Randolph P. Johnston, M.D.
2504 Hemingway Drive 2-B
Frederick, Maryland 21702

Robert G. Hennessy, M.D., M.B.A., Chair
Maryland Board of Physicians
4201 Patterson Avenue
4th Floor
Baltimore, Maryland 21215-2299

RE: Surrender of License to Practice Medicine
License Number: D57175
MBP Case Numbers: 2007-0434 & 2007-0591

Dear Dr. Hennessy and Members of the Board:

I have decided to **PERMANENTLY SURRENDER** my license to practice medicine in the State of Maryland, License Number D57175, effective immediately. I understand that upon surrender of my license, I may not give medical advice or treatment to any individual, with or without compensation, and cannot prescribe medications or otherwise engage in the practice of medicine in the State of Maryland as it is defined in the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ."), §§ 14-101 *et seq.* (2005 Repl. vol. & 2007 Supp.) and other applicable laws. In other words, as of the effective date of this Letter of Surrender, I understand that the surrender of my license means that I continue in the same position as an unlicensed individual in the State of Maryland. I understand that this Letter of Surrender is a **PUBLIC** document and on the Board's acceptance becomes a **FINAL ORDER** of the Board.

My decision to surrender my license to practice medicine in the State of Maryland has been prompted by an investigation of my license by the Maryland Board of Physicians (the "Board") and the Office of the Attorney General. The investigation resulted in the Board's issuance of Charges Under the Maryland Medical Practice Act (the "Charges") on January 21, 2009. Specifically, the Board charged me with violating Health Occ. §14-404(a)(22) – failure to meet the appropriate standard of quality care, and (40) – failure to maintain adequate medical records, based on my inappropriate prescription of Controlled Dangerous Substances to a patient with a known history of substance abuse.

I wish to make it clear that I have voluntarily, knowingly and freely chosen to submit this Letter of Surrender to avoid further investigation and prosecution under the Act, in order to resolve this matter. I acknowledge that if the case proceeded to an evidentiary hearing, the State would submit evidence to support the allegations in the January 21, 2009 Charges. I further acknowledge that for

all purposes relevant to medical licensure the Board's allegations will be treated as if proven.

I understand that by executing this Letter of Surrender I am waiving any right to contest the Charges in a formal evidentiary hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf and all other substantive and procedural protections provided by law, including the right to appeal.

I understand that the Board will advise the Federation of State Medical Boards and the National Practitioners' Data Bank and the Healthcare Integrity and Protection Databank of this Letter of Surrender and in any response to inquiry, that I have surrendered my license in lieu of further disciplinary action under the Act. I also understand that in the event I would apply for licensure in any form in any other state or jurisdiction, that this Letter of Surrender, including the Charges attached hereto and incorporated herein, may be released or published by the Board to the same extent as a final order that would result from disciplinary action, pursuant to Md. State Gov't. Code Ann § 10-611 *et seq.* (2004 Repl. vol. & 2008 Supp.), and that this Letter of Surrender may be considered to constitute a disciplinary action by the Board.

I hereby affirm that I terminated my medical practice in Maryland, effective February 23, 2007. I also affirm that I do not have active privileges at any hospital, outpatient surgical facility, nursing home or other health care facility in the State of Maryland.

I affirm that on or before the effective date of this Letter of Surrender, I will present the Board with my original Maryland medical license number D57175, and my most recent wallet-sized renewal card; all prescription forms and pads in my possession; and all prescription forms or pads on which my name and Drug Enforcement Administration Registration Number are imprinted.

I acknowledge that on or before the effective date of this Letter of Surrender, I shall deliver to Georgette Zoltani, Chief, (or any successor) Division of Drug Control, 4201 Patterson Avenue, 1st Floor, Baltimore, Maryland 21215, my Maryland Controlled Dangerous Substances Certificate; and my Drug Enforcement Administration Registration Card to Walter Staples, or any successor, Group Supervisor, Drug Enforcement Administration, Techworld Plaza, 800 K Street, NW, Suite 500, Washington, D.C. 20001.

I agree that on or before the effective date of this Letter of Surrender, I shall deliver to the Board any prescribed substances in my possession, other than those prescribed by a licensed physician for me; and any controlled dangerous substances in my possession, other than those prescribed by a licensed physician for me.

I further recognize and agree that by tendering this Letter of Surrender that my license will remain permanently surrendered. In other words, I agree that I have no right to reapply for a license to practice medicine in the State of Maryland. I further agree that the Board is not obligated to consider any application for licensure that I might file at a future date and that I waive any hearing rights that I might possess regarding any such application.

