

**BEFORE THE STATE MEDICAL BOARD OF OHIO**

IN THE MATTER OF

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JOHN BRUCE PAYNE, D.O.

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**ORDER AND ENTRY**

On December 8, 2004, the State Medical Board of Ohio issued a Notice of Opportunity for Hearing to John Bruce Payne, D.O., based upon Dr. Payne's alleged failure to conform to minimal standards of care with respect to treatment of two specified patients and failure to maintain adequate medical records, his alleged failure to provide complete and accurate information on an application that Dr. Payne submitted to the State Medical Board of Ohio and applications for reappointment of staff privileges, and prior action against Dr. Payne's licenses to practice medicine in Texas, Pennsylvania, and New Jersey. Dr. Payne requested a hearing based on the Ohio Board's Notice, which hearing was held on July 7, 2005, before Hearing Officer R. Gregory Porter.

Subsequently, on November 9, 2005, the Ohio Board issued a second Notice of Opportunity for Hearing to Dr. Payne based upon a Final Order issued by the Texas Medical Board which revoked Dr. Payne's license to practice medicine in Texas and upon additional allegations that Dr. Payne failed to provide complete and accurate information on an application Dr. Payne submitted to the State Medical Board of Ohio with respect to an application for licensure that Dr. Payne had submitted to the Delaware Board of Medical Practice, which was denied.

On the basis of the allegations set forth in the December 8, 2004, Notice of Opportunity for Hearing, the Board entered an Order on or about February 8, 2006, permanently denying the application for licensure of John Bruce Payne, D.O., to practice osteopathic medicine and surgery in the state of Ohio. No appeal of that Order was filed within the statutorily provided time period. In that the permanent denial of Dr. Payne's Ohio license makes further consideration of the November 9, 2005, allegations moot, it is ORDERED that the Notice of Opportunity for Hearing issued on November 9, 2005, be and is hereby DISMISSED without prejudice.

(SEAL)

  
\_\_\_\_\_  
Lance A. Talmage, M.D.  
Secretary

6-28-06  
\_\_\_\_\_  
Date

In the matter of John Bruce Payne, D.O.  
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This Order is being sent both certified and regular mail.

Certified Mail No. 7003 0500 0002 4329 9132  
Return Receipt Requested



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.med.ohio.gov](http://www.med.ohio.gov)

February 8, 2006

John Bruce Payne, D.O.  
4001 Stonehaven Drive  
Colleyville, TX 76034

Dear Doctor Payne:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on February 8, 2006, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.  
Secretary

LAT:jam  
Enclosures

CERTIFIED MAIL NO. 7003 0500 0002 4329 7596  
RETURN RECEIPT REQUESTED

*Mailed 2-10-06*

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on February 8, 2006, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of John Bruce Payne, D.O., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.  
Secretary

(SEAL)

February 8, 2006  
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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\*

JOHN BRUCE PAYNE, D.O.

\*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on February 8, 2006.

Upon the Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

The application of John Bruce Payne, D.O., for a certificate to practice osteopathic medicine and surgery in Ohio is PERMANENTLY DENIED.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.

(SEAL)



Lance A. Talmage, M.D.  
Secretary

February 8, 2006

Date

2006 JAN 12 P 4: 59

**REPORT AND RECOMMENDATION  
IN THE MATTER OF JOHN BRUCE PAYNE, D.O.**

The Matter of John Bruce Payne, D.O., was heard by R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on July 7, 2005.

**INTRODUCTION**

I. Basis for Hearing

- A. By letter dated December 8, 2004, the State Medical Board of Ohio [Board] notified John Bruce Payne, D.O., that it had proposed to take disciplinary action against or refuse to register or reinstate his certificate to practice osteopathic medicine and surgery in Ohio. The Board alleged that Dr. Payne had had action taken against hospital privileges based upon his treatment of two specified patients, that he had provided false information on applications for hospital privileges, and that the medical boards of Texas, Pennsylvania, and New Jersey had taken actions against his certificates to practice osteopathic medicine in those states.

The Board alleged that Dr. Payne's conduct constitutes

- “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,’ as that clause is used in Section 4731.22(B)(6), Ohio Revised Code”;
- “[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board,’ as that clause is used in Section 4731.22(B)(5), Ohio Revised Code”;
- “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual’s license to practice; acceptance of an individual’s license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,’ as that clause is used in Section 4731.22(B)(22), Ohio Revised Code”;

- “a failure to furnish satisfactory proof of good moral character as required by Sections 4731.29 and 4731.08, Ohio Revised Code.”

(State’s Exhibit 1A)

- B. By letter received by the Board on January 10, 2005, Dr. Payne requested a hearing.  
(State’s Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Kyle C. Wilcox, Assistant Attorney General.
- B. Dr. Payne did not appear for hearing in person or by representative, nor did he present a written defense.

**EVIDENCE EXAMINED**

I. Testimony Heard

No witnesses were presented.

II. Exhibits Examined

- A. State’s Exhibits 1A through 1H: Procedural exhibits.
- B. State’s Exhibit 2: Certified copies of documents maintained by the Board concerning Dr. Payne’s application for an Ohio osteopathic medical license.
- C. State’s Exhibit 3: Certified copies of documents maintained by the United States District Court for the Northern District of Texas concerning action taken by Harris Methodist H.E.B. Hospital against Dr. Payne’s privileges to practice at that institution.
- D. State’s Exhibit 4: Certified copies of documents regarding Dr. Payne maintained by the New Jersey State Board of Medical Examiners.
- E. State’s Exhibit 5: Certified copies of documents regarding Dr. Payne maintained by the Texas State Board of Medical Examiners.
- F. State’s Exhibit 6: Certified copies of documents regarding Dr. Payne maintained by the Commonwealth of Pennsylvania, Department of State, Bureau of Professional and Occupational Affairs, State Board of Osteopathic Medicine.

- G. State's Exhibit 7: Copy of a Texas State Board of Medical Examiners Medical Practice Questionnaire signed by Dr. Payne on August 17, 1999.
- H. State's Exhibit 9: Certified copy of Plaintiff's Appendix to Defendant's Motion to Dismiss and Alternative Motion for Summary Judgment, filed in the United States District Court for the Northern District of Texas, Fort Worth Division, in *John B. Payne, D.O. v. Columbia Plaza Medical Center of Fort Worth*, with attachments.
- I. State's Exhibits 10 through 13: Certified copy of documents filed in *John B. Payne, D.O. v. Harris Methodist H-E-B*, Case No. 499-CV-0273-R [*Payne v. Harris Methodist H-E-B*], maintained by the United States District Court for the Northern District of Texas, Fort Worth Division.
- J. State's Exhibits 14 and 15: Certified copies of judgments concerning *Payne v. Harris Methodist H-E-B* issued by the United States Court of Appeals for the Fifth Circuit.

### SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

1. On or about March 4, 2004, John Bruce Payne, D.O., submitted an Application for Certificate – Medicine or Osteopathic Medicine [License Application] to the Board. (State's Exhibit [St. Ex.] 2)

Dr. Payne's License Application indicates that he had obtained his osteopathic medical degree in 1978 from Des Moines University Osteopathic Medical Center. From 1978 through 1979, Dr. Payne completed an internship at Fitzsimmons Army Medical Center in Aurora, Colorado. From 1979 through 1980, Dr. Payne served as a Flight Surgeon at an Army hospital at Fort Rucker, Alabama. From 1980 through 1985, Dr. Payne completed a residency in neurosurgery at Thomas Jefferson University Hospital in Philadelphia, Pennsylvania. Dr. Payne was certified by the American Osteopathic Board of Surgery in 1989, and by the American Board of Neurosurgery in 1990. (St. Ex. 2 at 3, 5, 60)

2. From March 1995 through April 1997, Dr. Payne practiced neurosurgery at Harris Methodist H.E.B. Hospital [Harris H.E.B.] in Bedford, Texas. By letter dated October 29, 1996, the chief of the surgery department at Harris H.E.B. advised Dr. Payne that the Surgery Policy Committee had reviewed some of his cases and identified quality assurance concerns. The letter further advised Dr. Payne that a meeting had been scheduled for November 4, 1996, to address those concerns. Finally, the letter identified patients whose cases would be discussed at the meeting. (St. Ex. 3 at 2)

Following the meeting, by letter dated November 4, 1996, the Chief of Staff at Harris H.E.B. advised Dr. Payne that his privileges had been summarily suspended due to quality of care concerns and the medical staff's belief "that failure to take immediate action may result in imminent danger to the health of patients \* \* \* [.]" (St. Ex. 3 at 3-5 [Quote at 5])

From March 31 through April 3, 1997, a peer review hearing was conducted at which Dr. Payne was represented by counsel, and testimonial and documentary evidence was presented. On May 28, 1997, after considering all reports, supporting documentation, and recommendations of the Credentials Committee and the Hearing Panel, the Board of Trustees of Harris H.E.B. upheld the summary suspension action and terminated Dr. Payne's privileges. This action was based on a determination that Dr. Payne had "demonstrated a continuing pattern of lack of attention to clinically necessary details in the evaluation and treatment of patients and in the preparation for procedures[.]" and that his continued practice "may subject patients to unnecessary risks." (St. Ex. 3 at 28-31 [Quotes at 30]) The findings underlying these actions against Dr. Payne's privileges included:

- a. Regarding Patient 1, Dr. Payne failed to perform timely and appropriate diagnostic procedures, failed "to timely diagnose a shunt malfunction[.]" and "failed to timely place a new ventriculoperitoneal shunt in a timely manner leading to progressive clinical deterioration of the patient." (St. Ex. 3 at 29)
  - b. Regarding Patient 2, Dr. Payne failed to ensure that the patient's blood pressure was stabilized prior to beginning a cranioplasty, and failed to document any definitive or contingency plan of treatment prior to scheduling the cranioplasty. (St. Ex. 3 at 29)
  - c. Further, multiple medical records demonstrated that Dr. Payne maintained incomplete medical records, failed to sufficiently document comprehensive evaluations of patients prior to initiating surgical procedures, failed to document definitive treatment plans prior to initiating surgical procedures, failed to document specific details of the technical aspects of procedures performed, and failed to have available diagnostic studies in the operating room prior to the performance of procedures. (St. Ex. 3 at 29)
3. On April 9, 1999, Plaza Medical Center of Fort Worth [Plaza Fort Worth] in Fort Worth, Texas, advised Dr. Payne that his request for reappointment of privileges had been investigated and that his privileges were granted subject to certain limitations. Subsequently, by letter dated May 7, 1999, Dr. Payne resigned his privileges at Plaza Fort Worth. (St. Ex. 9 at 89-90, 109-113)
  4. On or about August 17, 1999, Dr. Payne completed and caused to be submitted to the Texas State Board of Medical Examiners [Texas Board] a Medical Practice Questionnaire [Texas Questionnaire] in which he answered "No" to question number 4, which asked:

Have you ever had your medical privileges monitored, revoked, suspended, limited or denied by any organization, health care facility, or excluded from participation in any Federal or State reimbursement program?

(St. Ex. 7 [Emphasis in original]) In fact, Dr. Payne's privileges at Harris H.E.B. had been summarily suspended on November 4, 1996, and were subsequently terminated on May 28, 1997. Further, on April 9, 1999, limitations had been imposed on Dr. Payne's privileges at Plaza Fort Worth. (St. Ex. 3 at 3-5, 28-31; St. Ex. 9 at 89-90, 112-113)

5. On September 7, 2001, the Texas Board entered an Agreed Order [September 2001 Order] which levied an administrative penalty against Dr. Payne and imposed a requirement that he report any address change to the Texas Board within ten days of said change. The Texas Board based its September 2001 Order, in part, on its finding that Dr. Payne had inappropriately answered "No" to question number 4 on his August 1999 Texas Questionnaire; and upon its conclusion that Dr. Payne had engaged in "unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public." (St. Ex. 5 [Quote at 3])
6. On December 7, 2001, the Texas Board entered an Agreed Order [December 2001 Order] that levied an administrative penalty against Dr. Payne and imposed a requirement that he report any address change to the Texas Board within ten days of said change. The Texas Board based its December 2001 Order, in part, upon the revocation of his privileges at North Hills Hospital, as described in detail below, and the disciplinary action taken by Plaza Fort Worth against Dr. Payne's privileges to practice at that institution. (St. Ex. 5)
7. In the December 2001 Order, the Texas Board included findings of fact that concern an action taken by North Hills Hospital against Dr. Payne's privileges to practice at that institution. The findings state, in pertinent part,
  - "6. [Dr. Payne] was subject to a disciplinary action at Plaza Medical Center of Fort Worth effective May 7, 1999.
  - "7. [Dr. Payne] failed to report this action to North Hills Hospital at the time this action was taken.
  - "8. Additionally, on his June 22, 1999, Reappointment Application to North Hills Hospital, [Dr. Payne] was asked if his privileges had been 'suspended, diminished, revoked, not renewed, voluntarily or involuntarily relinquished or allowed to lapse' at any hospital. [Dr. Payne] did not report the action at Plaza Medical Center.
  - "9. The Medical Executive Committee of North Hills Hospital investigated this matter and based on its investigation recommended that [Dr. Payne's] medical staff membership and privileges be revoked. This recommendation was approved by the Board of Trustees.

