on peer reviews (*Cornfeld*, 174 Md. App. at 462), and lying on a renewal application. (*Kim*, 423 Md. at 527). Though none of these cases directly involved a physician acting to treat or heal patients they each were considered within the practice of medicine. Based on this caselaw, the Panel rejects the ALJ's reasoning.

The State's expert, Dr. Silverman, testified that by holding the hands of the patients while they committed suicide, Dr. Egbert provided emotional support to the patient and ensured that the hood was not displaced because of an involuntary spasm of the patients' arms. Dr. Silverman opined that both – providing emotional support and ensuring the hood stay on – were the role of

a physician and, therefore, constituted the practice of medicine. Dr. Egbert did not provide any expert testimony contradicting this conclusion.

5. Dr. Egbert had Notice that his Review of Medical Records would be Considered In the Practice of Medicine.

Dr. Egbert argues in his exceptions that he was not given notice that his review of medical records was unprofessional conduct in the practice of medicine. The charges allege, however, that "[i]n his capacity as Medical Director, [Dr. Egbert] evaluated the records submitted by applicants to determine whether the applicant's request for assistance would be accepted." This allegation in the charges is sufficient notice that Dr. Egbert could be held responsible for unprofessional conduct in the practice of medicine for his review of medical records.

6. The Principle of *Edjusem Generis* does not Lead to the Conclusion that Assisted Suicide was Outside the Practice of Medicine.

The ALJ concluded assisted suicide was outside the practice of medicine, in part, because the definition of the practice of medicine in Health Occ. § 14-101(o) did not explicitly include assisted suicide, but did include "ending of a human pregnancy." The ALJ used the doctrine of *ejusdem generis* to infer that assisted suicide should not be considered "in the practice of medicine." The doctrine of *ejusdem generis* is defined as "when a general word or phrase follows a list of specifics, the general word or phrase will be interpreted to include only items of the same class as those listed." *Haile v. State*, 431 Md. 448, 468-69 (2013). *Ejusdem generis* may be applied under the following conditions: "(1) the statute contains an enumeration of specific words; (2) the members of the enumeration suggest a class; (3) the class is not exhausted by the enumeration; (4) a general reference supplementing the enumeration, usually following it; and (5) there is not clearly manifested an intent that the general term be given a

broader meaning than the doctrine requires." *Haile*, at 469 (quoting *Boyle v. Maryland-National Capital Park & Planning Comm'n*, 385 Md. 142, 156 (2005)).

The Panel finds that the ALJ's application of the doctrine of *ejusdem generis* was improper. None of the conditions required to apply the doctrine of *ejusdem generis* are present here. The statute does not have an enumeration of specific words and there is no applicable class. The sole inclusion of "ending of a human pregnancy" by itself cannot be sufficient to demonstrate that it is the first of a class of permitted actions. Even if there is an implicit class consisting of controversial practices, there is no indication that this one item, ending pregnancy, can, by itself, be considered an exhaustive list. Finally, there is no general reference supplementing the enumeration. In sum, the doctrine of *ejusdem generis* is not applicable to interpreting the definition of the practice of medicine.

Dr. Egbert's actions throughout the suicide process were "in the practice of medicine," under § 14-404(a)(3)(ii).

II. UNPROFESSIONAL CONDUCT

A. ALJ's Proposed Decision and Exceptions

The ALJ found that, because she had determined that participation during the actual assisted suicide did not constitute the practice of medicine, whether Dr. Egbert's actions were unprofessional or not was of no consequence. The ALJ found that, in Dr. Egbert's review of the medical records, Dr. Egbert's conduct was egregiously unprofessional.

The State took exception to the ALJ's analysis. Dr. Egbert excepted to the conclusion that his review of the medical records was inherently unprofessional.

B. Caselaw

"Unprofessional Conduct" is not defined by the Medical Practice Act, Health Occ. § 14-101. Maryland courts have broadly interpreted what may be considered to be "unprofessional conduct" under Health Occ. § 14-404(a)(3)(ii). *See Finucan*, 380 Md. at 597 (sexual relationship with three patients deemed unprofessional conduct); *Salerian v. Maryland State Bd. of Physicians*, 176 Md. App. 231, 249 (2007) (disclosing confidential physician-patient information was unprofessional conduct); *Cornfeld*, 174 Md. App. at 468 (dishonesty by lying to a hospital peer review deemed unprofessional conduct). Courts have stated that "unprofessional conduct" is "conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming" a physician in good standing. *Salerian*, 176 Md. App. at 248 (quoting *Finucan*, 380 Md. at 593).

C. Analysis

1. Disposing of the Suicide Paraphernalia was Unprofessional.

Dr. Egbert removed and disposed of the helium tanks, hoods and suicide paraphernalia. According to the *Final Exit* book, the Exit Guide removes suicide paraphernalia to hinder any police investigation, which would lead to longer inquiries. Dr. Egbert's actions in removing the suicide paraphernalia not only hindered police investigations, but also caused other physicians and medical examiners to list the cause of death incorrectly on the patients' death certificates. Dr. Silverman, the State's expert, opined that removing the suicide paraphernalia was deceptive for these reasons. Honesty with patients and colleagues is a fundamental principle of medical ethics. *See* AMA's Principles of Medical Ethics (http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page). *See also Cornfeld*, 174 Md. App. at 479 (quoting *Dr. K. v. State Bd. of Physician Quality Assurance*, 98

Md. App. 103 (1993)). Lying to or misleading other physicians, medical examiners, and/or the police is a dishonest act, *see Cornfeld*, 174 Md. App. at 479, and is unbecoming a medical professional in good standing. *See Salerian*, 176 Md. App. at 248.

2. Dr. Egbert's Conduct was Unprofessional because it was Contrary to the American Medical Association's Code of Medical Ethics.

Dr. Egbert's actions are contrary to the American Medical Association's Code of Medical Ethics, Opinion 2.211. "[A]llowing physicians to participate in assisted suicide would cause more harm than good. . . . Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. . . . Patients near the end of life must continue to receive emotional support . . . ." *See* State's Exhibit 25. The Panel concludes that performing actions that have been rejected by the AMA's Code of Medical Ethics is evidence of unprofessional conduct. *See Salerian*, 176 Md. App. at 248.

3. Dr. Egbert's Conduct was Unprofessional because it is Illegal under Maryland Law.

Assisting suicide is a criminal act under Section 3-102 of the Criminal Law Article. That Section provides as follows:

> With the purpose of assisting another individual to commit or attempt to commit suicide, an individual may not:
> (1) by coercion, duress, or deception, knowingly cause another individual to commit suicide or attempt to commit suicide;
> (2) knowingly provide the physical means by which another individual commits or attempts to commit suicide with knowledge of that individual's intent to use the physical means to commit suicide; or
> (3) knowingly participate in a physical act by which another individual commits or attempts to commit suicide.

Dr. Egbert participated in the patients' physical act of committing suicide, by holding down the patients' hands. Committing this illegal act is further evidence that Dr. Egbert's actions were unprofessional. *See Salerian*, 176 Md. App. at 248.

4. Dr. Egbert's Conduct was Unprofessional because it does not Include Protective Safeguards Required by States that Permit Physician Assisted Suicide.

Dr. Egbert's practices violate the strict protective standards to minimize the potential for abuse required in states that permit assisted suicide. In his expert report, Dr. Silverman noted that states that allow physician assisted suicide require a psychiatric consultation to ensure existence of a rational decision. Dr. Egbert and FEN do not have such a consultation to ensure rational decisions by the FEN applicant or member.