I acknowledge that I may not rescind this Letter of Surrender in part or in its entirety for any reason whatsoever. Finally, I wish to make clear that I have consulted with counsel before signing this Letter of Surrender. I understand both the nature of the Board's actions and this Letter of Surrender fully. I acknowledge that I understand and comprehend the language, meaning and terms and effect of this Letter of Surrender. I make this decision knowingly and voluntarily.

Sincerely,

Randolph P. Johnston

Randolph P. Johnston, M.D.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Frederick

I HEREBY CERTIFY that on this 16th day of March, 2009, before me, a Notary Public of the State and City/County aforesaid, personally appeared Randolph P. Johnston, M.D., and declared and affirmed under the penalties of perjury that signing the foregoing Letter of Surrender was his voluntary act and deed.

AS WITNESS my hand and Notarial seal.

Ma. Cristina Pastor
Notary Public

My Commission expires: 12/28/2009

ACCEPTANCE

On behalf of the Maryland Board of Physicians, on this 24th day of April, 2009, I accept Randolph P. Johnston, M.D.'s **PUBLIC SURRENDER** of her license to practice medicine in the State of Maryland.

Robert G. Hennessy, M.D.
Chair
Maryland Board of Physicians

IN THE MATTER OF	*	BEFORE THE MARYLAND
RANDOLPH P. JOHNSTON, M.D.	*	BOARD OF PHYSICIANS
Respondent	*	Case Numbers: 2007-0434 2007-0591
License Number: D57175	*	

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland Board of Physicians (the "Board") hereby charges Randolph P. Johnston, M.D. (the "Respondent") (D.O.B. 9/9/35), License Number D57175, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-401 *et seq.* (2005 Repl.Vol. & 2007 Supp.).

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

GENERAL ALLEGATIONS OF FACT[1]

The Board bases its charges on the following facts that the Board has reason

ATTACHMENT

[1]The statements of the Respondent's conduct with respect to the patients identified herein are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent.

to believe are true:

1. At all times relevant hereto, the Respondent, who is not board-certified, was and is licensed to practice medicine in the State of Maryland. The Respondent's self-designated specialty is psychiatry. The Respondent was originally licensed to practice medicine in Maryland on March 16, 2001. The Respondent holds active medical licenses in Iowa and Virginia and inactive licenses in the District of Columbia and Texas.

2. At all times relevant hereto, the Respondent practiced psychiatry with the Behavioral Health Partners of Frederick, Inc. ("BHP"), located in Frederick, Maryland.

3. On or about December 20, 2006, the Board received a complaint from the caseworker of a deceased patient ("Patient A"), of the Respondent. Patient A had a known history of substance abuse; the caseworker was concerned that the Respondent had prescribed controlled dangerous substances ("CDS") to Patient A who thereafter took an overdose of the drugs and died.

4. On or about February 27, 2007, the Board received an Adverse Action Report from Sheppard Pratt Health System ("Sheppard Pratt"), of which BHP is a component. As a result of the complaint filed with the Board, Sheppard Pratt curtailed the Respondent's prescribing privileges and

prohibited him from prescribing any narcotic analgesics or benzodiazepines to any patient for any reason until otherwise notified.[2]

5. The Board thereafter initiated an investigation. Pursuant to its investigation, the Board referred the matter to Permedion, a Peer Review organization, for review of the Respondent's treatment of Patient A, the results of which are set forth below.

Patient-Specific Allegations

6. Patient A, a female born in 1965, was referred to BHP on March 20, 2006 by a community agency for a psychiatric evaluation.

7. On April 11, 2006, Patient A was evaluated by a BHP psychiatrist other than the Respondent ("Physician A"). Physician A documented that Patient A had a history of substance abuse, including barbiturates, for the previous 20 years, and had obtained outpatient addiction treatment in 2002 or 2003. Patient A had been hospitalized for "probable overdose of barbiturates" in July 2005, and claimed to have been "clean" since then. Patient A reported a history of a brain tumor from which she suffered grand mal seizures and back pain from an injury sustained in an automobile accident. Patient A also reported a 15 year history of panic attacks. Her husband was reported to be an alcoholic and physically and verbally abusive towards her. At the time of the initial BHP evaluation, Patient A's medications included: Lexapro 20 mg,[3] Seroquel,[4] Neurontin[5]

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[2] On February 23, 2007, the Respondent submitted his resignation from Sheppard Pratt, to be effective May 1, 2007. In his letter, the Respondent stated in part, "Its *(sic)* past time for me to GO." (capitalization in original).

[3] Lexapro is an anti-depressant.

and Ativan.[6] Physician A diagnosed Patient A with Panic Disorder (without Agoraphobia) and Major Depressive Disorder, recurrent.