“10. [Dr. Payne] states that at the time he answered the inquiry in question, he believed that he answered it correctly. He did not think that the actions taken at Plaza Medical Center fell within the scope of the inquiry.”

(St. Ex. 5 at 6-7)

8. On September 30, 2002, the Commonwealth of Pennsylvania, Department of State, Bureau of Professional and Occupational Affairs, State Board of Osteopathic Medicine [Pennsylvania Board], entered an Adjudication and Order [Pennsylvania Order] that reprimanded Dr. Payne’s Pennsylvania medical license and levied a civil penalty of \$500. The Pennsylvania Board based its action upon the Texas Board’s September 2001 Order and December 2001 Order. (St. Ex. 6)
9. On April 17, 2003, the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Board of Medical Examiners [New Jersey Board] entered a Final Order of Discipline [New Jersey Order] that reprimanded Dr. Payne and required him to appear before the New Jersey Board to demonstrate fitness to practice prior to resuming active practice in New Jersey. The New Jersey Order was based in part upon Dr. Payne’s failure to notify the New Jersey Board about the Texas Board’s September 2001 Order and December 2001 Order. (St. Ex. 4)

### **FINDINGS OF FACT**

1. On or about March 4, 2004, John Bruce Payne, D.O., submitted an Application for Certificate – Medicine or Osteopathic Medicine [License Application] to the Board.
2. In the routine course of his practice as a neurosurgeon, Dr. Payne undertook the treatment of patients at Harris Methodist H.E.B. Hospital [Harris H.E.B.] in Bedford, Texas. On November 4, 1996, his privileges were summarily suspended at Harris H.E.B. due to quality of care concerns and the medical staff’s belief that failure to take immediate action could result in imminent danger to the health of patients. From March 31 through April 3, 1997, a four-day peer review hearing was conducted at which Dr. Payne was represented by counsel, and testimonial and documentary evidence was presented. On May 28, 1997, after considering all reports, supporting documentation, and recommendations of the Credentials Committee and the Hearing Panel, the Board of Trustees of Harris H.E.B. upheld the summary suspension action and terminated Dr. Payne’s privileges. This action was based on a determination that Dr. Payne had “demonstrated a continuing pattern of lack of attention to clinically necessary details in the evaluation and treatment of patients and in the preparation for procedures[.]” and that his practice “may subject patients to unnecessary risks.” The findings underlying these actions against Dr. Payne’s privileges included:
  - a. Regarding Patient 1, Dr. Payne failed to perform timely and appropriate diagnostic procedures, failed “to timely diagnose a shunt malfunction[.]” and “failed to timely

- place a new ventriculoperitoneal shunt in a timely manner leading to progressive clinical deterioration of the patient.”
- b. Regarding Patient 2, Dr. Payne failed to ensure that the patient’s blood pressure was stabilized prior to beginning a cranioplasty, and failed to document any definitive or contingency plan of treatment prior to scheduling the cranioplasty.
  - c. Further, multiple medical records demonstrated that Dr. Payne maintained incomplete medical records, failed to sufficiently document comprehensive evaluations of patients prior to initiating surgical procedures, failed to document definitive treatment plans prior to initiating surgical procedures, failed to document specific details of the technical aspects of procedures performed, and failed to have available diagnostic studies in the operating room prior to the performance of procedures.
3. On April 9, 1999, Plaza Medical Center of Fort Worth [Plaza Fort Worth] in Fort Worth, Texas, advised Dr. Payne that his request for reappointment of privileges had been investigated and that his privileges were granted subject to certain limitations. Subsequently, by letter dated May 7, 1999, Dr. Payne resigned his privileges at Plaza Fort Worth.
  4. On or about August 17, 1999, Dr. Payne completed and caused to be submitted to the Texas State Board of Medical Examiners [Texas Board] a Medical Practice Questionnaire [Texas Questionnaire] in which he answered “No” to question number 4, which asked:

Have you ever had your medical privileges monitored, revoked, suspended, limited or denied by any organization, health care facility, or excluded from participation in any Federal or State reimbursement program?

- In fact, Dr. Payne’s privileges at Harris H.E.B. had been summarily suspended on November 4, 1996, and were subsequently terminated on May 28, 1997. Further, on April 9, 1999, limitations had been imposed on Dr. Payne’s privileges at Plaza Fort Worth.
5. On September 7, 2001, the Texas Board entered an Agreed Order [September 2001 Order] that levied an administrative penalty against Dr. Payne and imposed a requirement that he report any address change to the Texas Board within ten days of said change. The Texas Board based its September 2001 Order, in part, on its finding that Dr. Payne had inappropriately answered “No” to question number 4 on his August 1999 Texas Questionnaire; and upon its conclusion that Dr. Payne had engaged in “unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.”
  6. On December 7, 2001, the Texas Board entered an Agreed Order [December 2001 Order] that levied an administrative penalty against Dr. Payne and imposed a requirement that he report any address change to the Texas Board within ten days of said change. The Texas Board based its December 2001 Order, in part, upon the revocation of Dr. Payne’s privileges at North Hills Hospital as described in Findings of Fact 7, below; and the

disciplinary action taken by Plaza Fort Worth against Dr. Payne's privileges to practice at that institution, as described in Findings of Fact 3, above.

7. In the December 2001 Order, the Texas Board included findings of fact that concern an action taken by North Hills Hospital against Dr. Payne's privileges to practice at that institution. The findings state, in pertinent part,
  - "6. [Dr. Payne] was subject to a disciplinary action at Plaza Medical Center of Fort Worth effective May 7, 1999.
  - "7. [Dr. Payne] failed to report this action to North Hills Hospital at the time this action was taken.
  - "8. Additionally, on his June 22, 1999, Reappointment Application to North Hills Hospital, [Dr. Payne] was asked if his privileges had been 'suspended, diminished, revoked, not renewed, voluntarily or involuntarily relinquished or allowed to lapse' at any hospital. [Dr. Payne] did not report the action at Plaza Medical Center.
  - "9. The Medical Executive Committee of North Hills Hospital investigated this matter and based on its investigation recommended that [Dr. Payne's] medical staff membership and privileges be revoked. This recommendation was approved by the Board of Trustees.
  - "10. [Dr. Payne] states that at the time he answered the inquiry in question, he believed that he answered correctly. He did not think that the actions taken at Plaza Medical Center fell within the scope of the inquiry."
8. On September 30, 2002, the Commonwealth of Pennsylvania, Department of State, Bureau of Professional and Occupational Affairs, State Board of Osteopathic Medicine [Pennsylvania Board], entered an Adjudication and Order [Pennsylvania Order] that reprimanded Dr. Payne's Pennsylvania medical license and levied a civil penalty of \$500. The Pennsylvania Board based its action upon the Texas Board's September 2001 Order and the December 2001 Order.
9. On April 17, 2003, the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Board of Medical Examiners [New Jersey Board] entered a Final Order of Discipline [New Jersey Order] that reprimanded Dr. Payne and required him to appear before the New Jersey Board to demonstrate fitness to practice prior to resuming active practice in New Jersey. The New Jersey Order was based in part upon Dr. Payne's failure to notify the New Jersey Board about the Texas Board's September 2001 Order and December 2001 Order.

### CONCLUSIONS OF LAW

1. The conduct of John Bruce Payne, D.O., as set forth in Findings of Fact 2 constitutes “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.
2. The conduct of Dr. Payne as set forth in Findings of Fact 4 and 7 constitutes “[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board,” as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.
3. The actions against Dr. Payne as set forth in Findings of Fact 5, 6, 8, and 9, constitute “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual’s license to practice; acceptance of an individual’s license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.
4. The conduct of Dr. Payne as set forth in Findings of Fact 4 through 9 constitutes a failure to furnish satisfactory proof of good moral character as required by Sections 4731.29 and 4731.08, Ohio Revised Code.

### PROPOSED ORDER

It is hereby ORDERED that:

The application of John Bruce Payne, D.O., for a certificate to practice osteopathic medicine and surgery in Ohio is PERMANENTLY DENIED.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.



R. Gregory Porter, Esq.  
Hearing Examiner



# State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

## EXCERPT FROM THE DRAFT MINUTES OF FEBRUARY 8, 2006

### REPORTS AND RECOMMENDATIONS

Dr. Robbins announced that the Board would now consider the findings and orders appearing on the Board's agenda. He noted that the case of Jabir Kamal Akhtar, M.D., which was scheduled for this meeting, would be considered at a later time due to the inability to achieve service of the Report and Recommendation on Dr. Akhtar.

Dr. Robbins asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Mark A Campano, M.D.; Philip L Creps, D.O.; Ruth Ann Holzhauser, M.D.; John Bruce Payne, D.O.; Alberto Pena, M.D.; Joseph Aloysius Ridgeway IV, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Steinbergh	- aye
	Dr. Robbins	- aye

Dr. Robbins asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye

Ms. Sloan	- aye
Dr. Davidson	- aye
Dr. Steinbergh	- aye
Dr. Robbins	- aye

Dr. Robbins noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

Dr. Robbins stated that, if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....  
JOHN BRUCE PAYNE, D.O.

.....  
**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER’S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER IN THE MATTER OF JOHN BRUCE PAYNE, D.O. DR. KUMAR SECONDED THE MOTION.**

.....  
A vote was taken on Dr. Steinbergh’s motion to approve and confirm:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Steinbergh	- aye

The motion carried.



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.med.ohio.gov](http://www.med.ohio.gov)

November 9, 2005

John Bruce Payne, D.O.  
4001 Stonehaven Drive  
Colleyville, TX 76034

Dear Doctor Payne:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) On or about March 4, 2004, you submitted an Application for Certificate – Medicine or Osteopathic Medicine [License Application] to the Board. By signing the “Affidavit and Release of Applicant” as part of your License Application, you certified under oath that the information provided therein was true. Your License Application is currently pending.
- (2) On or about December 8, 2004, the Board issued to you a Notice of Opportunity for Hearing, alleging violations of Sections 4731.22(B)(5), (B)(6) and (B)(22), Ohio Revised Code, and Sections 4731.29 and 4731.08, Ohio Revised Code, for which the hearing record was closed on or about July 7, 2005.
- (3) The “Additional Information” section of your License Application includes the instruction that, should you answer “Yes” to any question, “you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence or orders.”

Further, the “Affidavit and Release of Applicant” section of your License Application includes the instruction that you “will immediately notify the [Board] in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such change occurs at any time prior to a license to practice medicine or osteopathic medicine being granted to [you] by the [Board].”

*Mailed 11-10-05*

In that "Additional Information" section of your License Application you answered "No" to question number 9, which asks the following:

Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?

Further, you answered "Yes" to questions numbered 10 and 13, which ask, respectively, the following:

Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?

Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?

In your written response to your affirmative answers to questions numbered 10 and 13 above, you indicated that you received discipline from Texas, Pennsylvania and New Jersey; that you had been requested to appear before Columbia Plaza Medical Center and Columbia North Hills on three separate occasions; and that you had been notified about investigations concerning Harris Methodist, HEB, Columbia North Hills, Columbia Plaza Medical Center and N.E. Community Hospital.

In fact, you failed to notify the Board that, on or about April 12, 2004, the Delaware Board of Medical Practice [Delaware Board] issued a letter to you reflecting a proposal to deny you licensure in Delaware; that you requested a hearing; that said hearing was held on or about October 5, 2004; and that, on or about November 17, 2004, the Delaware Board denied your application to practice medicine and surgery in the State of Delaware.

- (4) On or about October 7, 2005, the Texas Medical Board entered a Final Order [2005 Texas Order] which revoked your Texas license to practice concluding that you failed to practice medicine in an acceptable professional manner, said conclusion being based upon your care of a patient who died. A copy of the 2005 Texas Order is attached hereto and fully incorporated herein.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (3) above, individually and/or collectively, constitute "[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the

practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

Further, the 2005 Texas Order as alleged in paragraph (4) above, constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (3) above, individually and/or collectively, constitute a failure to furnish satisfactory proof of good moral character as required by Sections 4731.29 and 4731.08, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

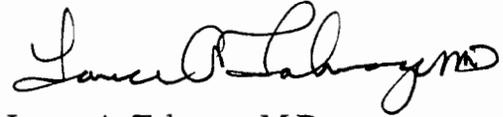
In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

John Bruce Payne, D.O.  
Page 4

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Lance A. Talmage, M.D.", written in a cursive style.