Dr. Egbert and FEN also ignore the strict requirement by states that permit assisted suicide that limit such practice only to terminal patients. Oregon, Washington and Vermont, the three states that have passed laws permitting physician assisted suicide, each limit physician assisted suicide to patients suffering from terminal disease. *See* 18 Vt. Stat. Ann. § 5281 (terminal disease is defined as "an incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months"); Or. Rev. Stat. 127.800 §1.01 (defining terminal disease as "incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months"); Wash. Rev. Code § 70.245.010 (same). Vermont specifies that "a bona fide physician–patient relationship with a patient *with a terminal condition* shall not be considered to have engaged in unprofessional conduct" under certain limited circumstances. 18 Vt. Stat. Ann. § 5289 (emphasis added). Oregon and Washington requires the attending physician to "[m]ake the initial determination of whether a patient has a terminal disease . . ." Or. Rev. Stat. 127.815 § 3.01; Wash. Rev. Code 70.245.040 (using identical language).[3]

[3] This does not mean to suggest that had Dr. Egbert complied with the other states' laws that his actions would be legal or professional in Maryland.

Dr. Egbert admitted by stipulation that none of the six patients whom he helped commit suicide had terminal diseases. Dr. Egbert's conduct towards non-terminal patients was not a mere administrative oversight. In FEN's first responder and exit guide training, FEN explained its approach to non-terminal patients as a feature of the FEN organization, explaining that FEN "was created specifically to take nonterminal as well as terminal cases." In a question and answer pamphlet, FEN claims to be "the only organization in the United States that will support individuals who are not 'terminally ill'" and explains "[n]o other organization in the US has the courage to make this commitment." Dr. Egbert's flagrant disregard for the common safeguards enacted by states that allow assisted suicides supports the conclusion that Dr. Egbert's actions are "conduct . . . unbecoming a member in good standing of a profession." *Finucan*, 380 Md. at 593.

III. DR. EGBERT'S ADDITIONAL EXCEPTIONS

A. Fraudulently Obtaining Medical Records

The ALJ's proposed decision concluded that Dr. Egbert improperly held himself out as a pain management physician in order to obtain patient medical records even though he had no intention of treating the patients' conditions. Dr. Egbert excepted to this conclusion. The Panel accepts Dr. Egbert's exception because no evidence in the record demonstrates that Dr. Egbert requested medical records from any physician, deceived any physician in order to obtain medical records, or that any medical records were directly transmitted to Dr. Egbert from another physician. The Panel, therefore, does not include these acts, for which there was no evidence, in the Board's determination of unprofessional conduct in the practice of medicine.

B. Admissibility of Newspaper Articles, Exhibits 1 and 3

Dr. Egbert objects to the admission into evidence of newspaper articles from the Baltimore Sun and Washington Post, Exhibits 1 and 3 respectively, because the articles contain unreliable hearsay and prejudicial hyperbole. The Panel concludes that the articles were properly admitted because they were relevant to the investigation and the issues raised in the charging documents. The panel, nevertheless, gives Exhibits 1 and 3 little weight based on their reliability limitations, and instead bases the Panel's opinion on the State's other evidentiary exhibits and testimony at the hearing and argument before the Board.

C. Admissibility of Dr. Silverman's Testimony

Dr. Egbert also excepts to the admission by the ALJ of Dr. Silverman's *curriculum vitae* and report based on the report's reliance on the AMA ethics opinion. Dr. Egbert claims that the AMA Code of Ethics was not adopted by the Panel and therefore cannot be applied to sanction a licensee. The Panel agrees with Dr. Egbert that the Panel is not *required* to adopt or consider the AMA's Ethics Opinion. Nor is the Panel required to accept the opinion of Dr. Silverman. The Panel may do so and chooses to do so here. The Board concludes that Dr. Silverman's expert report is relevant and its reliance on the AMA ethics opinion does not render it inadmissible. The Panel agrees with the State that unprofessional conduct expressly includes conduct that breaches rules or ethical codes of professional conduct. *Finucan*, 380 Md. at 593. *See also Salerian*, 176 Md. App. at 248.

CONCLUSIONS OF LAW

The Panel concludes that Dr. Egbert's actions, as described above, constitute unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority of the quorum of Disciplinary Panel B hereby

ORDERED that the license of Lawrence D. Egbert, M.D., to practice medicine in Maryland is **REVOKED;** and it is further

ORDERED that this is a **PUBLIC** document pursuant to Md. Gen. Prov. Code Ann. §§ 4-101 to 4-601 (2014 Vol.)

12/12/2014
Date

Christine A. Farrelly
Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Egbert has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Egbert files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

MARYLAND STATE BOARD	*	BEFORE JENNIFER M. CARTER JONES,
OF PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE OF
LAWRENCE D. EGBERT, M.D.,	*	ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH CASE NO.: DHMH-SBP-71-13-19027
LICENSE NO.: D16409	*	

* * * * * * * * * * * * * *

PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
FINDINGS OF FACT
DISCUSSION
CONCLUSION
PROPOSED ORDER

STATEMENT OF THE CASE

On or about November 18, 2012, Maryland's State Board of Physicians (the Board or SBP) issued charges (the Charges) against Lawrence D. Egbert, M.D. (the Respondent). The SBP specifically alleged that the Respondent acted as the Medical Director for Final Exit Network (the Organization or FEN), a right to die organization, and participated in assisted suicides in violation of section 14-404(a)(3)(ii) of the Annotated Code of Maryland Health Occupations Article.

On July 15, 2013, the Respondent filed a Motion to Dismiss the Charges. On August 1, 2013, the Board filed the State's Opposition to Respondent's Motion to Dismiss. On August 14, 2013, the Respondent filed a Reply to the Opposition to Respondent's Motion to Dismiss. On August 28, 2013, I conducted a hearing on the Motion at the Office of Administrative Hearings (OAH), 11101 Gilroy Road, Hunt Valley, Maryland. Lee Baylin, Esquire, represented the Respondent. Victoria H. Pepper, Assistant Attorney General, represented the State. On

September 18, 2013, I issued a decision denying the Respondent's Motion to Dismiss the Charges.

On September 26, 2013, I conducted a hearing on the merits at the OAH. Once again, Lee Baylin, Esquire, represented the Respondent and Victoria H. Pepper, Assistant Attorney General, represented the State.