8. The Respondent initially saw Patient A on May 17, 2006. The Respondent added Attention Deficit Disorder to Patient A's diagnoses and methylphenidate (the generic name for Ritalin), a Schedule II CDS, to her medication regimen. He also prescribed Xanax (alprazolam) 1 mg, a benzodiazepine (90 tablets), and Tylenol #3, a Schedule III CDS (90 tablets).[7]

9. At Patient A's next office visit, on May 31, 2006, the Respondent noted that, according to Patient A's husband, she had forged prescriptions for benzodiazepines in the past and that Patient A denied this. The Respondent documented that Patient A's judgment and insight were "impaired;" in the Assessment section, he noted "The Con?" The Respondent further documented that his review of prior notes regarding Patient A revealed that in April, she had "'lost Lorazepam bottle.'"

10. Patient A returned to the Respondent on June 16, 2006. The Respondent documented, "no barbiturates" and that Patient A had a history of abusing Fiorinal.[8] The Respondent did not prescribe any medications to Patient A at this visit.

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[4] Seroquel is an anti-psychotic.
[5] Neurontin is an anticonvulsant.
[6] Ativan is a trade name for lorazepam, a benzodiazepine.
[7] The Respondent typically did not document the amount to each drug he prescribed in Patient A's office notes; however, in her chart, there are copies of most of the prescriptions referenced in his notes that indicate the amount prescribed. The Respondent did not document in his May 17 note that he prescribed Tylenol #3; there is, however, a copy of the prescription in the chart.
[8] Fiorinal is non-narcotic barbiturate.

11. On June 23, 2006, the Respondent added Vicodin[9] (60 tablets) and Ambien[10] (30 tablets) to Patient A's medication regimen, noting "pain" and "can't sleep." The Respondent prescribed the Vicodin on a "prn" (as needed) basis.

12. On July 7, 2006, the Respondent increased Patient A's dosage of Lexapro from 20 mg to 40 mg "to ↓ panic freq. & intensity." He also replaced Patient A's Vicodin with Percocet[11] (60 tablets) because the Vicodin caused nausea. The Respondent prescribed the Percocet on a prn basis.

13. On August 9, 2006, the Respondent prescribed to Patient A 240 tablets of Percocet, 180 tablets of alprazolam and 60 tablets of methylphenidate. The Respondent failed to document the quantities of drugs he prescribed in his office note; a copy of the prescriptions are included in her chart. The Respondent prescribed both drugs on a prn basis.

14. On August 25, 2006, the Respondent noted that Patient A, whom he documented was accompanied by her caseworker, had taken an overdose the previous week and had slept for long periods of time. In the Respondent's response to the complaint, he noted that at this visit, Patient A's caseworker expressed her concerned about Patient A's medication regimen, particularly opiates and benzodiazepines, because of the potential for abuse. The Respondent also stated that Patient A acknowledged that she had taken excessive doses of the medications prescribed by the Respondent.

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[9] Vicodin, a trade name for hydrocodone and acetaminophen, is a Schedule III CDS.
[10] Ambien is a Schedule IV CDS.
[11] Percocet, a trade name for oxycodone and acetaminophen, is a Schedule II CDS.

15. In the August 25, 2006 office note, the Respondent noted that Patient A "can't manage to *(sic)* controlled substances or benzos," and "No controlled substances or benzos." The Respondent's plan was to prepare the assessments necessary to admit Patient A to a drug treatment facility. The Respondent did not prescribe any CDS to Patient A at this visit. The Respondent instructed Patient A to return in 4 weeks.

16. Patient A returned to the Respondent on September 1, 2006, 1 week after her August 25 visit for an emergency appointment. On September 1, the Respondent noted that Patient A had been hospitalized and that she had had a seizure, but was "stable/feels good." At this office visit, the Respondent prescribed 240 tablets of Lortab,[12] 1 or 2 tablets every 4 to 6 hours for "pain or H[ead] A[ches], up to 8 tabs daily," and 120 tablets of Xanax. The Respondent authorized 1 refill of Lortab. The Respondent did not document this prescription in his note; there is a copy of the prescription in the chart. The Respondent prescribed both medications on a prn basis.

17. Patient A returned to the Respondent on September 6, 2006. The Respondent noted that, "husb. flushed her meds down the toilet?" He further noted that he had called the pharmacy to refill Patient A's Neurontin and gave her samples of Lexapro. He further noted that he "refused refills of Ritalin, opiates & alprazolam [Xanax]." The Respondent documented that Patient A was agitated, anxious and tearful and had

[12] Lortab, a trade name for hydrocodone and acetaminophen, is a Schedule III CDS.

suicidal ideation, "want to die." In the Plan section of the note, he documented that he planned to call a drug treatment facility.