Lance A. Talmage, M.D.  
Secretary

LAT/blt  
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4333 3805  
RETURN RECEIPT REQUESTED

SOAH DOCKET NO. 503-04-1393  
LICENSE NO. H-5943

IN THE MATTER OF  
THE COMPLAINT AGAINST  
JOHN BRUCE PAYNE, D.O.

BEFORE THE  
  
TEXAS MEDICAL BOARD

FINAL ORDER

During open meeting at Austin, Texas, the Texas Medical Board, f/k/a Texas State Board of Medical Examiners ("Board") finds that after proper and timely notice was given, the above-styled case was heard by an Administrative Law Judge ("ALJ") of the Texas State Office of Administrative Hearings ("SOAH"). The Honorable ALJ Paul D. Keeper prepared a Proposal For Decision ("PFD"), containing proposed Findings of Fact and Conclusions of Law. The proposal for decision was properly served on all parties, and all parties were given an opportunity to file exceptions and replies as part of the record herein.

The Texas Medical Board, after review and due consideration of the proposal for decision and exceptions filed, adopts the proposed Findings of Fact and Conclusions of Law of the ALJ, with the exception of Conclusion of Law No. 12 and 13, which are recommendations by the ALJ, and are not proper Conclusions of Law.

FINDINGS OF FACT

1. On January 27, 1999, J.F. sought medical care for an occupational injury.
2. J.F. had such pain that he could no longer move his neck.
3. In 1991 or 1992, J.F. had a surgical fusion of his cervical spine at C5-6.
4. On January 28, 1999, J.F.'s physician evaluated J.F.'s x-rays and found some joint space narrowing, spurring, and calcification above and below the fusion site.
5. On February 3, 1999, J.F. returned for a follow-up examination, and J.F.'s symptoms persisted.
6. On March 3, 1999, a magnetic resonance imaging (MRI) study was performed on J.F. by a radiologist, John G. Maley, M.D.

7. The MRI study showed that: (1) J.F. had a protruding disk at C4-5 that was impinging on the lateral recess and slightly on the cervical spinal cord; (2) no abnormal signal in the cord itself; (3) that the anatomy at the foramina magna appeared normal; and (4) the disk at C4-5 was probably herniating.
8. J.F. was referred to John Bruce Payne, O.D., a board-certified neurologist.
9. Dr. Payne is a 1969 graduate of West Point and a 1978 graduate of the medical school at Des Moines University.
10. Dr. Payne completed a five-year neurosurgical residency at Thomas Jefferson University Hospital, and as of March 1999, had been in practice for fourteen years.
11. On March 26, 1999, Dr. Payne examined J.F.
12. J.F. was in constant but moderate pain with a good range of motion in his neck and extremities. J.F.'s neurological examination reflected no other abnormalities.
13. Dr. Payne reviewed the MRI of March 3, 1999, and did not agree with many of Dr. Maley's conclusions.
14. Dr. Payne determined that the MRI showed significant spondylitic changes at C4-5 with bilateral foraminal encroachment and a degenerative disk that contributed to the stenosis.
15. Dr. Payne recommended a series of non-surgical types of care.
16. On May 4, 1999, Roger S. Blair, M.D., performed on J.F. an electromyographic/nerve conduction velocity (EMG/NCV) evaluation.
17. Dr. Blair identified: (1) a significant left carpal tunnel syndrome, (2) a left ulnar nerve entrapment at the elbow (a conclusion that ruled out any C8 involvement), and (3) a left C5 radiculopathy.
18. On May 11, 1999, J.F. had a myelogram of the complete cervical spine followed by a post-myelogram computerized axial tomographic x-ray (CT) scan.
19. J.F.'s cervical spine was unremarkable with the following exceptions: (1) a bilateral uncovertebral joint bony hypertrophy at C3-4 with no significant neural foraminal stenosis; (2) at C5-6 a bony hypertrophic leftward posterior vertebral body.
20. J.F.'s vertebral body axial heights and alignment appeared normal, and the disk spaces appeared to be satisfactorily preserved.
21. On May 14, 1999, Dr. Payne saw J.F. for a second time.

22. Dr. Payne concluded independently and differently from Dr. Blair that the post-myelogram CT scan showed: (1) significant degenerative changes with probably foraminal encroachment, bilaterally, at C5; (2) minimal foraminal narrowing at C5-6; (3) significant thinning of the anterior subarachnoid space from diffuse spur at C4-5; (4) insufficiently filled out nerve roots; and (5) degenerative changes at C4-C5 causing bilateral C5 radiculopathy.
23. By J.F.'s second examination, J.F. had obtained most of the conservative treatments and studies that Dr. Payne had recommended, none of which brought J.F. any consistent relief.
24. Dr. Payne recommended surgery for J.F.'s condition.
25. Because J.F.'s injuries were covered by workers' compensation insurance, Dr. Payne was required to obtain a second, confirming surgical opinion.
26. The physician who was chosen to provide that second opinion was Ralph Saunders, M.D.
27. Dr. Saunders is a board-certified orthopedic surgeon who has been in practice since 1989 with experience in cervical and lumbar surgery.
28. Dr. Saunders did not recommend surgery.
29. Dr. Saunders found that: (1) the imaging studies and the physical examination did not sustain the need for surgery; and (2) other forms of therapy and other diagnostic studies should continue to be performed.
30. Dr. Payne wrote a letter of complaint to the Texas Workers' Compensation Commission (TWCC) on July 16, 1999, alleging that Dr. Saunders failed to perform a thorough examination of J.F.
31. TWCC agreed to allow J.F. to obtain a third pre-surgical opinion.
32. On August 10, 1999, J.F. was examined by Joe Ellis Wheeler, M.D., a neurologist.
33. Dr. Wheeler's report did not provide significant additional medical information or medical insight upon which to base a conclusion about J.F.'s need for surgery.
34. Dr. Wheeler concurred with Dr. Payne's recommendation for an anterior cervical discectomy and fusion (ACDF) surgical procedure for J.F.
35. On September 1, 1999, TWCC notified J.F. that his surgery had been approved.
36. On September 20, 1999, J.F. presented himself to the Osteopathic Medical Center of Texas in Fort Worth for pre-operative admission procedures.
37. At the time of his pre-admission tests, J.F. was taking two types of eyedrops for glaucoma.

**Background: surgical**

38. On September 22, 1999, J.F. was admitted for surgery.
39. Dr. Payne identified a very large lip of osteophytic growth along the C4-5 border and removed J.F.'s disk toward the back of the vertebral body.
40. The surgery went well with no complications.

**Background: post-surgical**

41. On September 22, 1999, around 9:00 p.m., J.F. began to complain of pain, and the nurses gave him Stadol by IV because he was having difficulty swallowing.
42. On September 23, 1999, post-operative day 1, J.F. complained of pain throughout the day.
43. The nursing staff gave J.F. 1 mg. of Stadol at 12:15 a.m., Percocet and Stadol at 4:00 a.m., Flexeril at 6:00 a.m., an unrecorded pain medication at 8:00 a.m., Demerol at 2:00 p.m., and Stadol and OxyContin (a time release opioid) at 8:00 p.m.
44. On September 24, 1999, post-operative day 2, J.F. complained of pain throughout the day.
45. The nursing staff gave J.F. Stadol and Valium at 3:00 a.m. and Percocet (in crushed form to make it easier to swallow) at noon, Percocet (in crushed form) at 7:45 p.m., OxyContin (in crushed form) at 8:00 p.m., and OxyContin (in crushed form) at 9:30 p.m.
46. At 5:00 p.m. on September 24, 1999, J.F. complained of dizziness when he went to the bathroom and had to be assisted back to bed, and at 7:00 p.m., J.F. was showing "activity intolerance" and "alteration in comfort," specified as "general stiffness and weakness.
47. On September 25, 1999, post-operative day 3, the nursing staff discovered J.F. on the floor at 6:05 a.m. in a very cyanotic state, unresponsive, and frothing sputum at the mouth.
48. At 6:20 a.m., J.F. had poor coloration, nonpalpable pulses, and was unresponsive to all stimuli.
49. J.F. was administered 0.4 mg. IV of Narcan by the house officer.
50. Narcan is a narcotic that makes other opioids ineffective in the respiratory centers and allows the patient to wake up and breathe.
51. J.F. immediately became aroused and alert, complaining of severe pain and trying to get out of bed.

52. By 7:50 a.m., J.F. had become drowsy again and his mental status was lethargic.
53. J.F. began making coarse lung sounds, had a productive cough, and was producing brown sputum.
54. At 8:00 a.m., the nursing staff paged Dr. Payne.
55. At 8:20 a.m., Gregory H. Smith, O.D., a board-certified neurosurgeon, examined J.F. at the request of the nursing staff.
56. J.F. was administered a second dose of Narcan on Dr. Smith's orders, but J.F. had no significant response.
57. J.F. was experiencing a pan-organ failure of uncertain etiology.
58. J.F. was evaluated by the hospital's cardiology, nephrology, gastrointestinal, and internal medicine staff and was transferred to the intensive care unit (ICU).
59. By 10:30 a.m., J.F. was in acute renal failure.
60. During the course of the day, J.F. became lethargic, confused, and agitated.
61. Between 5:30 and 6:00 p.m., J.F. was vomiting and having dry heaves.
62. At 11:50 p.m., J.F. was intubated by an anesthesiologist.
63. By 8:00 a.m. on September 26, 1999, post-operative day 4, J.F. was sedated, intubated, and was unable to respond.
64. His family was at his bedside.
65. J.F. had: (1) massively elevated liver function tests with high probability of ischemic hepatitis, (2) multi-organ failure, including renal failure, respiratory failure, and cerebellar/thalamic infarctions, (3) rhabdomyolysis, and (4) thrombocytopenia of multifactorial etiology.
66. A neurological consult report revealed that J.F. was virtually comatose.
67. At 1:45 p.m. that day, the nursing staff received a telephone call from Dr. Payne at a hotel in Laredo, Texas.
68. Dr. Payne was providing coverage for another neurosurgeon.

69. Dr. Payne understood that Trey Fulp, O.D., an orthopedic surgeon, had agreed to cover his two hospitalized patients and that Dr. Smith had agreed to cover any of Dr. Payne's new patients.
70. Neither Dr. Fulp nor Dr. Smith understood that they were providing coverage for J.F. for Dr. Payne.
71. Dr. Fulp went to the hospital on Saturday, September 25, 1999, and learned about J.F.'s condition.
72. On Sunday, September 26, 1999, Dr. Fulp made a note in J.F.'s chart about his role in the events of September 25 and 26, 1999.
73. On Sunday, September 26, 1999, Dr. Fulp contacted Dr. Payne by telephone at his hotel.
74. When Dr. Payne learned of J.F.'s condition, he made arrangements to return to Fort Worth as soon as the physician for whom he was providing coverage returned to Laredo.
75. Dr. Payne contacted the specialists at the hospital in Fort Worth who were trying to diagnose and treat J.F.
76. Dr. Payne returned to Fort Worth on Tuesday, September 28, 1999, post-operative day 6, and went to the hospital to assess J.F.
77. When Dr. Payne arrived, J.F. was in pan-systemic failure.
78. J.F. had acute respiratory distress syndrome, complete renal and liver failure, a cerebellar infarct, edema of the posterior fossa, and severe hypotension.
79. Dr. Payne performed a ventriculostomy on J.F.
80. J.F. continued to suffer from blood in the ventricle and increased intracerebral edema.
81. On September 30, 1999, post-operative day 8, Dr. Payne performed two additional ventriculostomies to relieve the pressure, one of which hemorrhaged.
82. J.F.'s family signed a "Do Not Resuscitate" consent form to give the hospital and physicians authority to withhold life-sustaining procedures.
83. At 5:00 p.m., J.F. was exhibiting probable brain death.
84. By 5:45 p.m., the assessment of brain death was confirmed.
85. On Friday, October 1, 1999, post-operative day 9, J.F.'s family signed a "Consent to Withdraw Medical Treatment."

86. At 12:30 a.m., the ventilator was discontinued with J.F.'s family at his bedside.

87. At 12:45 a.m., the medical resident on call pronounced J.F. dead.

#### **Issue 1: Need for surgery**

88. The objective medical tests available to Dr. Payne when he decided to perform surgery on J.F. were the MRI of March 3, 1999, the EMG/NCV of May 4, 1999, and the myelogram and post-myelogram CT of May 11, 1999.

89. Dr. Payne's March 26, 1999, conclusions from his reading of the MRI films were different from those of Dr. Maley, the radiologist who performed the MRI.

90. Dr. Payne's conclusions about the results of the EMG/NCV were different from those of Dr. Blair, the neurologist who performed the test.

91. The myelogram films were of such poor quality that they were completely uninterpretable.

92. Dr. Payne concluded that the myelogram provided evidence of significant degenerative changes with compression on the nerve roots.

93. A post-myelogram CT provides the most thorough visual information about a patient's neurological condition.

94. The radiologists' post-myelogram CT study failed to discuss the status of J.F.'s spine at the proposed surgical site, C4-5.