The contested case provisions of the Administrative Procedure Act, the Board's Rules of Procedure and OAH's Rules of Procedure govern procedure in this case. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2009 & Supp. 2013); Code of Maryland Regulations (COMAR) 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent engage in unprofessional conduct in the practice of medicine, in violation of section 14-404(a)(3(ii) of the Maryland Annotated Code's Health Occupations Article?
2. If so, what sanction is appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

The State submitted the following documents, which unless otherwise noted, I admitted into evidence as the exhibits numbered below:

1. February 29, 2012 letter from the Board to the Respondent, with attached May 21, 2011 Baltimore Sun article entitled "Baltimore Doctor Helps the Ill Commit Suicide."
2. March 8, 2012 letter from the Respondent to the Board, with attached completed Information Form, dated March 8, 2012
3. January 19, 2012 Washington Post article, entitled "After the Death of Jack Kevorkian, Lawrence Egbert is the new Public Face of American Assisted Suicide."
4. FEN records for Patient A, including correspondence and medical records

5. May 27, 2008 Death Certificate for Patient A
6. FEN records for Patient B, including correspondence and medical records
7. November 20, 2008 Death Certificate for Patient B
8. FEN records for Patient C, including correspondence and medical records
9. October 16, 2008 Death Certificate for Patient C
10. FEN records for Patient D, including correspondence and medical records
11. July 18, 2008 Death Certificate for Patient D
12. FEN records for Patient E, including correspondence and medical records
13. August 7, 2006 Death Certificate for Patient E
14. FEN records for Patient F, including correspondence and medical records
15. May 28, 2004 Death Certificate for Patient F
16. Excerpts from *Final Exit – The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (3rd Ed. 2010)
17. 2007 First Responder and Exit Guide Training Manual
18. Not offered
19. Not offered
20. Not admitted
21. Transcript of Respondent's April 12, 2012 interview with the Board
22. Curriculum Vitae – Henry Silverman, M.D., M.A.
23. October 5, 2012 report by Dr. Silverman
24. January 25, 2012 report by Dr. Silverman
25. American Medical Association – Medical Ethics – Opinion 2.211 – Physician Assisted Suicide
26. Oregon Statute ORS 127.800 et seq.

27. November 28, 2012 Charges against the Respondent under the Maryland Medical Practices Act

The Respondent did not offer any exhibits for admission into evidence.

Testimony

The State presented the testimony of Dr. Henry Silverman, who was accepted as an expert in internal medicine with subspecialties in medical ethics as it relates to end-of-life issues. The Respondent did not testify or offer the testimony of any witnesses.

FINDINGS OF FACT

The Parties stipulate to the following facts:

1. The charges in this case are limited to section 14-404(a)(3)(ii) of the Annotated Code of Maryland Health Occupations Article.
2. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent is Board-certified in anesthesiology, and was originally licensed to practice medicine in Maryland on July 15, 1952.
3. The Respondent has retired from the practice of anesthesiology.
4. The Respondent was one of the founders of the FEN.
5. The FEN is a non-profit organization granted 501(c)(3) status as an educational organization by the United States Revenue Service.
6. The Organization provides information and advice to its members[1] who choose to hasten their deaths by the inhalation of inert gas (helium). The Organization is a national organization with volunteers located throughout the country.

[1] Throughout the Organization information's and in the documentary evidence, those who sought FEN's assistance with terminating their lives are sometimes referred to as "patients" and other times referred to as "members." Throughout this decision, I shall use both of those terms.

7. Organization literature states, "[t]he Organization is the only organization in the United States that will support individuals who are not 'terminally ill' – six months or less to live – to hasten their death [;]." . . . **No other organization in the US has the courage to make this commitment."** [Emphasis in original.] These sentiments are echoed in the slogan: "[The Organization] will serve many whom other organization may turn away." (State Ex. 27)

8. In order to obtain advice from the Organization, an applicant must become an Organization member by paying a small fee. The applicant then submits medical documentation of his or her condition and a letter written by the applicant which, according to the Organization training manual, subjectively detail[s] their condition, the length of time they've had it, the effect it's had on their quality of life and any other information that has led to their decision to exit." The training manual states that an applicant is also required to read a book titled "Final Exit" by Derek Humphry. (State Ex. 17)

9. In his capacity as Medical Director, the Respondent evaluated the records submitted by applicants to determine whether the applicant's request for advice would be accepted.

10. When interviewed by Board staff, the Respondent stated that if he was "uncomfortable with the psychology of the members, I could consult with the [Organization] psychologist."

11. In addition to being the Organization's Medical Director, the Respondent was also a Senior Exit Guide.

12. The Exit Guide's function is to provide the member and the member's family with information about the Member's suicide, or "death event," the term used by the Organization. The Exit Guide and the member discuss family members or friends who may wish to be present and who will maintain confidentiality regarding the circumstances of the

member's death. The Exit Guide discusses the logistics and timing of "discovering" the member's body and reporting the death. The Exit Guide also rehearses the death event with the member.

13. The Organization does not require that Exit Guides and Senior Exit Guides be physicians, and to the Respondent's knowledge, he was the only physician who acted in such capacity.
14. The inhaled helium displaces the oxygen in the body and initiates brain death.
15. After a few minutes, the Exit Guide announces that death has occurred. After the tanks have emptied, the Exit Guide removes the bag, detaches it from the tanks and places the tanks in their boxes, ready to be disposed of.
16. The Exit Guide reminds the person who has agreed to "discover" the body to wait at least two hours before making the discovery. The passage of time permits the body to cool and discourages attempts at resuscitation.
17. Death by inhalation of helium is not detectable when the body is autopsied.
18. The Respondent was present at six suicides in Maryland. Four occurred in 2008, one in 2006 and one in 2004.
19. None of the six suicide members had a terminal condition, in that they were not facing imminent death within six months.
20. When interviewed by Board staff, the Respondent stated that he was an Exit Guide at each of the suicides and that he "always" performed a rehearsal of the procedure prior to the "death event."

I find the following additional facts by a preponderance of the Evidence:

21. First Responders are Organization members who initially interview individuals who are interested in becoming an Organization members and ending their lives.

22. The Organization created a document entitled "First Responder and Exit Guide Training Chicago IL, June 08 -10 2007" (Training Manual) which provides instructions for Organization Exit Guides and First Responders. (State Ex. 17).

23. The Training Manual includes the following language:

> Patients frequently express concern over obtaining their medical records. They're entitled to these records by law, but it isn't unusual for them to say that their doctor will question the need for the records and they're reluctant to approach a doctor they don't feel confident about. Sometimes doctors will mail or fax records only to another doctor. If that should be the case, as a last resort, tell the patient to ask the doctor to send the records to:
>
> Lawrence Egbert, MD, MPH
> 814 Powers Street
> Baltimore, MD 21211
>
> The record can also be faxed to him . . . . If a doctor questions why the patient is sending records to Baltimore, tell him/her to say that Dr. Egbert is a specialist in pain management (maybe the patient found him on the Internet) and consults throughout the country on difficult cases (he is and he does, and people do come across his name on the Internet). As an alternative, the patient may say that other doctors have asked for information the patient can't recall so he/she has started keeping copies of records.
>
> (State Ex. 17).

24. The Organization has produced a document entitled "Procedure for Hastened Death Using Inert Gas," which details the procedure and materials the Organization must use to effectuate a member's death by helium. That document states that was written "[b]y Richard MacDonald, M.D. edited by Lawrence D. Egbert, MD, MPH." (State Ex. 17)

25. As part of the Organization's written material, the Respondent wrote a document entitled "Voluntary Stopping of Eating and Drinking (VSED)." The document details the effectiveness of VSED for individuals who wish to end their lives. The Respondent used his professional designation, M.D., as the named author of that document. (State Ex. 17)

26. As Medical Director for the Organization, the Respondent received and evaluated the medical records for each member who wished to end his or her life along with a copy of a

letter from the member "stating why life had become only suffering and was no longer bearable." It was the Respondent's responsibility to "evaluate the care they were receiving." (State Ex. 1; State Ex. 17).