18. Patient A's last visit to the Respondent was on September 15, 2006. She reported more spousal abuse, both verbal and physical. She also reported that her husband had not destroyed her medications, but was withholding them as bribes for sex. The Respondent noted that Patient A did not have suicidal ideation, but had stated, "maybe I'll get CA [cancer] & die."

19. At the September 15, 2006 visit, the Respondent prescribed: Neurontin (180 tablets); alprazolam (90 tablets) and Lortab (180 tablets). The Respondent prescribed the Lortab on a prn basis.

20. On the evening of September 16, 2006, Patient A's husband called 911 for emergency assistance. He had found Patient A unconscious and not breathing. Efforts to resuscitate Patient A failed and she expired on September 16.

21. The Medical Examiner reported that the cause of Patient A's death was hydrocodone intoxication.

22. The Frederick County Police Department documented that on September 17, Patient A's husband provided a detective with several bottles of Patient A's medication. Of the medications prescribed by the Respondent on September 15, the following remained: 51 ½ tablets of alprazolam (90 tablets prescribed); 84 tablets of Lortab (180 tablets prescribed); and 164 capsules of Neurontin (180 tablets prescribed).

23. On September 21, 2006, the Respondent wrote a note to Patient A's husband. The note read in part: As I understand it, the cause of death is awaiting the results of an autopsy. I bear some responsibility if the means was provided by medications. I regret that."

24. The standard of quality care when treating a depressed patient with a history of substance abuse and attempts to commit suicide by drug overdose includes, but is not limited to:

a. Restriction of prescriptions for CDS. CDS should be prescribed in very limited quantities without refills. CDS dosages should be tapered and followed closely;

b. Referral of the patient to a substance abuse treatment facility for out-patient or in-patient treatment with appropriate follow-up with the patient.

c. Referral of the patient to a pain management specialist for treatment of pain is clinically appropriate particularly in the instant case where comorbidity of substance abuse is prominent; and

d. Review of past medical records, particularly when past medical records reveal a history of substance abuse.

25. Maintenance of adequate medical records when treating a depressed patient with a history of substance abuse and suicide attempts by drug overdose includes, requires clear and thorough documentation, particularly of hospitalizations and reported instances of drug overdose.

Reasonable efforts should be made to obtain past medical records and records of hospitalizations.

26. The Respondent's conduct as set forth above, in whole or in part constitutes the failure to meet the standard of quality medical care, in violation of H.O. § 14-404(a)(22) and/or the failure to maintain adequate medical records, in violation of H.O. § 14-404(a)(40) for reasons including, but not limited to, the following:

a. The Respondent prescribed an excessive quantity of CDS to Patient A, whom he was aware had a history of substance abuse;

b. The Respondent prescribed an excessive quantity of CDS to Patient A after documenting that she had recently attempted suicide and had expressed suicidal ideation;

c. The Respondent failed to taper the amount of CDS and benzodiazepines he prescribed to Patient A;

d. The Respondent failed to refer Patient A to a pain specialist for the treatment of her pain. Furthermore, the Respondent failed to attempt non-narcotic interventions to address Patient A's pain symptoms;

e. The Respondent noted that he had planned a referral to a substance abuse treatment facility; however, he failed to document that he followed up on the referral; and

f. The Respondent either failed to review his own records or to document a significant change in his treatment plan. On August 25, 2006, the Respondent noted in Patient A's chart, "No controlled substance or benzo;" yet less than 1 week later, he prescribed an excessive quantity of both Lortab, a CDS, and Xanax, a benzodiazepine. The Respondent failed to document why he contravened his treatment plan. In his response to the Board, the Respondent stated that he had resumed prescribing CDS to Patient A on September 6, 2006 because of "speculation" that the "sudden withdrawal of Xanax, if not the opiate, had triggered the seizure." There are, however, no records of Patient A's hospitalization or any other documentation of the details of the hospitalization.

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under H.O. §§ 14-404(a)(22) and/or (40), the Board may impose disciplinary sanctions against the Respondent's license, including revocation, suspension, or reprimand and may place the Respondent on probation, and/or may impose a monetary penalty.

NOTICE OF CASE RESOLUTION CONFERENCE

A Case Resolution Conference in this matter is scheduled for **Wednesday, April 1, 2009 at 10:00 a.m.** the Board's office, 4201 Patterson

Avenue, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference and prehearing conference is described in the attached letter to the Respondent. If this matter is not resolved on terms accepted by the Board, an evidentiary hearing will be scheduled.

1/20/09
Date

C. Irving Pinder, Jr.
Executive Director
Maryland Board of Physicians