95. The study's conclusions about the condition of the other cervical spine levels disclosed no significant pathology, and the radiology report concluded that the results showed an otherwise unremarkable cervical spine CT post-myelography.

96. Dr. Payne referred to the study in his hospital admission records as additional evidence of J.F.'s nerve root compression.

97. The post-myelogram CT study showed that J.F.'s cervical spine had mild stenosis but was not sufficiently narrow to prevent the nerve roots from performing.

98. The post-myelogram CT study showed some impingement by osteophytes or disk protrusion but not of sufficient quality to affect the cord or its nerves.

99. J.F.'s pain ranged from moderate to severe and emerged at various times in his back, arms, shoulders, and face.

100. The medically significant determinant for pathology based on medical tests was whether the spinal cord or nerve root suffered impingement to the degree that the cerebral spinal fluid (CSF) was obscured from view.
101. Although pain is one determinant among clinical findings, it is not the only determinant.
102. Muscle weakness and muscle atrophy reflect the progression of the disease process, but neither condition defines the pathology nor confirms surgery as the most appropriate therapy.
103. J.F.'s cervical spinal cord was impinged at the C4-5 level but not to the point that the CSF was prevented from surrounding the cord or preventing the cord from performing its function.
104. J.F.'s foramina at the C4-5 level were affected by stenosis, but the narrowing was not sufficient to prevent the nerve roots from exiting.
105. J.F.'s nerve roots at C4-5 were surrounded by CSF.
106. J.F.'s pain was a confirming indicator that he was suffering from some sort of significant and ongoing neurological problem.
107. ACDF is a commonly performed surgical procedure and is widely regarded as an appropriate therapy to address the type of pain suffered by J.F.
108. Dr. Payne had an obligation to consider surgery based not only on the requests of his patient but also based on the standards of professional practice.
109. Those standards required that Dr. Payne exercise a level of caution in relying upon his own conclusions about the diagnostic tests and clinical observations.

**Issue 2: Failure to provide adequate post-operative care by over-medicating**

110. J.F. was entitled to receive medication sufficient to control his expected levels of discomfort following his surgical procedure.
111. The terms "opioid naive" and "opioid tolerant," were used at the hearing with such imprecision as to make them meaningless for the purpose of determining a standard of care.
112. J.F. had no sensitivity to (or lack of sensitivity to) or intolerance of opioids.
113. J.F. was not taking painkillers by the time he was admitted to the hospital for his surgery.
114. J.F. suffered at least moderate, ongoing pain from his cervical problems well in advance of his surgery.
115. Post-operative ACDF patients commonly experience pain from the surgical procedure, including pain in the back or shoulders and difficulty in swallowing for 24 to 48 hours.

116. For a patient undergoing a second procedure, this type of pain may be expected.
117. J.F. received a tremendous amount of pain medication after his surgery, including Stadol, Percocet, Flexeril, OxyContin, Demerol, and Valium.
118. Dr. Payne authorized the nurses to administer OxyContin to J.F. every twelve hours at 40 mg. per dose.
119. The dosage of OxyContin should have been diminished to 10-20 mg. every twelve hours, a half to a third of the standard dose if J.F. was receiving other opioids concurrently.
120. J.F. was receiving other opioids concurrently with OxyContin.
121. On September 24, 1999, the nursing staff administered one dose of OxyContin to J.F. at 8:00 p.m. and another at 9:30 p.m., a time period that was in violation of Dr. Payne's orders.
122. The hospital nursing staff did not contact Dr. Payne to tell him about the medication administration error.
123. The hospital nurses crushed the OxyContin pills to make them easier for J.F. to swallow.
124. The crushing of OxyContin eliminates the time release qualities of the drug, so that the entire amount of the drug affects the patient much more quickly than prescribed.
125. Dr. Payne was unaware that the hospital nursing staff was crushing the OxyContin pills.

### **Issue 3: Adequacy of coverage arrangements**

126. Dr. Payne had the obligation to use proper diligence in making coverage arrangements for the post-operative care of J.F.
127. Dr. Payne could have noted his coverage arrangements in J.F.'s chart with the name and telephone number of the physician who was to provide coverage.
128. An acceptable alternative practice is to make verbal arrangements with the covering physicians but only if: (1) the departing physician ensures that the covering physician is capable of managing the patient and any possible complications; (2) the covering physician is given the relevant information for the care of the patient; and (3) if the departing physician's information is not written in the patient's records, then the departing physician's answering service must know exactly who is covering for the departing physician. In addition, the hospital nursing staff must be informed in some manner that the departing physician's patients are being covered by the covering physician.
129. Dr. Payne believed that he made verbal arrangements with Dr. Fulp to cover his in-patients and with Dr. Smith to cover new patients and non-in-patient emergencies.

130. Dr. Payne knew both Dr. Fulp and Dr. Smith, and he had shared coverage with them before.

131. Neither Dr. Fulp nor Dr. Smith knew of an agreement for them to provide coverage for J.F. during J.F.'s hospitalization in September 1999.

132. Dr. Payne's answering service did not contact him when the hospital staff tried to reach him on the morning of September 25, 1999.

133. Dr. Payne's answering service should have known that he was at home on the morning of September 25, 1999.

134. All of Dr. Payne's patient coverage mechanisms failed to operate properly beginning on the morning of September 25, 1999.

### **Sanctions**

135. A physician who performs surgery before eliminating more conservative forms of therapy poses a level of potential harm to the public.

136. A physician who performs surgery based on insufficient diagnostic results poses a level of potential harm to the public.

137. A physician who prescribes drugs in a non-therapeutic manner poses a level of potential harm to the public.

138. A physician who fails to provide reliable post-surgical coverage for his patients during his absence poses a level of potential harm to the public.

139. In his treatment of J.F., Dr. Payne performed surgery before eliminating more conservative forms of therapy and thereby poses a level of potential harm to the public.

140. In his treatment of J.F., Dr. Payne performed surgery based on insufficient diagnostic results and thereby poses a level of potential harm to the public.

141. In his treatment of J.F., Dr. Payne prescribed drugs in a non-therapeutic manner and thereby poses a level of potential harm to the public.

142. In his treatment of J.F., Dr. Payne failed to provide reliable post-surgical coverage for his patients during his absence and thereby poses a level of potential harm to the public.

143. Dr. Payne was denied staff privileges at two hospitals in March or April 1997.

144. Dr. Payne was the subject of at least eight medical malpractice lawsuits filed against him prior to September 1999, including one involving a patient's death.

145. Dr. Payne was the subject of a disciplinary action in May 1999 at Plaza Medical Center of Fort Worth.

146. After September 1999, additional claims of medical negligence were made against Dr. Payne regarding his conduct as a spinal surgeon at Osteopathic Medical Center of Texas.

147. Dr. Payne was required by the Board to pay two administrative fines for failing to disclose disciplinary actions at two different hospitals.

### CONCLUSIONS OF LAW

1. The State Board of Medical Examiners (Board) has jurisdiction to discipline its licensees pursuant to the Texas Medical Practices Act (Act), TEX. OCC. CODE ANN., chs. 151-165.
2. The State Office of Administrative Hearings has jurisdiction to hear this matter and issue a proposal for decision, including findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. ch. 2003.
3. All parties received adequate and timely notice of hearing in this matter and appeared or were represented at the hearing.
4. Section 164.052(a)(5) of the Act prohibits a Board licensee from committing unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure the public.
5. The Board may discipline its licensees for committing an act prohibited under Section 164.051(a)(6) of the Act for failing to practice medicine in an acceptable professional manner consistent with the public health and welfare.
6. Section 164.053(a)(5) of the Act defines unprofessional or dishonorable conduct to include administering non-therapeutic treatment.
7. Section 164.053(a)(6) of the Act defines unprofessional or dishonorable conduct to include the prescription of dangerous drugs or controlled substances in a manner inconsistent with public health and welfare.
8. In assessing the appropriate sanction against a licensee, the Board must consider the factors listed at 22 TEX. ADMIN. CODE § 190.14.
9. Dr. Payne did not adhere to the standard of care in his treatment of J.F. and thus violated Sections 164.051(a)(6) (failure to practice in an acceptable professional manner), 164.052(a)(5) (engaging in unprofessional or dishonorable conduct likely to deceive, defraud or injure the public), Section 164.053(a)(5) (engaging in unprofessional or dishonorable conduct including administering non-therapeutic treatment), and Section 164.053(a)(6) (engaging in unprofessional

or dishonorable conduct including the prescription of dangerous drugs or controlled substances in a manner inconsistent with public health and welfare).

10. In his treatment of J.F., Dr. Payne committed unprofessional and dishonorable conduct related to the practice of medicine.

11. In his treatment of J.F., Dr. Payne failed to practice medicine in an acceptable professional manner consistent with the public health and welfare.

The Board does not adopt Conclusion of Law No. 12 that reads, "The Board should discipline Dr. Payne for his violations of the Act." 22 Tex. Admin. Code § 187.40(h)(11). *[This recommendation is not a proper conclusion of law. Board Rule 190.2; states, "The appropriate sanction is not a proper finding of fact or conclusion of law." Tex. Occ. Code Section 151.003(2) states, 'the board should remain the primary means of licensing, regulating and disciplining physicians.' Tex. Occ. Code 164.007(a) states in part, ". . . After receiving the administrative law judge's findings of fact and conclusions of law, the board shall determine the charges on the merits." Board rule 190.2 states in part, ". . . The Board shall render the final decision in a contested case and has the responsibility to assess sanctions against licensees who are found to have violated the Act."*

The Board does not adopt Conclusion of Law No. 13 that reads, "The Board should revoke Dr. Payne's license to practice medicine in Texas." 22 Tex. Admin. Code § 187.40(h)(11). *[This is not a proper conclusion of law. Board Rule 190.2; states, "The appropriate sanction is not a proper finding of fact or conclusion of law." Tex. Occ. Code Section 151.003(2) states, 'the board should remain the primary means of licensing, regulating and disciplining physicians.' Tex. Occ. Code 164.007(a) states in part, ". . . After receiving the administrative law judge's findings of fact and conclusions of law, the board shall determine the charges on the merits." Board rule 190.2 states in part, ". . . The Board shall render the final decision in a contested case and has the responsibility to assess sanctions against licensees who are found to have violated the Act."*

### **ORDER**

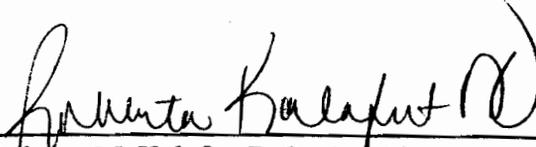
Based on the foregoing Findings of Fact, 1-147; and Conclusions of Law 1-11, and pursuant to Tex. Occ. Code, §151.003(2); §164.007(a); and Tex. Admin Code §190.2:

The Board finds that the reasoning as stated in the Proposal for Decision is supported by evidence adduced at trial and found in the record, and is sufficient to revoke this Respondent's license, and therefore the Board ORDERS that:

Respondent's Texas medical license is hereby REVOKED.

In accordance with TEX. OCC. CODE ANN §2001.177 and 22 TEX. ADMIN. CODE §187.39(C), should Respondent appeal this Final Order, the Respondent shall be responsible for payment of all costs of preparation of the original or certified copy of the record of the agency proceedings.

SIGNED AND ENTERED by the presiding officer of the Texas Medical Board on this 7 day of October, 2005.

  
\_\_\_\_\_  
Roberta M. Kalafut, D.O., President  
Texas Medical Board

STATE OF TEXAS  
COUNTY OF TRAVIS

I, Loris Jones, certify that I am an official assistant custodian of records for the Texas Medical Board, and that this is a true and correct Copy of the original, as it appears on file in this office.

Witness my official hand and seal of the Board,  
this 13<sup>th</sup> day of October, 2005  
Loris Jones  
Assistant Custodian of Records



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.med.ohio.gov](http://www.med.ohio.gov)

December 8, 2004

John Bruce Payne, D.O.  
4001 Stonehaven Drive  
Colleyville, TX 76034

Dear Doctor Payne:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) On or about March 4, 2004, you submitted an Application for Certificate – Medicine or Osteopathic Medicine [License Application] to the Board. Your License Application is currently pending.
- (2) In the routine course of your practice as a neurosurgeon, you undertook the treatment of patients at Harris Methodist H.E.B. Hospital [Harris H.E.B.], located in Bedford, Texas. On or about November 4, 1996, your privileges were summarily suspended at Harris H.E.B. due to quality of care concerns and the Medical Staff's belief that failure to take immediate action could result in imminent danger to the health of patients. During or about April 1997, a four-day peer review hearing was conducted at which you were represented by counsel, and testimonial and documentary evidence was presented. On or about May 28, 1997, after considering all reports, supporting documentation and recommendations of the Credentials Committee and the Hearing Panel, the Board of Trustees of Harris H.E.B. upheld the summary suspension action and further terminated your privileges based on a determination that you had demonstrated a continuing pattern of lack of attention to clinically necessary details in the evaluation and treatment of patients and in the preparation for procedures, and that your practice may subject patients to unnecessary risks. The findings underlying these actions against your privileges included:
  - (a) Regarding Patient 1 (as identified on the attached confidential Patient Key - Key confidential and not subject to public disclosure), you failed to perform timely and appropriate diagnostic procedures and/or you failed to

MAILED 12-09-04

timely diagnose a shunt malfunction and/or you failed to timely place a new ventriculoperitoneal shunt leading to progressive clinical deterioration of the patient.