27. On April 12, 2012, Heather McLaughlin, Board Lead Compliance Analyst, conducted an interview of the Respondent. During the interview, the Respondent reported that he reviewed the medical records of all of the members who solicited the Organization for its assistance with suicide. When Ms. Laughlin asked the Respondent to further explain how he evaluated individual patients, the Respondent replied as follows:

> So, for example, if they want - - I'll give you a good example that we've had. A patient who had terrible pain and I realized that she was not being taken care of, just from the paperwork. All patients had to send in their medical records so that I could read their medical records.
>
> So I called the patient up and said, you're not getting pain care, you know. And she said, tell me about it. So she was quite upset about it, and I said, well, why don't you - - this is a long conversation that I am speeding up - - but why don't you tell your doctors that this doctor from Hopkins will be glad to tell him how to do it right.
>
> So - - and that was a bit of an overstatement of my credentials. But - - so I called her up about a month later. She didn't call back or anything. And she said, no, I'm not going to die now, I'm okay, I've been taken care of, I'm okay. It's tolerable, the pain is tolerable. And I said well you jacked up the dose of the morphine then. I said, did you tell him that? And she said, yes. And I said, you're getting the proper dose.

(State Ex. 21).

28. The Organization requires patients to obtain the helium tanks and bag on his or her own. The Organization's training manual stresses that Exit Guides are prohibited from obtaining this equipment for the patient.

29. Senior Exit Guides and sometimes a second Guide are present at the death event and in most cases, dispose of the helium tanks and other equipment used for the patient's suicide.

30. The Respondent was an Exit Guide in at least six suicides, including the suicides of Member A., a male (DOD: May 25, 2008); Member B., a female. (DOD: November 20, 2008);

Member C., a female (DOD: October 15, 2008); Member D, a female (DOD: July 16, 2008); Member E, a female (DOD: August 5, 2006); and Member R, a female (DOD: May 27, 2004).

31. The cause of death as stated on each patient's death certificate is a medical condition from which the patient had suffered, such as Parkinson's disease or coronary artery disease.

32. The Respondent knew that each patient's death was caused by the inhalation of helium and he knew that none of the patients' death certificates would state that helium inhalation was the cause of the patients' death. (State Ex. 17).

33. The American Medical Association (AMA) issued Opinion 2.211 – *Physician-Assisted Suicide*, which provides as follows:

> Physician-assisted suicide occurs when a physician facilitates a patients's death by providing the necessary means and/or information to enable patient to perform the life-ending act (e.g. the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).
>
> It is understandable, though tragic, that some patients in extreme duress – such as those suffering from a terminal, painful, debilitating illness – may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as a healer, would be difficult or impossible to control, and would pose serious societal risks.
>
> (State Ex. 25).

DISCUSSION

I. The Applicable Law and Board Charges.

The Board may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

> . . .
>
> (2) Fraudulently or deceptively uses a license;
> (3) Is guilty of:
> (i) Immoral conduct in the practice of medicine; or
> (ii) Unprofessional conduct in the practice of medicine[.]

Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (Supp. 2012).

The State, as the moving party, has the burden of proof by a preponderance of the evidence to demonstrate that the Respondent violated the statutory section at issue. Md. Code Ann., State Gov't § 10-217 (2009); Md. Code Ann. Health Occ., § 14-405(b)(2) (2009); *Comm'r of Labor and Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) citing *Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959). *See also Schaffer v. Weast,* 546 U.S. 49, 56 - 57 (2005).

II. The Parties' Positions.

The State argued that the Respondent is guilty of unprofessional conduct in the practice of medicine by advocating for and participating in actual suicides of at least six of the Organization's members. Particularly, the State argued that in his role as medical director, the Respondent undertook responsibilities that constitute the practice of medicine. That is, as Medical Director for the Organization, the Respondent personally evaluated the medical records submitted by members to determine whether the request for assisted suicide would be accepted. Based upon his medical expertise, the State asserts that the Respondent determined the appropriateness of assisting members with their desire to end their lives. In fact, argues the Board, the Respondent referred to those he agreed to assist as "patients."

In support of its position, the State offered the testimony of Dr. Silverman, who was accepted as an expert in internal medicine, with a subspecialty in pulmonology, critical care medicine, and medical ethics as it relates to end-of-life issues. The State based its charges upon Dr. Silverman's written reports, his testimony, documentary evidence of the Respondent's actions as the FEN Medical Director, and AMA Opinion - 2.211 – *Physician-Assisted Suicide.*

The Respondent argued that his actions did not occur within "the practice of medicine." Particularly, the Respondent argues that his activities related to the Organization did not involve

diagnosis or treatment of medical conditions for the members, or any other attribute of the practice of medicine. Therefore, regardless of the ethical implications of his actions, the Board has no basis to revoke his medical license under section 14-404(a)(3)(ii).

The Respondent also argued that his actions within the Organization constitute free association which is protected by the First Amendment of the United States Constitution.[2]

The Practice of Medicine

According to section 14-101 of the Health Occupations Article "practice medicine" is defined as follows:

> **(o) Practice medicine. --**
> **(1)** "Practice medicine" means to engage, with or without compensation, in medical:
> **(i)** Diagnosis;
> **(ii)** Healing;
> **(iii)** Treatment; or
> **(iv)** Surgery.
> **(2)** "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following:
> **(i)** Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual:
> **1.** By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or
> **2.** By appliance, test, drug, operation, or treatment;
> **(ii)** Ending of a human pregnancy; and
> **(iii)** Performing acupuncture as provided under § 14-504 of this title.
> **(3)** "Practice medicine" does not include:
> **(i)** Selling any nonprescription drug or medicine;
> **(ii)** Practicing as an optician; or
> **(iii)** Performing a massage or other manipulation by hand, but by no other means.

[2] In my September 18, 2013 Ruling on the Respondent's Motion to Dismiss, I found that his actions within the Organization do not constitute free association protected by the First Amendment. As the Respondent offered nothing new regarding this position, my ruling regarding that argument stands.

The rules of statutory construction been often presented by the Maryland Court of Appeals as follows:

> The cardinal rule of statutory interpretation is to ascertain and effectuate the real and actual intent of the Legislature. A court's primary goal in interpreting statutory language is to discern the legislative purpose, the ends to be accomplished, or the evils to be remedied by the statutory provision under scrutiny.
>
> To ascertain the intent of the General Assembly, we begin with the normal, plain meaning of the statute. If the language of the statute is unambiguous and clearly consistent with the statute's apparent purpose, our inquiry as to the legislative intent ends ordinarily and we apply the statute as written without resort to other rules of construction. We neither add nor delete language so as to reflect an intent not evidenced in the plain and unambiguous language of the statute, and we do not construe a statute with forced or subtle interpretations that limit or extend its application.
>
> We, however, do not read statutory language in a vacuum, nor do we confine strictly our interpretation of a statute's plain language to the isolated section alone. Rather, the plain language must be viewed within the context of the statutory scheme to which it belongs, considering the purpose, aim, or policy of the Legislature in enacting the statute. We presume that the Legislature intends its enactments to operate together as a consistent and harmonious body of law, and, thus, we seek to reconcile and harmonize the parts of a statute, to the extent possible consistent with the statute's object and scope. Where the words of a statute are ambiguous and subject to more than one reasonable interpretation, or where the words are clear and unambiguous when viewed in isolation, but become ambiguous when read as part of a larger statutory scheme, a court must resolve the ambiguity by searching for legislative intent in other indicia, including the history of the legislation or other relevant sources intrinsic and extrinsic to the legislative process. In resolving ambiguities, a court considers the structure of the statute, how it relates to other laws, its general purpose and relative rationality and legal effect of various competing constructions.
> In every case, the statute must be given a reasonable interpretation, not one that is absurd, illogical or incompatible with common sense.