- (b) Regarding Patient 2 (as identified on the attached confidential Patient Key - Key confidential and not subject to public disclosure), you failed to ensure that the patient's blood pressure was stabilized prior to beginning a cranioplasty and/or you failed to document any definitive or contingency plan of treatment prior to scheduling the cranioplasty.
  - (c) Further, multiple medical records demonstrated that you maintained incomplete medical records and/or you failed to sufficiently document a comprehensive evaluation of patients prior to initiating surgical procedures and/or you failed to document definitive treatment plans prior to initiating surgical procedures and/or you failed to document specific details of technical aspects of the procedures performed and/or you failed to have available diagnostic studies in the operating room prior to the performance of procedures.
- (3) On or about April 9, 1999, Plaza Medical Center of Fort Worth [Plaza Fort Worth], located in Fort Worth, Texas, advised you that your request for reappointment of privileges had been investigated and that your privileges were granted with certain limitations. On or about May 7, 1999, you resigned your privileges at Plaza Fort Worth.
- (4) On or about June 22, 1999, you completed and caused to be submitted to North Hills Hospital [North Hills], located in North Richland Hills, Texas, a "Medical Staff Reappointment Application" [North Hills Application] in which you answered "No" to questions numbered 12 and 14, which asked, respectively:

Have you ever been, or are you currently being subject [sic] to any disciplinary action or investigation at or by any hospital or professional organization?

Has your request for any specific clinical privilege(s) at any hospital/healthcare facility ever been denied or granted with limitations/restrictions?

In fact, North Hills determined that you had provided material misstatements/omissions in your "No" responses based on your failure to disclose information about an investigation concerning your privileges at Plaza Fort Worth, and a subsequent limitation on your Plaza Fort Worth privileges.

Further, you answered "Yes" to question 15 on your North Hills Application which asked:

Have your privileges at any hospital ever been suspended, diminished, revoked, not renewed, voluntary or involuntary [sic] relinquished or allowed to lapse?

In fact, although you mentioned the termination of your privileges at Harris H.E.B., you failed to disclose that, on or about May 7, 1999, you resigned your privileges at Plaza Fort Worth.

On or about December 8, 2000, North Hills revoked your privileges based, in part, on findings that your answers to the above questions contained material misstatements or omissions and that you failed to notify North Hills about your privilege status at Plaza Fort Worth.

- (5) On or about August 17, 1999, you completed and caused to be submitted to the Texas State Board of Medical Examiners [Texas Board] a "Medical Practice Questionnaire" [Texas Questionnaire] in which you answered "No" to question number 4 which asked:

Have you ever had your medical privileges monitored, revoked, suspended, limited or denied by any organization, health care facility, or excluded from participation in any Federal or State reimbursement program? [Emphasis in the original].

In fact, your privileges were summarily suspended at Harris H.E.B., on or about November 4, 1996, and were subsequently terminated on or about May 28, 1997. Further, your privileges were limited at Plaza Fort Worth on or about April 9, 1999.

- (6) On or about September 7, 2001, the Texas Board entered an Agreed Order [September 2001 Order] which levied an administrative penalty against you and imposed the requirement that you report any address change to the Texas Board within ten days of said change based on you answering "No" to question number 4 on your August 1999 Texas Questionnaire, concluding that you had engaged in unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public. A copy of the September 2001 Order is attached hereto and fully incorporated herein.
- (7) On or about December 7, 2001, the Texas Board entered an Agreed Order [December 2001 Order] which levied an administrative penalty against you and imposed the requirement that you report any address change to the Texas Board

within ten days of said change based upon the revocation of your privileges at North Hills and a disciplinary action taken by Plaza Fort Worth. A copy of the December 2001 Order is attached hereto and fully incorporated herein.

- (8) On or about September 30, 2002, the Commonwealth of Pennsylvania, Department of State, Bureau of Professional and Occupational Affairs, State Board of Osteopathic Medicine [Pennsylvania Board], entered an Adjudication and Order [Pennsylvania Order] which reprimanded your Pennsylvania medical license and levied a civil penalty of \$500 based upon the aforementioned Texas Board September 2001 Order and December 2001 Order. A copy of the Pennsylvania Order is attached hereto and fully incorporated herein.
- (9) On or about April 17, 2003, the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Board of Medical Examiners [New Jersey Board] entered a Final Order of Discipline [New Jersey Order] which reprimanded you and required you to appear before the New Jersey Board to demonstrate fitness to practice prior to resuming active practice in New Jersey. The New Jersey Order is in part based upon your failure to notify the New Jersey Board about the aforementioned Texas Board September 2001 Order and December 2001 Order. A copy of the New Jersey Order is attached hereto and fully incorporated herein.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (4) and (5) above, individually and/or collectively, constitute “[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board,” as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (6) through (9) above, individually and/or collectively, constitute “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a

license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (4) through (9) above, individually and/or collectively, constitute a failure to furnish satisfactory proof of good moral character as required by Sections 4731.29 and 4731.08, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.  
Secretary

LAT/blt  
Enclosures

John Bruce Payne, D.O.  
Page 6

CERTIFIED MAIL # 7000 0600 0024 5143 2501  
RETURN RECEIPT REQUESTED

IN THE MATTER OF  
THE LICENSE OF  
JOHN B. PAYNE, D.O.

H-5943

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BEFORE THE  
TEXAS STATE BOARD  
OF MEDICAL EXAMINERS

AGREED ORDER

On this the 7th day of September, 2001, came on to be heard before the Texas State Board of Medical Examiners ("the Board" or "the Texas Board"), duly in session the matter of the license of John B. Payne, D.O. ("Respondent"). On June 21, 2001, Respondent appeared in person with counsel, Jeffrey Grass, at an Informal Settlement Conference/Show Compliance Proceeding in response to a letter of invitation from the staff of the Board. Mari Robinson represented Board Staff.

The Board was represented at the Informal Settlement Conference/Show Compliance Proceeding by Peter Chang, M.D., a member of the Board, and Buddy Siebenlist, M.D., a District Review Committee member. Upon recommendation of the Board's representatives, and with the consent of Respondent, the Board makes the following findings of fact and conclusions of law and enters this Order as set forth herein:

FINDINGS OF FACT

1. Respondent, John B. Payne, D.O., holds Texas medical license H-5943.
2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice that may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied under TEX. OCC. CODE ANN. Subtitle B (Vernon 2000) (hereinafter the "Act").
3. By entering into this agreed order, Respondent waives any defect in the notice and any further right to notice and hearing under the Act, TEX. GOV'T CODE ANN. §§2001.051 - .054, and the Rules of the State Board of Medical Examiners.
4. Respondent is fifty-four (54) years of age.
5. Respondent is a board certified neurosurgeon.
6. Respondent was subject to a disciplinary action at Plaza Medical Center of Ft. Worth effective May 7, 1999.

7. Respondent was the subject of discipline action by Harris Methodist H.E.B. on May 28, 1997.

8. Respondent answered "No" to question number 4 on his Medical Practice Questionnaire dated August 17, 1999, which states "Have you ever had your medical privileges monitored, revoked, suspended, limited or denied by any organization, health care facility, or excluded from participation in any Federal or State reimbursement program?"

9. After being questioned by the Board on this matter, Respondent submitted a corrected Medical Practice Questionnaire on April 17, 2000.

### CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Board concludes the following:

1. Respondent is subject to disciplinary action pursuant to Section 164.051(a)(1) of the Act based on Respondent's commission of an act prohibited under Section 164.052 of the Act. Specifically, Respondent has committed a prohibited act or practice within the meaning of Section 164.052(a)(5) of the Act based upon unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.

2. Section 164.002(a) of the Act authorizes the Board to resolve and make a disposition of this matter through an Agreed Order.

3. Sections 165.001 and 165.003 of the Act authorize the Board to impose a monetary administrative penalty not to exceed five thousand dollars (\$5,000.00) for each separate violation of the Act or Board rule by a person licensed or regulated under the Act.

4. Section 164.002(d) of the Act provides that this Agreed Order is a settlement agreement under the Texas Rules of Evidence for purposes of civil litigation.

### ORDER

Based on the above Findings of Fact and Conclusions of Law, the Board ORDERS that:

1. Respondent shall pay an administrative penalty in the amount of one thousand dollars (\$1000.00) within ninety (90) days of the signing of this Order by the presiding officer of the Board.

2. The administrative penalty shall be paid in a single payment by cashier's check or money order payable to the Texas State Board of Medical Examiners and shall be submitted to

the Director of Compliance for the Board for routing so as to be remitted to the Comptroller of Texas for deposit in the general revenue fund.

3. Respondent's failure to pay the administrative penalty as ordered shall constitute unprofessional and dishonorable conduct that is likely to deceive or defraud the public and shall constitute grounds for further disciplinary action by the Board as provided for in the Act, and may result in a referral by the Executive Director of the Board for collection by the Office of the Attorney General.

4. Respondent shall comply with all the provisions of the Act and other statutes regulating the Respondent's practice.

5. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within ten (10) days of the address change. This information shall be submitted to the Verification Department and the Director of Compliance for the Board. Failure to provide such information in a timely manner shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

6. Any violation of the terms, conditions, or requirements of this Order by Respondent shall constitute unprofessional conduct likely to deceive or defraud the public, and to injure the public, and shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

RESPONDENT WAIVES ANY FURTHER HEARINGS OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED ORDER. RESPONDENT AGREES THAT THIS IS A FINAL ORDER.

THIS ORDER IS A PUBLIC RECORD.

I, JOHN B. PAYNE, D.O., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: August 10, 2001.

ID # 315655

AUG 13 2001

*John B. Payne*  
JOHN B. PAYNE, D.O.  
RESPONDENT

STATE OF Texas  
COUNTY OF Tarrant

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BEFORE ME, the undersigned Notary Public, on this day personally appeared JOHN B. PAYNE, D.O., known to me to be the person whose name is subscribed to this instrument, an Agreed Order, and who after being by me duly sworn, on oath, stated that he executed the same for all purposes expressed therein.

Given under my hand and official seal and office this 10<sup>th</sup> day of August, 2001.



*Ellen Jean Wallace*  
Signature of Notary Public  
Ellen Jean Wallace  
Printed or typed name of Notary Public  
My commission expires: \_\_\_\_\_

SIGNED AND ENTERED by the presiding officer of the Texas State Board of Medical Examiners on this 7th day of September 2001.

*Les S. Anderson*  
Les S. Anderson, President  
Texas State Board of Medical Examiners

IN THE MATTER OF  
THE LICENSE OF  
JOHN B. PAYNE, D.O.

H-5943

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BEFORE THE  
TEXAS STATE BOARD  
OF MEDICAL EXAMINERS

AGREED ORDER

On this the 7th day of December, 2001, came on to be heard before the Texas State Board of Medical Examiners ("the Board" or "the Texas Board"), duly in session the matter of the license of John B. Payne, D.O. ("Respondent"). On October 26, 2001, Respondent appeared in person with counsel, Jeffrey Grass, at an Informal Settlement Conference/Show Compliance Proceeding in response to a letter of invitation from the staff of the Board. Mari Robinson represented Board Staff.

The Board was represented at the Informal Settlement Conference/Show Compliance Proceeding by Lee S. Anderson, M.D., a member of the Board, and Larry Price, D.O., a member of the Board. Upon recommendation of the Board's representatives, and with the consent of Respondent, the Board makes the following findings of fact and conclusions of law and enters this Order as set forth herein:

FINDINGS OF FACT

1. Respondent, John B. Payne, D.O., holds Texas medical license H-5943.
2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice that may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied under TEX. OCC. CODE ANN. Subtitle B (Vernon 2000) (hereinafter the "Act").
3. By entering into this agreed order, Respondent waives any defect in the notice and any further right to notice and hearing under the Act, TEX. GOV'T CODE ANN. §§2001.051 - .054, and the Rules of the State Board of Medical Examiners.
4. Respondent is fifty-four (54) years of age.
5. Respondent is a board certified neurosurgeon.
6. Respondent was subject to a disciplinary action at Plaza Medical Center of Ft. Worth effective May 7, 1999.

7. Respondent failed to report this action to North Hills Hospital at the time this action was taken.

8. Additionally, on his June 22, 1999 Reappointment Application to North Hills Hospital, Respondent was asked if his privileges had been "suspended, diminished, revoked, not renewed, voluntary or involuntary relinquished or allowed to lapse" at any hospital. The Respondent did not report the action at Plaza Medical Center.

9. The Medical Executive Committee of North Hills Hospital investigated this matter and based on its investigation recommended that the Respondent's medical staff membership and privileges be revoked. This recommendation was approved by the Board of Trustees.

10. The Respondent states that at the time he answered the inquiry in question, he believed that he answered it correctly. He did not think that the actions taken at Plaza Medical Center fell within the scope of the inquiry.

#### CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Board concludes the following:

1. Respondent is subject to disciplinary action pursuant to Section 164.051(a)(7) of the Act by being removed, suspended, or subject to disciplinary action taken by Respondent's peers in a local, regional, state or national professional medical association or society; or is disciplined by a licensed hospital or medical staff of a hospital, including removal, suspension, limitation of hospital privileges, or other disciplinary action.

2. Section 164.002(a) of the Act authorizes the Board to resolve and make a disposition of this matter through an Agreed Order.

3. Sections 165.001 and 165.003 of the Act authorize the Board to impose a monetary administrative penalty not to exceed five thousand dollars (\$5,000.00) for each separate violation of the Act or Board rule by a person licensed or regulated under the Act.

4. Section 164.002(d) of the Act provides that this Agreed Order is a settlement agreement under the Texas Rules of Evidence for purposes of civil litigation.

## ORDER

Based on the above Findings of Fact and Conclusions of Law, the Board ORDERS that:

1. Respondent shall pay an administrative penalty in the amount of one thousand dollars (\$1000.00) within ninety (90) days of the signing of this Order by the presiding officer of the Board.

2. The administrative penalty shall be paid in a single payment by cashier's check or money order payable to the Texas State Board of Medical Examiners and shall be submitted to the Director of Compliance for the Board for routing so as to be remitted to the Comptroller of Texas for deposit in the general revenue fund.

3. Respondent's failure to pay the administrative penalty as ordered shall constitute unprofessional and dishonorable conduct that is likely to deceive or defraud the public and shall constitute grounds for further disciplinary action by the Board as provided for in the Act, and may result in a referral by the Executive Director of the Board for collection by the Office of the Attorney General.

4. Respondent shall comply with all the provisions of the Act and other statutes regulating the Respondent's practice.

5. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within ten (10) days of the address change. This information shall be submitted to the Verification Department and the Director of Compliance for the Board. Failure to provide such information in a timely manner shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

6. Any violation of the terms, conditions, or requirements of this Order by Respondent shall constitute unprofessional conduct likely to deceive or defraud the public, and to injure the public, and shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

RESPONDENT WAIVES ANY FURTHER HEARINGS OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED ORDER. RESPONDENT AGREES THAT THIS IS A FINAL ORDER.

THIS ORDER IS A PUBLIC RECORD.

I, JOHN B. PAYNE, D.O., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: 11/15, 2001.

*John B. Payne*  
JOHN B. PAYNE, D.O.  
RESPONDENT

STATE OF Texas  
COUNTY OF Tarrant

§  
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BEFORE ME, the undersigned Notary Public, on this day personally appeared JOHN B. PAYNE, D.O., known to me to be the person whose name is subscribed to this instrument, an Agreed Order, and who after being by me duly sworn, on oath, stated that he executed the same for all purposes expressed therein.

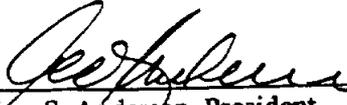
Given under my hand and official seal and office this 15<sup>th</sup> day of November, 2001.



*Ellen Jean Wallace*  
Signature of Notary Public

Ellen Jean Wallace  
Printed or typed name of Notary Public  
My commission expires: \_\_\_\_\_

SIGNED AND ENTERED by the presiding officer of the Texas State Board of Medical  
Examiners on this 7th day of December 2001.

  
\_\_\_\_\_  
Lee S. Anderson, President  
Texas State Board of Medical Examiners



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS  
STATE BOARD OF OSTEOPATHIC MEDICINE  
P.O. BOX 2649  
HARRISBURG, PENNSYLVANIA 17105  
717-783-4858  
OSTEOPAT@PADOS.DOS.STATE.PA.US

FAX: (717) 787-7769  
WWW.DOS.STATE.PA.US

March 18, 2004

**CERTIFICATION AND ATTESTATION**

I, Gina Bittner, do attest that I am the Administrative Assistant and Custodian of Records for the State Board of Osteopathic Medicine (Board); that I have examined the records of the Board pertaining to John B. Payne, D.O.; and, that the enclosed Adjudication and Order is a true and correct copy.

Seal

A handwritten signature in cursive script that reads "Gina Bittner".

Gina Bittner  
Administrative Assistant/Custodian of Records  
State Board of Osteopathic Medicine

OHIO STATE MEDICAL BOARD

MAR 22 2004

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BEFORE THE STATE BOARD OF OSTEOPATHIC MEDICINE

Commonwealth of Pennsylvania  
Bureau of Professional and  
Occupational Affairs

vs.

John Bruce Payne, D.O.  
Respondent

Docket No. 0267-53-2002  
File No. 01-53-07089

PROCESSED  
2012 OCT -2 11:11:21  
Department of State

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ADJUDICATION AND ORDER

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124 Pine Street Suite 200  
Harrisburg, PA 17105

Joyce McKeever  
Hearing Examiner

OHIO STATE MEDICAL BOARD

MAR 22 2004

## HISTORY

On March 4, 2002, the Commonwealth by Elena R. Morgan, prosecuting attorney, filed an Order to Show Cause against John Bruce Payne, D.O. (Respondent), alleging that Respondent violated Section 15(a) of the Osteopathic Medical Practice Act (Act), Act of October 5, 1978, P.L. 1109, *as amended*, 63 P.S. §271.15(a)(4), by having disciplinary action taken against his license to practice as a physician by a proper licensing authority in Texas.

Respondent filed a timely answer, in which he denied that his license to practice as a physician in Texas was subject to disciplinary action by the authorities of that state.

Respondent requested a hearing to defend against the allegations.

On March 25, 2002, the State Board of Osteopathic Medicine (Board) issued an order delegating the case to a hearing examiner for further proceedings in accordance with Sections 902 through 905 of the former Health Care Services Malpractice Act, Act of October 15, 1975, P.L. 390, *as amended*, 40 P.S. §§1301.901-905.<sup>1</sup>

A hearing was held before a Board hearing examiner on June 18, 2002. Respondent was present and was represented by Jeffrey C. Grass, Esquire. At the conclusion of the hearing the Commonwealth requested and was granted an additional 10 days to serve and file any national practitioner data bank record of the disciplinary action. No record was filed. Thereafter, the parties filed post-hearing briefs in accordance with a briefing scheduled ordered at the hearing.

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<sup>1</sup> Section 5107 of the Medical Care Availability and Reduction of Error (Mcare) Act, Act No. 13 of 2002 continued orders issued under the former act.

## FINDINGS OF FACT

1. Respondent holds a license to practice medicine in the Commonwealth at No. OS-004504-L; the license is currently renewed to October 31, 2002. (Board Records)
2. Respondent received a notice and order to show cause issued against him in this matter at his address of record with the Board at 4001 Stonehaven Drive, Colleyville, Texas 76034. (Answer, Board Records)
3. Respondent filed an answer to the show cause order. (Record)
4. On September 7, 2001, the Texas State Board of Medical Examiners ("Texas Board") entered an Agreed Order *In the Matter of the License of John B. Payne, D.O.*, H-5943. (Exhibit C-1, Exhibit 1)
5. In the Order, the Texas Board imposed a \$1,000 administrative penalty based upon an agreed finding of fact that Respondent engaged in unprofessional conduct by denying that he was the subject of a disciplinary action in a Medical Practice Questionnaire dated August 17, 1999 when in fact his medical privileges at two health care facilities had been subject to disciplinary action in 1997 and 1999. (*Id.*)
6. Respondent submitted a corrected Medical Practice Questionnaire on April 17, 2000 to the Texas Board. (*Id.*)

CONCLUSIONS OF LAW

1. The Board has jurisdiction in this matter. (Finding of Fact No. 1)
2. Respondent was given notice of the charge against him and an opportunity to be heard in accordance with the Administrative Agency Law, 2 Pa. C.S. §504. (Finding of Fact No. 2)
3. Respondent is subject to disciplinary action against his license to practice medicine in the Commonwealth by having his license to practice medicine subject to the imposition of an administrative fine by the Texas State Board of Medical Examiners. (Findings of Fact Nos. 4-6)

## DISCUSSION

Section 15(a) of the Osteopathic Medical Practice Act, 63 P.S. §422.15(a)(4), provides that:

“The board shall have authority to impose disciplinary or corrective measures on a board-regulated practitioner for any and all of the following reasons:

....

- (4) Having a license to practice osteopathic medicine and surgery revoked or suspended or having other disciplinary action taken...by a proper licensing authority of another state....”

In his answer and at the hearing, Respondent disputed the assertion that the administrative fine imposed by the Texas Board is a disciplinary action under the Act. In Respondent's post-hearing brief Respondent reiterated his argument that the Texas action was an administrative fine or penalty rather than a disciplinary action. Respondent notes that the Commonwealth has not filed a report from the National Practitioner Data Bank on the action by the Texas Board. The Respondent essentially asks that a negative inference be drawn by the failure of the Commonwealth to produce the report.

Respondent testified that the administrative penalty resulted from inadvertence in completing a Board questionnaire incident to an investigation by the Texas Board. Thus, he argues the penalty concerned Board administration and enforcement and was not related to patient care.

The Commonwealth in its post-hearing brief argues that Section 11(c) of the Act, 63 P.S. § 271.11(c), authorizing the Board to impose a civil penalty should be construed in

pari materia with Section 15 authorizing the Board to impose disciplinary or corrective measures on a Board-regulated practitioner. The Commonwealth cites to provisions of the Texas Occupational Code which treat an administrative fine in its consequence and effect in the same manner as other disciplinary actions. Finally, the Commonwealth cites *Blunket v. State ex rel. Missouri State Board of Registration of the Healing Arts*, 787 S.W. 2d 882 (MO App. 1990) should be construed in its nontechnical sense "with a view toward suppressing the wrongs undertaken to be remedied."

As noted in the seminal decision of *Johnston v. State Board of Medical Education and Licensure*, 410 A.2d 103 (Pa. Cmwlth. 1980), recently affirmed by the Court in *Tandon v. State Board of Medicine*, 705 A.2d 1338 (Pa. Cmwlth. 1997) the purpose of imposing reciprocal discipline is to allow the Pennsylvania Board to act swiftly upon official verification of disciplinary action in another state in order to protect and safeguard patient safety within the Commonwealth. Maintaining a current license in Pennsylvania authorizes the physician to practice medicine and surgery in the Commonwealth for the biennial registration period.

The purpose of the disciplinary provision of the Act, as well as similar provisions in other professional licensing laws, is to deter wrongful conduct by licenses and to impose an appropriate sanction where a violation is found. Although many disciplinary provisions concern patient care, others relate to the general duties of a licensee to adhere to ethical standards and to comply with enforcement provisions of a licensing law. For these reasons, the hearing examiner finds that the position of the Commonwealth is persuasive as to the meaning of the term "disciplinary action" under Pennsylvania law. Further, the arguments of Respondent seem more

appropriate to the question of the appropriate sanction, rather than the authority to act.

The Respondent testified that he objected to paying a civil penalty to the Pennsylvania Board for an infraction that was, upon examination of the underlying details, a technical violation for not filling out a form properly." He further testified: "I don't feel I should have to pay a fine. I feel I've been punished enough....I think if you look at the facts ...it would be unfair or a little harsh for [Pennsylvania] to report me to the National Data Bank and to make me pay a fine for such a minimal situation." (N.T. 19)<sup>2</sup>

In this case, the Respondent was subject to a \$1,000 "administrative penalty" for an act which the Texas Board characterized as unprofessional conduct. The hearing examiner also notes that Respondent maintains a license in Pennsylvania. However, he has practiced in Texas since 1985 and last practiced in the Commonwealth as a resident.

The hearing examiner finds that the evidence in this case warrants an action which mirrors the Texas action, but the imposition of a lesser civil penalty. Accordingly, the following Order shall issue.

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<sup>2</sup> Although Respondent thinks the penalty too harsh, he does not say what penalty he thinks would be appropriate. Obviously, imposing no penalty where a violation is found would be justified only in the most extraordinary circumstances not present here.

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BEFORE THE STATE BOARD OF OSTEOPATHIC MEDICINE

Commonwealth of Pennsylvania:  
Bureau of Professional and  
Occupational Affairs

vs.