Gardner v. State, 420 Md. 1, 8-9 (Md. 2011) (internal quotation marks and citations omitted).

A clear reading of section 14-101 reveals that the practice of medicine focuses on providing care for patients with the goal of healing those patients, or relieving them from symptoms of an ailment or condition. Arguably, assisting an individual with ending his or her

life, particularly, if that individual has been diagnosed with a degenerative or painful medical condition, could be interpreted as the removal of "any physical, mental, or emotional ailment or supposed ailment of an individual." That is, upon the patient's death, he or she would be relieved of the medical condition; however, such an interpretation of section 14-101 is implausible and incompatible with the definition of "practic[ing] medicine."

The statutory construction doctrine of *ejusdem generis* dictates that "when general words in a statute follow the designation of particular things or classes of subjects or persons, the general words will usually be construed to include only those things or persons of the same class or general nature as those specifically mentioned." *Haile v. State*, 431 Md. 448, 458 (Md. 2013). Section 14-101 defines the of "practice medicine" to include the "ending of a human pregnancy." Certainly, the inclusion of what has been and continues to be a controversial medical practice was intended to make clear that the ending of human pregnancy is acknowledged as a legal form of authorized medical practice in the State of Maryland. Pursuant to the doctrine of *ejusdem generis*, therefore, the omission of assisted suicide, which is prohibited under Maryland law[3] and certainly controversial, makes it clear that the legislature did not intend the definition of "practice of medicine" to include assisted suicide.

However, the fact that *participation* in assisted suicide, generally, does not constitute the practice of medicine does not necessarily merit the conclusion that any act that a physician undertakes with the goal of assisting an individual or individuals achieve death also must be deemed as outside of the practice of medicine. Indeed, Maryland courts have made it clear that the actions of a physician constitute the practice of medicine when there is a nexus between the physician's actions and the provision of treatment to patients. *McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426 (1984); *Finucan v. Md. Bd. of Physician Quality Assur.*, 380 Md. 577

[3] *See* Md. Code Annotated, Crim. Law § 3-102 (2012).

(2004); *Board of Physician Quality Assurance v. Banks*, 354 Md. 59 (1999); *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456, *cert. denied*, 400 Md. 647 (2007); and *Kim v. Md. State Bd. of Physicians*, 423 Md. 523 (2011).

By contrast, the Maryland Court of Appeals has made it clear that the practice of medicine does not include acts that are only tangentially-related to the responsibilities and practice as a physician. *McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426 (1984).

Particularly, the *McDonnell* Court held that the actions of a physician, who attempted to intimidate experts scheduled to testify against him in a medical malpractice case, did not occur in the practice of medicine. In so holding, the Court explained that although "Dr. McDonnell's act was 'related to his professional practice . . . [it] was insufficient to bring his conduct within the statute's requirement that the conduct occur in his practice as a physician." *Id.* at 437. The Court further elucidated that the physician's actions were aimed at prevailing at an adjudicative matter and had only a "general or associative relationship to the physician in his capacity as a member of the medical profession." Essentially the Court opined that the adjudication of McDonnell's medical malpractice case was tangential to the work he performed as a physician.

After the *McDonnell* Court made clear that the physician's conduct in that case **did not** constitute the practice of medicine, in *Finucan v. Md. Bd. of Physicians Quality Assur.* and *Board of Physician Quality Assurance v. Banks*, 354 Md. 59 (1999), the Maryland Court of Appeals addressed when a physician's actions may be considered to have occurred within the practice of medicine. Particularly, the Court held that a physician violates section 14-404 (a)(3) when he displays unprofessional conduct within the medical setting, or while he is generally performing tasks that are integral to the practice of medicine, whether or not the conduct itself is medical in nature.

In *Banks,* a physician was charged with sexually harassing three female colleagues while on extended duty at a hospital. The Board determined that each of the instances of sexual harassment occurred while the physician was engaged in the practice of medicine "because his presence in the hospital and on-call status clearly involved more than merely a general or associative relationship with his practice as a physician." *Banks*, 354 Md. at 66. The physician appealed and the Circuit Court for Carroll County, Maryland, affirmed the Board's determination, reasoning that section 14-403(a)(3) did not require face-to-face dealing with patients to constitute the practice of medicine. Rather, because the physician was on his shift at the hospital, in uniform, and present at the hospital for the sole purpose of practicing medicine, the physician's acts occurred in the practice of medicine. *Id.* at 66.

The Court of Special Appeals reversed the Circuit Court regarding two of the instances of sexual harassment because they did not occur "during the diagnosis, care, or treatment of patients." *Banks v. Bd. or Physicians Quality Assur.*, 116 Md. App. 249, 262 (1996).[4]

The Court of Appeals granted certiorari on the matter and reversed the Court of Special Appeals decision with regard to the two instances of sexual harassment,[5] reasoning that

> [t]he Board could reasonably hold that Dr. Banks' conduct of sexually harassing hospital employees was within the practice of medicine because he was on duty and in the working areas of the hospital. When on duty, Dr. Banks was responsible for admitting patients, caring for patients and assisting in the operating room and emergency department. He was not free to leave, and he was expected to be available at all times. When Dr. Banks was on duty he was there for the purpose of practicing medicine; *i.e.* for the 'diagnosis, care, or treatment of patients.'

[4] The Court affirmed the Circuit Court's finding regarding one instance of harassment because it occurred as the physician was using an addressograph machine and requesting a patient record when the harassment occurred. As both of those actions were "necessary procedures and . . . part of treatment of the patient," the Court of Special Appeals determined that the harassment occurred in the course of the practice of medicine. *Id.* at 263.
[5] The Court of Appeals affirmed the finding that the third instance of sexual harassment occurred in the practice of medicine.

Banks, 354 Md. at 72 (quoting *McDonnell*, 301 Md. at 437). In so holding, the Court distinguished the circumstances in *Banks* from those in *McDonnell* and offered the following reasoning:

> On one previous occasion this Court examined what is embraced by the phrase "in the practice of medicine." In *McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426, 429-430, 483 A.2d 76, 77-78 (1984), we considered the question of whether a physician's attempt to intimidate adverse expert witnesses scheduled to testify against him in a medical malpractice case was "immoral conduct of a physician in his practice as a physician" in violation of § 14-404(a)(3)'s statutory predecessor, Code (1957, 1980 Repl. Vol.), Article 43, § 130(h)(8). We held that, although Dr. McDonnell's conduct was "improper and not to be condoned," it was "not censurable under § [14-404(a)(3)]." *McDonnell*, 301 Md. at 434, 483 A.2d at 80. The Court agreed that Dr. McDonnell's act was "related to his professional practice" but was insufficient to bring his conduct within the statute's requirement that the conduct occur in his "practice as a physician." 301 Md. at 437, 483 A.2d at 81. We held that immoral conduct merely committed during the term of licensure or having only a "general or associative relationship to the physician in his capacity as a member of the medical profession" is not within the language of the statute. 301 Md. at 436, 483 A.2d at 81. Rather, the "application of [§ 14-404(a)(3)] is directly tied to the physician's conduct in the actual performance of the practice of medicine, i.e., in the diagnosis, care, or treatment of patients." 301 Md. at 437, 483 A.2d at 81.

Banks, 354 Md. at 70-71.