John Bruce Payne, D.O.,  
Respondent

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Docket No. 0257-53-2002  
File No. 01-53-07089

ORDER

And now, this 30<sup>th</sup> day of September, 2002, based upon the foregoing Findings of Fact, Conclusions of Law, and Discussion, the hearing examiner for the State Board of Osteopathic Medicine, hereby orders that the license of John Bruce Payne, D.O., at No. OS-004504-L, be and the same hereby is **SUBJECT TO A REPRIMAND.**

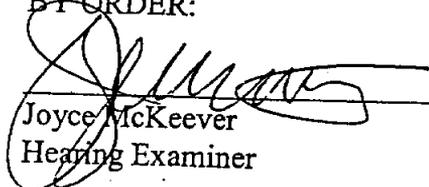
Respondent is also assessed a civil penalty of \$500, payable by certified or attorney's check or money order to the "Commonwealth of Pennsylvania—State Board of Osteopathic Medicine" due in accordance with the attached notice and mailed to Board Counsel, State Board

OHIO STATE MEDICAL BOARD

MAR 22 2004

of Osteopathic Medicine, P.O. Box 2649, Harrisburg, PA 17105-2649.

BY ORDER:

  
Joyce McKeever  
Hearing Examiner

Respondent's Attorney:

Jeffrey C. Grass, Esquire  
8204 Elmbrook Drive  
Suite 211  
Dallas, Texas 75247

Prosecuting Attorney:

Elena R. Morgan, Esquire  
P.O. Box 2649  
Harrisburg, PA 17105-2649

Date of Mailing: 10/2/02

OHIO STATE MEDICAL BOARD

MAR 22 2004

# FILED

April 17, 2003

**NEW JERSEY STATE BOARD  
OF MEDICAL EXAMINERS**

STATE OF NEW JERSEY  
DEPARTMENT OF LAW & PUBLIC SAFETY  
DIVISION OF CONSUMER AFFAIRS  
BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE LICENSE OF	:	Administrative Action
	:	
JOHN PAYNE, D.O.	:	
License No: MB38343	:	
	:	
	:	FINAL ORDER
	:	OF DISCIPLINE
TO PRACTICE MEDICINE AND SURGERY	:	
IN THE STATE OF NEW JERSEY	:	
	:	
	:	

This matter was opened to the New Jersey State Board of Medical Examiners upon receipt of information which the Board has reviewed and on which the following preliminary findings of fact and conclusions of law are made;

## FINDINGS OF FACT

1. On or about September 7, 2001 Respondent entered into an Agreed Order with the Texas Board of Medical Examiners ("The Texas Board"). The Texas Board determined that Respondent had engaged in unprofessional conduct that is likely to deceive or defraud the public or injure the public by failing to disclose to the Board on

**"CERTIFIED TRUE COPY"**

his Medical Practice Questionnaire that he was the subject of hospital disciplinary action in May 1999.

2. More specifically, the Agreed Order stated that effective May 7, 1999, Respondent had been the subject of disciplinary action at Plaza Medical Center of Fort Worth. The agreed Order further stated that on May 28, 1987 Respondent was also the subject of a disciplinary action by Harris Methodist H.E. B.

3. The Agreed Order further stated that Respondent answered "No" to question 4 when he completed his Medical Practice Questionnaire dated August 17, 1999 which states, "Have you ever had your medical privileges monitored, revoked, suspended, limited or denied by any organization, health care facility, or excluded from participation in any federal or state reimbursement program?"

4. On August 10, 2001, Respondent voluntarily signed the Agreed Order which was entered by the Texas Board on September 7, 2001. The Agreed Order provided for the payment of an administrative penalty in the amount of one thousand dollars within ninety (90) days of the signing of the Order by the presiding officer of the Board.

5. Thereafter, on or about December 7, 2001, Respondent entered into a second Agreed Order for failing to report to North Hills Hospital the May 7, 1999 disciplinary action taken by Plaza Medical Center of Fort Worth at the time the action was taken.

6. The Texas Board also found that on or about June 22, 1999 Respondent did not report the disciplinary action taken at Plaza Medical Center when asked on his reappointment application if his privileges had been "suspended, diminished, revoked, not renewed, voluntary or involuntary relinquished or allowed to lapse" at any hospital.

7. Respondent stated that at the time he answered the question he believed he answered the inquiry question correctly. He stated that he did not think the actions taken at Plaza Medical Center fell within the scope of the inquiry.

8. As a result, there was an investigation by the Medical Executive Committee of North Hills Hospital. Based on the investigation the Committee recommended the revocation of Respondent's medical staff membership and privileges. The Hospital Board of Trustees approved that recommendation.

9. As a consequence, on November 15, 2001 Respondent voluntarily signed a second Agreed Order which was entered by the Texas Board on December 7, 2001 requiring Respondent to pay an administrative penalty in the amount of one thousand dollars within ninety (90) days of the signing of the Order by the presiding officer of the Texas Board.

### CONCLUSIONS OF LAW

The above-described Texas action provides grounds to take disciplinary action against Respondent's license to practice medicine and surgery in New Jersey because the Texas Board made findings of conduct which would be violative of New Jersey law pursuant to N.J.S.A. 1-21(b) and (e). Furthermore, the Agreement constitutes an admission of the conduct in that his consent to these findings is tantamount to an admission.

### DISCUSSION ON FINALIZATION

Based on the foregoing findings and conclusions, a Provisional Order of Discipline ("POD") was entered by this Board on March 22, 2002, and served upon Respondent. The POD was subject to finalization by the Board at 5:00 PM on the 30<sup>th</sup> business day following entry unless Respondent requested a modification or dismissal of the stated Findings of Fact or Conclusions of Law by submitting a written request for modification or dismissal setting forth in writing any and all reasons why said findings and conclusions should be modified or dismissed and submitting any and all documents or other written evidence supporting Respondent's request for consideration and reasons therefor.

Respondent submitted a response dated April 1, 2002, wherein he requested a dismissal of the Findings of Fact contained in the Provisional Order. Respondent did not dispute the Board's findings

that he had been subject to disciplinary action by Plaza Medical center of Forth Worth on May 7, 1999 and by Harris Methodist H.E.B. on May 28, 1997. However, Respondent provided explanation that in both matters he was exonerated of wrongdoing after an investigation by the Texas Board. Respondent also acknowledged that he received a \$1000 administrative fine because he neglected to record the Harris Methodist H.E.B. case on State forms. Respondent stated that this omission was a mere technicality, and unintentional as the Texas Board already knew about the action but imposed a fine to maintain its position requiring full disclosure.

Regarding the revocation of his privileges at Plaza Medical Center in Fort Worth, Respondent stated that he was suddenly notified that he would be required to have 12 consults or second opinions to continue on staff at that location. In light of this new requirement, Respondent decided to quit and rely on the State to investigate and exonerate him.

Regarding his termination from North Hills Hospital, respondent stated that he was the recipient of unfair and malicious treatment, and that many of the physicians at Harris Methodist H.E.B. are on staff at North Hills Hospital and that this may have been a factor contributing to his poor reputation at that hospital.

Respondent's submissions were reviewed by the Board and the Board determined that further proceedings were not necessary as no material discrepancies had been raised. The Board was unpersuaded

by Respondent's arguments that he had been unfairly treated and that the Texas Board had exonerated him of wrongdoing with regard to his disciplinary actions at the two hospitals. The Board found that Respondent's failure to disclose disciplinary action to the Texas Board on the Medical Practice Questionnaire, as well as to North Hills Hospital was sufficient grounds for the Board to reprimand Respondent pursuant to N.J.S.A. 45:1-21(b) and (e). Moreover, pursuant to N.J.S.A. 45:9-19.16 and N.J.A.C. 13:35-6.19(c)2,3, Respondent was required to notify the New Jersey Board of Medical Examiners of action taken against his license by any other state licensing board and any action affecting his privilege to practice by any out of state hospital. As such, the Board found that there was sufficient grounds to reprimand Respondent for his failure to disclose the disciplinary actions as discussed herein.

ACCORDINGLY, IT IS on this 17th day of April, 2003

ORDERED that:

1. Respondent be and hereby is reprimanded.
2. Prior to resuming active practice in New Jersey, Respondent shall be required to appear before the Board (or a committee thereof) to demonstrate fitness to resume practice, and any practice in this State prior to said appearance shall constitute grounds for a charge of unlicensed practice. In addition, the board reserves the right to place restrictions on Respondent's practice should his license be reinstated.

NEW JERSEY STATE BOARD OF  
MEDICAL EXAMINERS

*William V. Harrer M.D. B.L.D.*

By:

\_\_\_\_\_  
William V. Harrer, M.D., B.L.D.  
Board President

DAVID SAMSON  
ATTORNEY GENERAL OF NEW JERSEY  
Division of Law 5th Floor  
124 Halsey Street  
P.O. Box 45029  
Newark, New Jersey 07101  
Attorney for the Board of Medical Examiners

**FILED**

March 22, 2002

**NEW JERSEY STATE BOARD  
OF MEDICAL EXAMINERS**

By: Joyce Brown  
Deputy Attorney General  
Tel. (973) 648-2975

STATE OF NEW JERSEY  
DEPARTMENT OF LAW & PUBLIC SAFETY  
DIVISION OF CONSUMER AFFAIRS  
BOARD OF Medical Examiners

IN THE MATTER OF THE SUSPENSION  
OR REVOCATION OF THE LICENSE OF

John Bruce Payne, D.O.

License No. MB38343

TO PRACTICE MEDICINE AND SURGERY:  
IN THE STATE OF NEW JERSEY

Administrative Action

PROVISIONAL ORDER  
OF DISCIPLINE

This matter was opened to the New Jersey State Board of Medical Examiners upon receipt of information which the Board has reviewed and on which the following preliminary findings of fact and conclusions of law are made;

FINDINGS OF FACT

1. Respondent, John Bruce Payne, D.O., License No. MB38343, is a physician licensed in the state of New Jersey and has been a licensee at all times relevant hereto. On or about July 1, 1999, Respondent elected to place his New Jersey license on inactive status.
2. On or about September 7, 2001 Respondent entered into an Agreed Order with the Texas Board of Medical Examiners ("The Texas Board"). The Texas Board determined that Respondent had engaged in unprofessional conduct that is likely to deceive or defraud the

**"CERTIFIED TRUE COPY"**

- public or injure the public by failing to disclose to the Board on his Medical Practice Questionnaire that he was the subject of hospital disciplinary action in May 1999.
3. More specifically, the Agreed Order stated that effective May 7, 1999, Respondent had been the subject of disciplinary action at Plaza Medical Center of Fort Worth. The agreed Order further stated that on May 28, 1987 Respondent was also the subject of a disciplinary action by Harris Methodist H.E. B.
  4. The Agreed Order further stated that Respondent answered "No" to question 4 when he completed his Medical Practice Questionnaire dated August 17, 1999 which states, "Have you ever had your medical privileges monitored, revoked, suspended, limited or denied by any organization, health care facility, or excluded from participation in any federal or state reimbursement program?"
  5. On August 10, 2001, Respondent voluntarily signed the Agreed Order which was entered by the Texas Board on September 7, 2001. The Agreed Order provided for the payment of an administrative penalty in the amount of one thousand dollars within ninety (90) days of the signing of the Order by the presiding officer of the Board.
  6. Thereafter, on or about December 7, 2001, Respondent entered into a second Agreed Order for failing to report to North Hills Hospital the May 7, 1999 disciplinary action taken by Plaza Medical Center of Fort Worth at the time the action was taken.
  7. The Texas Board also found that on or about June 22, 1999 Respondent did not report the disciplinary action taken at Plaza Medical Center when asked on his reappointment application if his privileges had been "suspended, diminished, revoked, not renewed, voluntary or involuntary relinquished or allowed to lapse" at any hospital.
  8. Respondent stated that at the time he answered the question he believed he answered the inquiry question correctly. He stated that he did not think the actions taken at Plaza Medical Center fell within the scope of the inquiry.

9. As a result, there was an investigation by the Medical Executive Committee of North Hills Hospital. Based on the investigation the Committee recommended the revocation of Respondent's medical staff membership and privileges. The Hospital Board of Trustees approved that recommendation.
10. As a consequence, on November 15, 2001 Respondent voluntarily signed a second Agreed Order which was entered by the Texas Board on December 7, 2001 requiring Respondent to pay an administrative penalty in the amount of one thousand dollars within ninety (90) days of the signing of the Order by the presiding officer of the Texas Board.

CONCLUSIONS OF LAW

1. The above-described Texas action provides grounds to take disciplinary action against Respondent's license to practice medicine and surgery in New Jersey because the Texas Board made findings of conduct which would be violative of New Jersey law pursuant to N.J.S.A. 45:1-21 (b) and (e). Furthermore, the Agreement constitutes an admission of the conduct in that his consent to these findings is tantamount to an admission.