Particularly, the Court explained that "the primary factors that distinguish the *Banks* case from *McDonnell* were that Dr. Banks was on duty at the hospital, and was present in the working areas of the hospital." *Id.* at 74. The Court further explained that "[i]n other cases considering whether a physician's conduct was within the statutory definition of "in the practice of medicine," a critical factor has been whether the conduct occurred while the physician was performing a task integral to his or her medical practice." *Id.* The Court refused to apply "a narrow definition of the practice of medicine." *Id.*

In *Finucan,* a case relatively similar to *Banks*, a physician engaged in sexual relationships with patients and argued that his conduct did not occur in the practice of medicine because he

was not treating the patients at the time of his sexual encounters with them. The Court of Appeals disagreed.

Relying on its decision in *Banks*, the Court reiterated its refusal to apply a technical or narrow definition of the "practice of medicine" and concluded that "Finucan used his professional skills and his knowledge of his three female patients' personal and familial situations to play upon their emotional vulnerabilities, even if they facially consented to sexual relationships. *Finucan*, 380 Md. at 596. Ultimately, the Court explained that conduct "may indicate an unfitness to practice medicine if it raises reasonable concerns that an individual abused, or may abuse, the status of being a physician in such a way as to harm patients or diminish standing of the medical profession in the eyes of a reasonable member of the general public." *Id.* at 601.

The Court of Special Appeals echoed the *Banks* and *Finucan* Court's reasoning of what constitutes conduct in the practice of medicine in *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456, *cert. denied*, 400 Md. 647 (2007). In that case, the Circuit Court for Baltimore City affirmed the Board's determination that the Appellant physician had engaged in unprofessional conduct in violation of section 14-404(a)(3) of the Health Occupations Article when he made false statements to hospital peer reviewers and Board investigators related to the mechanical settings for a surgical instrument he used on a patient. In making its determination, the Court did not simply categorize Dr. Cornfeld's behavior as improper because he was in the hospital setting. To the contrary, the Court recognized that like *McDonnell*, the conduct at issue took the form of statements made or actions taken during an adjudicatory review or proceeding. However, unlike the case in *McDonnell*, in which the focus or the impetus of the physician's acts were to prevail in an adjudicatory hearing generally unrelated to his practice of medicine, Dr. Cornfeld's false or

misleading statements directly related to a procedure he had recently performed on a patient and shifted blame from himself to other hospital staff.

The Court of Special Appeals affirmed the Circuit Court, explaining that "the touchstone for determining whether misconduct occurred 'in the practice of medicine' must be whether it is 'sufficiently intertwined with patient care' to pose a threat to patients or the medical profession." *Id.* at 474 (quoting *Banks*, 354 Md. at 76-77).

In this vein, the *Cornfeld* Court echoed the Court of Appeals' reasoning in *McDonnell* that the nature and effect of a particular act of professional misconduct determines whether it occurred in the practice of medicine, and that "[m]isconduct reasonably may be considered to be in the practice of medicine when it 'relates to the effective delivery of patient care.'" *Cornfeld*, 174 Md. App. at 477-78. Considering the Court of Appeals' rejection of the "narrow view" of the practice of medicine in *Banks* and *Finucan*, the Court of Special Appeals found Dr. Cornfeld's actions sufficiently tied to the practice of medicine to warrant the charges by the Board.

The Court of Appeals amplified its interpretation of "in the practice of medicine" in *Kim v. Md. State Bd. of Physicians*, 423 Md. 523 (2011), in which the Court of Appeals affirmed the Board's determination that the physician's actions occurred in the practice of medicine when he willfully failed to report the pendency of a malpractice action on his application for renewal of his license. Relying on *Finucan*, the *Kim* Court explained that 'in the practice of medicine' applies not only to diagnosing and treating patients, but also to 'misconduct relating to the effective delivery of patient care." *Id.* at 541 (quoting *Finucan*, 380 Md. at 597).

It is clear that the Respondent's actions in this case do not fit neatly into any of the scenarios at issue in *McDonnell, Banks, Finucan, Cornfeld* or *Kim*. As I have stated, the Respondent's *participation* in assisted suicide, while illegal, does not, alone, constitute the

practice of medicine. In fact, his participation in assisted suicide is antithetical to the long-standing prevailing purpose of medical practice to treat and heal patients and/or to make patients comfortable. However, *aspects* or *actions* the Respondent undertook as Medical Director of the FEN do fall within the definition of the practice of medicine.

First, the Respondent does not dispute that he reviewed medical records to ensure that patients were suffering to the extent that they would be approved for assisted suicide by the FEN. Although the FEN had a three-member medical panel, the Respondent admitted in his April 12, 2012 interview with Board Compliance Analyst, Heather McLaughlin, that as Medical Director, he reviewed and evaluated all of the prospective patients' medical documents and made the determination whether the individual was suffering sufficiently to qualify for FEN's assistance with suicide. Certainly, such a review of the medical documentation provided by members to determine whether the person meets medical criteria for additional treatment is an action physicians undertake as part of their practice of medicine.

I have already determined that assisted suicide does not constitute the practice of medicine. It logically follows that if the Respondent reviewed medical documentation as a formality – that is, if the outcome of his review of those documents always resulted in his acceptance of the member's request for assisted suicide, regardless of other available medical options or treatments of the members' underlying ailments, then I might find that the review was inextricably linked to the Respondent's participation in assisted suicide in furtherance of his personal ethical involvement with FEN and I might find that his medical document review did not constitute the practice of medicine.

However, it is clear that the Respondent sometimes reviewed patients' medical records and made diagnoses with an eye toward healing those patients or improving their lives rather than approving them for FEN-assisted suicide. As the Respondent explained during his April 12,

2012 interview with Ms. McLaughlin, as the Medical Director for FEN, he was assigned to review "complicated cases." When Ms. McLaughlin asked the Respondent to elaborate, he gave the following example of a "complicated case":

> A patient who had terrible pain and I realized that she was not being taken care of, just from the paperwork. All patients had to send in their medical records so that I could read their medical records.
>
> So I called the patient up and said, you're not getting pain care, you know. And she said, tell me about it. So she was quite upset about it, and I said, well, why don't you - - this is a long conversation that I am speeding up - - but why don't you tell your doctors that this doctor from Hopkins will be glad to tell him how to do it right.
>
> So - - and that was a bit of an overstatement of my credentials. But - - so I called her up about a month later. She didn't call back or anything. And she said, no, I'm not going to die now, I'm okay, I've been taken care of, I'm okay. It's tolerable, the pain is tolerable. And I said well you jacked up the dose of the morphine then. I said, did you tell him that? And she said, yes. And I said, you're getting the proper dose.

As this passage demonstrates, the Respondent advised this patient to tell her practicing physician that he, a doctor from Johns Hopkins Hospital,[6] had advised her to increase her pain medication. In other words, the Respondent held himself out not only as the Medical Director of FEN, but as a physician. He recommended a course of treatment, advised the patient to convey his prescribed treatment to her treating physician, and stood prepared to interact with her physician in support of his prescription of increased pain medication. The Respondent's actions in reviewing medical records to determine whether patients were sufficiently suffering, and diagnosing the patient's pain and prescribing increased pain medication fall squarely within the context of the practice of medicine. Unlike *McDonnell*, in which the Respondent's actions of threatening a witness in a malpractice case was ancillary to the diagnosis, treatment, or care of patients, the Respondent's actions, although performed as the Medical Director of an organization that is generally antithetical to the practice of medicine, still bears the hallmark of

[6] The Respondent indicated in his statement to Ms. McLaughlin that his representation that he was a doctor at Johns Hopkins Hospital was inaccurate. Indeed, the Respondent presented no evidence that he is a physician working at Johns Hopkins Hospital.

the practice of medicine. The fact that the Respondent provided this "example" of the complicated cases he handled merits the conclusion that he recommended to other members that they should seek further medical treatment rather than ending their lives.