ACCORDINGLY, IT IS on this 22nd day of March, 2002

ORDERED that:

1. Respondent be and hereby is reprimanded.
2. The within Order shall be subject to finalization by the Board at 5:00 p.m. on the 30<sup>th</sup> business day following its filing unless Respondent requests a modification or dismissal of the above stated Findings of Fact or Conclusions of Law by:

- a) Submitting a written request for modification or dismissal to William Roeder Executive Director, State Board of Medical Examiners P.O. Box 183, Trenton, New Jersey 08625-0183.
- b) Setting forth in writing any and all reasons why said findings and conclusions should be modified or dismissed.

- c) Submitting any and all documents or other written evidence supporting Respondent's request for consideration and reasons therefore or in mitigation of the penalty proposed,
3. Any submissions will be reviewed by the Board, and the Board will thereafter determine whether further proceedings are necessary. If no material discrepancies are raised through the submission by Respondent during the thirty-day period, or if the Board is not persuaded that the submitted materials merit further consideration, a Final Order of Discipline will be entered.
4. In the event that Respondent's submissions establish a need for further proceedings, including, but not limited to, an evidentiary hearing, Respondent shall be notified with regard thereto. In the event that an evidentiary hearing is ordered, the preliminary findings of fact and conclusions of law contained herein shall serve as notice of the factual and legal allegations in such proceeding.

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

By   
William V. Harrer, M.D., B.L.D.  
Board President

IN THE MATTER OF  
THE LICENSE OF  
JOHN B. PAYNE, D.O.

H-5943

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BEFORE THE  
TEXAS STATE BOARD  
OF MEDICAL EXAMINERS

AGREED ORDER

On this the 7th day of December 2001, came on to be heard before the Texas State Board of Medical Examiners ("the Board" or "the Texas Board"), duly in session the matter of the license of John B. Payne, D.O. ("Respondent"). On October 26, 2001, Respondent appeared in person with counsel, Jeffrey Grass, at an Informal Settlement Conference/Show Compliance Proceeding in response to a letter of invitation from the staff of the Board. Mari Robinson represented Board Staff.

The Board was represented at the Informal Settlement Conference/Show Compliance Proceeding by Lee S. Anderson, M.D., a member of the Board, and Larry Price, D.O., a member of the Board. Upon recommendation of the Board's representatives, and with the consent of Respondent, the Board makes the following findings of fact and conclusions of law and enters this Order as set forth herein:

FINDINGS OF FACT

1. Respondent, John B. Payne, D.O., holds Texas medical license H-5943.
2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice that may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied under TEX. OCC. CODE ANN. Subtitle B (Vernon 2000) (hereinafter the "Act").
3. By entering into this agreed order, Respondent waives any defect in the notice and any further right to notice and hearing under the Act, TEX. GOV'T CODE ANN. §§2001.051 - .054, and the Rules of the State Board of Medical Examiners.
4. Respondent is fifty-four (54) years of age.
5. Respondent is a board certified neurosurgeon.
6. Respondent was subject to a disciplinary action at Plaza Medical Center of Ft. Worth effective May 7, 1999.

7. Respondent failed to report this action to North Hills Hospital at the time this action was taken.

8. Additionally, on his June 22, 1999 Reappointment Application to North Hills Hospital, Respondent was asked if his privileges had been "suspended, diminished, revoked, not renewed, voluntary or involuntary relinquished or allowed to lapse" at any hospital. The Respondent did not report the action at Plaza Medical Center.

9. The Medical Executive Committee of North Hills Hospital investigated this matter and based on its investigation recommended that the Respondent's medical staff membership and privileges be revoked. This recommendation was approved by the Board of Trustees.

10. The Respondent states that at the time he answered the inquiry in question, he believed that he answered it correctly. He did not think that the actions taken at Plaza Medical Center fell within the scope of the inquiry.

#### CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Board concludes the following:

1. Respondent is subject to disciplinary action pursuant to Section 164.051(a)(7) of the Act by being removed, suspended, or subject to disciplinary action taken by Respondent's peers in a local, regional, state or national professional medical association or society; or is disciplined by a licensed hospital or medical staff of a hospital, including removal, suspension, limitation of hospital privileges, or other disciplinary action.

2. Section 164.002(a) of the Act authorizes the Board to resolve and make a disposition of this matter through an Agreed Order.

3. Sections 165.001 and 165.003 of the Act authorize the Board to impose a monetary administrative penalty not to exceed five thousand dollars (\$5,000.00) for each separate violation of the Act or Board rule by a person licensed or regulated under the Act.

4. Section 164.002(d) of the Act provides that this Agreed Order is a settlement agreement under the Texas Rules of Evidence for purposes of civil litigation.

## ORDER

Based on the above Findings of Fact and Conclusions of Law, the Board ORDERS that:

1. Respondent shall pay an administrative penalty in the amount of one thousand dollars (\$1000.00) within ninety (90) days of the signing of this Order by the presiding officer of the Board.
2. The administrative penalty shall be paid in a single payment by cashier's check or money order payable to the Texas State Board of Medical Examiners and shall be submitted to the Director of Compliance for the Board for routing so as to be remitted to the Comptroller of Texas for deposit in the general revenue fund.
3. Respondent's failure to pay the administrative penalty as ordered shall constitute unprofessional and dishonorable conduct that is likely to deceive or defraud the public and shall constitute grounds for further disciplinary action by the Board as provided for in the Act, and may result in a referral by the Executive Director of the Board for collection by the Office of the Attorney General.
4. Respondent shall comply with all the provisions of the Act and other statutes regulating the Respondent's practice.
5. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within ten (10) days of the address change. This information shall be submitted to the Verification Department and the Director of Compliance for the Board. Failure to provide such information in a timely manner shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.
6. Any violation of the terms, conditions, or requirements of this Order by Respondent shall constitute unprofessional conduct likely to deceive or defraud the public, and to injure the public, and shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

RESPONDENT WAIVES ANY FURTHER HEARINGS OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED ORDER. RESPONDENT AGREES THAT THIS IS A FINAL ORDER.

THIS ORDER IS A PUBLIC RECORD.

I, JOHN B. PAYNE, D.O., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: 11/15, 2001.

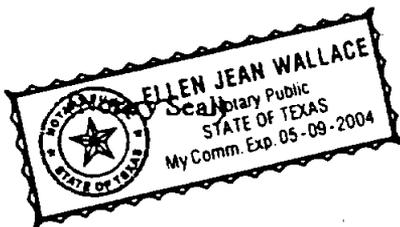
*John B. Payne*  
JOHN B. PAYNE, D.O.  
RESPONDENT

STATE OF Texas  
COUNTY OF Tarrant

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§

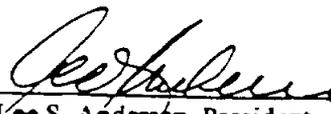
BEFORE ME, the undersigned Notary Public, on this day personally appeared JOHN B. PAYNE, D.O., known to me to be the person whose name is subscribed to this instrument, an Agreed Order, and who after being by me duly sworn, on oath, stated that he executed the same for all purposes expressed therein.

Given under my hand and official seal and office this 15<sup>th</sup> day of November, 2001.



*Ellen Jean Wallace*  
Signature of Notary Public  
Ellen Jean Wallace  
Printed or typed name of Notary Public  
My commission expires: \_\_\_\_\_

SIGNED AND ENTERED by the presiding officer of the Texas State Board of Medical  
Examiners on this 7<sup>th</sup> day of December 2001.

  
\_\_\_\_\_  
Lee S. Anderson, President  
Texas State Board of Medical Examiners

IN THE MATTER OF  
THE LICENSE OF  
JOHN B. PAYNE, D.O.

H-5943

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BEFORE THE  
TEXAS STATE BOARD  
OF MEDICAL EXAMINERS

AGREED ORDER

On this the 7th day of September, 2001, came on to be heard before the Texas State Board of Medical Examiners ("the Board" or "the Texas Board"), duly in session the matter of the license of John B. Payne, D.O. ("Respondent"). On June 21, 2001, Respondent appeared in person with counsel, Jeffrey Grass, at an Informal Settlement Conference/Show Compliance Proceeding in response to a letter of invitation from the staff of the Board. Mari Robinson represented Board Staff.

The Board was represented at the Informal Settlement Conference/Show Compliance Proceeding by Peter Chang, M.D., a member of the Board, and Buddy Siebenlist, M.D., a District Review Committee member. Upon recommendation of the Board's representatives, and with the consent of Respondent, the Board makes the following findings of fact and conclusions of law and enters this Order as set forth herein:

FINDINGS OF FACT

1. Respondent, John B. Payne, D.O., holds Texas medical license H-5943.
2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice that may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied under TEX. OCC. CODE ANN. Subtitle B (Vernon 2000) (hereinafter the "Act").
3. By entering into this agreed order, Respondent waives any defect in the notice and any further right to notice and hearing under the Act, TEX. GOV'T CODE ANN. §§2001.051 - .054, and the Rules of the State Board of Medical Examiners.
4. Respondent is fifty-four (54) years of age.
5. Respondent is a board certified neurosurgeon.
6. Respondent was subject to a disciplinary action at Plaza Medical Center of Ft. Worth effective May 7, 1999.

7. Respondent was the subject of discipline action by Harris Methodist H.E.B. on May 28, 1997.

8. Respondent answered "No" to question number 4 on his Medical Practice Questionnaire dated August 17, 1999, which states "Have you ever had your medical privileges monitored, revoked, suspended, limited or denied by any organization, health care facility, or excluded from participation in any Federal or State reimbursement program?"

9. After being questioned by the Board on this matter, Respondent submitted a corrected Medical Practice Questionnaire on April 17, 2000.

### CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Board concludes the following:

1. Respondent is subject to disciplinary action pursuant to Section 164.051(a)(1) of the Act based on Respondent's commission of an act prohibited under Section 164.052 of the Act. Specifically, Respondent has committed a prohibited act or practice within the meaning of, Section 164.052(a)(5) of the Act based upon unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.
2. Section 164.002(a) of the Act authorizes the Board to resolve and make a disposition of this matter through an Agreed Order.
3. Sections 165.001 and 165.003 of the Act authorize the Board to impose a monetary administrative penalty not to exceed five thousand dollars (\$5,000.00) for each separate violation of the Act or Board rule by a person licensed or regulated under the Act.
4. Section 164.002(d) of the Act provides that this Agreed Order is a settlement agreement under the Texas Rules of Evidence for purposes of civil litigation.

### ORDER

Based on the above Findings of Fact and Conclusions of Law, the Board ORDERS that:

1. Respondent shall pay an administrative penalty in the amount of one thousand dollars (\$1000.00) within ninety (90) days of the signing of this Order by the presiding officer of the Board.
2. The administrative penalty shall be paid in a single payment by cashier's check or money order payable to the Texas State Board of Medical Examiners and shall be submitted to

the Director of Compliance for the Board for routing so as to be remitted to the Comptroller of Texas for deposit in the general revenue fund.

3. Respondent's failure to pay the administrative penalty as ordered shall constitute unprofessional and dishonorable conduct that is likely to deceive or defraud the public and shall constitute grounds for further disciplinary action by the Board as provided for in the Act, and may result in a referral by the Executive Director of the Board for collection by the Office of the Attorney General.

4. Respondent shall comply with all the provisions of the Act and other statutes regulating the Respondent's practice.

5. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within ten (10) days of the address change. This information shall be submitted to the Verification Department and the Director of Compliance for the Board. Failure to provide such information in a timely manner shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

6. Any violation of the terms, conditions, or requirements of this Order by Respondent shall constitute unprofessional conduct likely to deceive or defraud the public, and to injure the public, and shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

RESPONDENT WAIVES ANY FURTHER HEARINGS OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED ORDER. RESPONDENT AGREES THAT THIS IS A FINAL ORDER.

THIS ORDER IS A PUBLIC RECORD.

I, JOHN B. PAYNE, D.O., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: August 10, 2001.

ID # 315655

AUG 13 2001

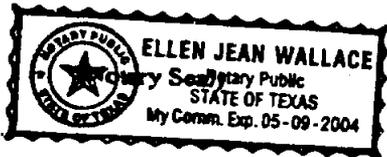
*John B. Payne*  
JOHN B. PAYNE, D.O.  
RESPONDENT

STATE OF Texas  
COUNTY OF Tarrant

§  
§  
§

BEFORE ME, the undersigned Notary Public, on this day personally appeared JOHN B. PAYNE, D.O., known to me to be the person whose name is subscribed to this instrument, an Agreed Order, and who after being by me duly sworn, on oath, stated that he executed the same for all purposes expressed therein.

Given under my hand and official seal and office this 10<sup>th</sup> day of August, 2001.



*Ellen Jean Wallace*  
Signature of Notary Public

Ellen Jean Wallace  
Printed or typed name of Notary Public  
My commission expires: \_\_\_\_\_

SIGNED AND ENTERED by the presiding officer of the Texas State Board of Medical Examiners on this 7th day of September, 2001.

*Les S. Anderson*  
Les S. Anderson, President  
Texas State Board of Medical Examiners