It was only after the Respondent reviewed the patients' medical documents that he was able to determine whether they would be accepted for FEN's assistance with suicide. According to the Respondent, if he determined the patient had other alternatives for treatment, he recommended against suicide and recommended the appropriate medical treatment.

In light of the admitted fact that the Respondent made medical diagnoses and determinations that some patients should seek additional or alternative medical treatment, I find the Respondent's argument that he did not practice medicine as the Medical Director, and that a lay person could have served as the Medical Director to be disingenuous. Although it may be true that a layperson could have served as Medical Director and could have made decisions accepting patients for assisted suicide based upon criteria established by the FEN, the fact is that the Respondent *is* a physician and he clearly used his medical knowledge and expertise in making *medical* determinations and *prescribed* treatment that would help alleviate some of the symptoms of some patients' medical conditions. Indeed, in the example the Respondent gave, the Respondent even suggested that the patient could have her primary care physician consult with him regarding his advisement that she should seek additional treatment for her pain. I find that the Respondent's act of reviewing medical documentation and making determinations regarding treatment patients should receive constituted medical practice.

Similarly, I find that by virtue of the fact that the Respondent decided when patients could potentially benefit from medical treatment in lieu of suicide, he also decided when patients *could not* potentially benefit from additional medical treatment in lieu of suicide. According to the unrebutted evidence, the FEN accepted applications and assisted in suicides of patients who

were not diagnosed with terminal illnesses. Nevertheless, the Respondent reviewed these patients' records and determined that they were eligible for assisted suicide. The fact that the Respondent occasionally determined that some individuals would benefit from additional medical or psychological treatment, but determined that others could not benefit from such treatment, merits the conclusion that he undertook a medical analysis for many, if not each of the patients he approved for assisted suicide. I find that the Respondent's review of the medical documents resulting in assisted suicide cannot be extracted from his review of medical documents resulting in further medical treatment because at the time of review, either option was available. The fact that the Respondent ultimately approved assisted suicide in many of the cases does not take his review of the medical documents outside of the practice of medicine. Therefore, I find that each time the Respondent reviewed medical records to determine whether they would be accepted for assistance with suicide, he engaged in the practice of medicine.

It is also clear that the Respondent held himself out as a practicing physician to patients and other physicians for the purpose of obtaining medical records. According to the FEN training manual, patients were advised that they could have their medical records sent to the Respondent, a doctor, if they were uncomfortable obtaining the documents themselves. Particularly, the FEN training manual provided the following regarding obtaining medical records:

> Patients frequently express concern over obtaining their medical records. They're entitled to these records by law, but it isn't unusual for them to say that their doctor will question the need for the records and they're reluctant to approach a doctor they don't feel confident about. Sometimes doctors will mail or fax records only to another doctor. If that should be the case, as a last resort, tell the patient to ask the doctor to send the records to:
>
> Lawrence Egbert, MD, MPH
> 814 Powers Street
> Baltimore, MD 21211
>
> The record can also be faxed to him . . . . If a doctor questions why the patient is sending records to Baltimore, tell him/her to say that Dr. Egbert is a specialist in pain management (maybe the patient found him on the Internet) and consults

throughout the country on difficult cases (he is and he does, and people do come across his name on the Internet). As an alternative, the patient may say that other doctors have asked for information the patient can't recall so he/she has started keeping copies of records.

Again, unlike *McDonnell*, the Respondent is performing a traditional function of a physician, requesting medical documents from another physician, ostensibly, to review those documents for the purpose of pain management. Although the Respondent's actions may not have occurred within the context of a medical facility, as was the case in *Banks* and *Finucan*, his physician-related actions were inextricably linked to the traditional duties and actions of a physician. Indeed, it is reasonable to conclude that if a layperson held himself out as a physician, reviewed and evaluated medical documents, and prescribed additional medical treatment, one could reasonably interpret that individual's action as practicing medicine without a license.

Ultimately, I find that the Respondent's acts including reviewing patients' medical records, determining whether they would benefit from additional medical treatment or determining whether their condition could not benefit from additional medical treatment constituted the practice of medicine. I further find that holding himself out as a physician to whom other physicians could send patients' medical documents, constituted the practice of medicine.

Unprofessional Conduct

The term "unprofessional conduct" is not defined in the Maryland Medical Practice Act. The Court of Appeals has, however, considered that term, in the context of the Maryland Medical Practice Act, and it determined that "unprofessional conduct" refers to conduct that breaches rules or ethical codes of professional conduct, or is conduct unbecoming a member in good standing in the profession. *Finucan*, 380 Md. at 593.

Much of the State's position in this case focused on the fact that the Respondent participated in assisted suicide, and that, generally, his actions were unprofessional. Dr. Silverman testified that physicians bear an extremely important role when it comes to end-of-life

issues. Often, patients who are struggling with end-of-life considerations turn to physicians for guidance and explanation of their options. According to Dr. Silverman, the physician fulfills a significant role in the psyche of their patients and, often, patients' families who are making decisions about the patient's end-of-life choices. The physician, opined Dr. Silverman, is charged with providing the patient and his or her family with options that will result in a dignified death, with as little pain as possible. The Respondent, however, inappropriately used his authority as a physician to guide, or at the very least, provide the means for patients to commit suicide. This, explained Dr. Silverman, is in discord with the primary tenet of medicine – to do no harm.

The State also argued that the Respondent acted unprofessionally because he admittedly knew that helium was not detectable in the human body and he was aware that the death certificate for the FEN's assisted-suicide patients would reflect an erroneous cause of death by the Medical Examiner and on the death certificate.

As I have stated, the actual participation in assisted suicide and the advocacy of assisted suicide, does not constitute the practice of medicine as those actions are antithetical to the practice of medicine and are illegal in the State of Maryland. Therefore, generally, whether the Respondent's actions were unprofessional within the context of his actual participation in the assisted suicide of the FEN's patients is of no consequence because the unprofessional acts must occur in the practice of medicine.

Because I have found that the participation in assisted suicide, alone, does not constitute the practice of medicine, I similarly find that the consequences of the Respondent's participation in assisted suicide can not constitute the practice of medicine. That is, although the Respondent knew that the patients' death certificates would reflect an inaccurate cause of death, although there may be legal implications to that knowledge, his knowledge alone can not create a nexus between the Respondent's actions and the practice of medicine. Again, the entire goal of assisted

suicide is wholly divorced from the treatment of patients and the practice of medicine. Accordingly, although the result of his actions would be considered unprofessional, and subject to sanction under section 14-404(a)(3)(ii) if his actions occurred within the context of his "practice of medicine," because his actions in physically participating in the assisted suicide cannot be classified as the practice of medicine, its result cannot be so classified either.[7]

I have, however, determined that two aspects of the Respondent's actions as the Medical Director of FEN constituted the practice of medicine – that is, 1) the Respondent's review and evaluation of medical records and the resulting prescribed action following that review; and, 2) the Respondent's act of holding himself out as a physician to whom other physicians could transmit member's medical records for review. I now turn to whether the Respondent's actions related to those two aspects of medical practice were unprofessional.

Medical document review and evaluation

The Respondent does not dispute that he reviewed and evaluated the medical records for patients who sought FEN's assistance with terminating their lives. He also acknowledges that after that review, he occasionally made "suggestions to improve their care." (State Ex. 1). In those instances when the Respondent made suggestions to improve care, I cannot determine that such suggestions were improper or unprofessional because the State has offered no evidence regarding those patients. However, it is also undisputed – and supported amply by the evidence – that in many cases, after the Respondent reviewed the medical documentation of members, he determined that those members were suffering sufficiently to qualify for assisted suicide. Essentially, in his role as a physician, the Respondent rendered a medical determination and sanctioned a "remedy" to the patients' condition that was wholly antithetical to the purpose and

[7] Furthermore, if the Board wished to pursue the Respondent for knowingly causing the filing of a false medical report, it could have charged him with violating section 14-404(a)(12) of the Health Occupations Article, which it did not do.

goal of medicine – to do no harm. I find that the Respondent's action to approve assisted suicide "abused . . . the status of being a physician in such a way as to harm patients or diminish standing of the medical profession in the eyes of a reasonable member of the general public." *Finucan*, 380 Md. at 601.

For the foregoing reasons, I find that the only plausible interpretation of the Respondent's review and evaluation of medical records and sanctioning assisted suicide is that it was egregiously unprofessional. He is therefore, subject to sanction under section 14-404(a)(3)(ii) of the Health Occupations Article.

Holding self out as a physician to whom other physicians could send patients' medical documents

As I have stated, the Respondent held himself out as a practicing physician to patients and other physicians for the purpose of obtaining medical records. According to the FEN training manual, when patients were reluctant to request medical documents from their physicians, or when their physicians would only fax medical documents to another physician, those patients were advised that they could have their physicians send their medical documents to the Respondent in his capacity as a physician. The Exit Guide also advises that patients could tell their physicians that the Respondent is a specialist in pain management.

Essentially, therefore, the Respondent mislead, or stood ready to mislead fellow physicians who elected to send medical documents to the Respondent that he would receive medical documents ostensibly, to *treat* the patients for their underlying ailments. As has been proven, in many cases, the Respondent did not treat patients in accord with the practice of medicine, but rather, sanctioned a course of action that ultimately resulted in the termination of the patients' lives. I find that the Respondent's actions divested - or stood prepared to divest - patients' treating physicians from the opportunity to offer their patients alternatives to the life-ending measures they had chosen. Accordingly, I find that such action or willingness to act in this manner was

wholly unprofessional because it prevented - or potentially prevented - those patients' treating physicians from effectively delivering patient care. *Cornfeld*, 174 Md. App. at 477-78.

Proposed Sanction

The State recommends that the Respondent's license be revoked. In support of that recommended sanction, the State argued that the purpose of the sanction in cases before the Board is two-fold. First, it serves as a prophylactic against further similar action by the Respondent. Second, it serves as a deterrent. That is, the sanction serves as notice to physicians that engaging in the practice of medicine in connection with assisted suicide is unconscionable and will result in the revocation of one's medical license.

COMAR 10.32.02.10 and .11 announce the specific sanctions the Board may levy against a physician found in violation of section 14-404 of the Health Occupations Article. Among other things, COMAR 10.32.02.10B(6) dictates that the Board may consider aggravating factors when determining the appropriate. sanction for unprofessional conduct in the practice of medicine. Among those aggravating factors is whether "[t]he offense had the potential for or actually did cause patient harm."

The evidence in this case certainly proves that the Respondent's conduct not only resulted in harm to his patients, but it resulted in many of his patients' deaths. I agree with the State that it has a vested interest in making it clear that it will not abide physicians who use their medical practice and expertise for the purpose of ending human life.

In so finding, I acknowledge the Respondent's position that any lay person could have undertaken the actions that the Respondent undertook as Medical Director for the FEN; the fact remains, however, that the Respondent took these actions as a physician – performing traditionally physician-related tasks. The Board has a strong interest in preventing behavior such as the

Respondent's to preserve the integrity of the medical profession as one that uses medical expertise to heal and treat its patients.

Accordingly, based on the evidence presented in this case, I propose that revocation of the Respondent's license is an appropriate sanction.

CONCLUSIONS OF LAW

I conclude that the Respondent violated section 14-404(a)(3)(ii) of the Health Occupations Article. I further conclude that because of this violation the Board may discipline the Respondent. Md. Code Ann., Health Occ. § 14-404(a).

PROPOSED ORDER

I **PROPOSE** that the charge filed by the Board on November 18, 2012, against the Respondent for violation of section 14-404(a)(3)(ii) be **UPHELD**.

I **PROPOSE** that the Respondent's license be **REVOKED**.

December 23, 2013
Date Decision Mailed

Jennifer M. Carter Jones /mp
Jennifer M. Carter Jones
Administrative Law Judge

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file written exceptions to this Proposed Decision with the Board of Physicians within fifteen days of issuance of the decision. Md. Code Ann., State Gov't § 10-216 (2009) and COMAR 10.32.02.03F. The Office of Administrative Hearings is not a party to any review process.

JCJ/emh
#146840

MARYLAND STATE BOARD	*	BEFORE JENNIFER M. CARTER JONES,
OF PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE OF
LAWRENCE D. EGBERT, M.D.,	*	ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH CASE NO.: DHMH-SBP-71-13-19027
LICENSE NO.: D16409	*	

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FILE EXHIBIT LIST

The State submitted the following documents, which unless otherwise noted I admitted into evidence as the exhibits numbered below:

1. February 29, 2012 letter from the Board to the Respondent, with attached May 21, 2011 Baltimore Sun article entitled "Baltimore doctor helps the ill commit suicide."
2. March 8, 2012 letter from the Respondent to the Board, with attached completed Information Form, dated March 8, 2012
3. January 19, 2012 Washington Post article, entitled "After the Death of Jack Kevorkian, Lawrence Egbert is the new Public Face of American Assisted Suicide."
4. FEN records for Patient A, including correspondence and medical records
5. May 27, 2008 Death Certificate for Patient A
6. FEN records for Patient B, including correspondence and medical records
7. November 20, 2008 Death Certificate for Patient B
8. FEN records for Patient C, including correspondence and medical records
9. October 16, 2008 Death Certificate for Patient C
10. FEN records for Patient D, including correspondence and medical records
11. July 18, 2008 Death Certificate for Patient D

12. FEN records for Patient E, including correspondence and medical records

13. August 7, 2006 Death Certificate for Patient E

14. FEN records for Patient F, including correspondence and medical records

15. May 28, 2004 Death Certificate for Patient F

16. Excerpts from *Final Exit – The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (3rd Ed. 2010)

17. 2007 First Responder and Exit Guide Training Manual

18. Not offered

19. Not offered

20. Not admitted

21. Transcript of Respondent's April 12, 2012 interview with the Board

22. Curriculum Vitae – Henry Silverman, M.D., M.A.

23. October 5, 2012 report by Dr. Silverman

24. January 25, 2012 report by Dr. Silverman

25. American Medical Association – Medical Ethics – Opinion 2.211 – Physician Assisted Suicide

26. Oregon Statute ORS 127.800 et seq.

27. November 28, 2012 Charges against the Respondent under the Maryland Medical Practices Act

The Respondent did not offer any exhibits for admission into evidence.