BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE LICENSE OF:

JEAN MARIE BARKER, M.D.

DETERMINATION AND ORDER

The above-titled matter came before the Mississippi State Board of Medical Licensure (hereinafter "Board") in Jackson, Hinds County, Mississippi, on January 21, 2021, pursuant to a Summons and Amended Affidavit issued to Jean Marie Barker, M.D. A quorum of Board members was present throughout the hearing and deliberation in the matter.

Board Counsel Stan Ingram, Esq., presented the charges as set forth in the Amended Affidavit. Licensee, having been served with the Summons and being fully informed of her rights to a formal hearing before the Board, was represented by Penny Lawson, Esq. The matter was called to hearing without objection from either party.

Alexis Morris, Esq., Special Assistant Attorney General, who served as Administrative Hearing Officer, presided at the hearing and was directed to prepare the Board's written decision in accordance with its deliberations.

And now, upon consideration of all the material produced in the record before the Board, along with the testimony presented at the hearing, the Board makes the following Findings of Fact, Conclusions of Law and Order based on clear and convincing evidence:

FINDINGS OF FACT

1. The Board is established pursuant to the Mississippi State Board Medical Licensure Act, Title 73, Chapter 43 of the Mississippi Code of 1972 as amended, and is charged with the duty of licensing and regulating the practice of medicine in the State of Mississippi pursuant to Title 73, Chapter 25 of the Mississippi Code of 1972 as amended

2. Sections 73-25-29, 73-25-83 and 73-25-87 of the Mississippi Code Annotated (1972) as amended provide that the Board may revoke or suspend a license or take any other actions as deemed necessary if a license has violated any provisions therein.

3. Jean Marie Barker M.D., hereinafter referred to as "Licensee," is a physician licensed to practice medicine in the State of Mississippi, currently holding License No.12431, said license is current through June 30, 2021. Licensee reports her area of practice to be Family Medicine. Licensee's medical practice is conducted at Jean Marie Barker, M.D., Family Practice, 1659 East Union Street, Greenville, Mississippi.

4. That a record check with the U.S. Drug Enforcement Administration (DEA) indicated that Licensee's Uniform Controlled Substance Registration Certificate No. AB1721542 was last renewed June 4, 2019. The expiration date is July 31, 2022. She is authorized in schedules II-V controlled substances.

5. The Board received a complaint from a Greenville area pharmacist on May 21, 2018, related to the prescribing practices of Licensee, inquiring whether she was operating an approved pain clinic. Two (2) other Greenville area pharmacists also voiced concern over Licensee's prescribing practices and the quantities of Methadone and Xanax she was prescribing to multiple patients. In response, prescription records were obtained from the Mississippi Prescription Monitoring Program (MPMP), a division of the Mississippi Pharmacy Board. Based on complaints received and review of controlled substances prescription records, approximately nine (9) patient records were obtained from Licensee, three (3) of which are the basis for the charges as hereinafter set forth.

PATIENT NO. 1

6. That on or about August 15, 2018, the Board received a complaint from a relative of one of Licensee's patients, hereinafter identified as Patient No. 1. The complaint alleged that Licensee's treatment of Patient No. 1 may have contributed to the August 20, 2016 overdose death of said patient. Based upon review of the patient records and prescriptions, Licensee treated Patient No. 1 from December 4, 2014 to August 15, 2016, the last clinical visit being five (5) days prior to the patient's death. During this period of time, Licensee issued to Patient No. 1 prescriptions for the following controlled substances and other medication:

20 prescriptions for approximately 1522 Methadone HCL 10 mg
13 prescriptions for approximately 785 Lyrica 300 mg with refills
1 prescription for approximately 62 Lyrica 150 mg
1 prescription for approximately 60 Lyrica 75 mg

7. In addition to the above, Licensee prescribed to Patient No. 1 non-controlled medications, including Prozac 20 mg, Promethazine 25 mg, Depakote 250 mg, Omeprazole 20 mg, Trazodone 50 mg, and Lithium 150 mg.

8. Patient No. 1, a 33-year old female, initially saw Licensee on December 4, 2014. The patient's chief complaint was as follows:

"The patient presents today with the complaint above, which is hip pain and bipolar disorder. She used to see Dr. Beauchamp. He gave her hip injections. Her hip was dislocated in a MVA. She is depressed and anxious"

Notwithstanding the above reference to treatment by a Dr. Beauchamp (should be "Beacham"), the medical record contains no documentation of prior treatment from Dr. Beacham or any other practitioners, and no diagnostic tests, studies, or imaging to support the diagnosis of "Hip & Thigh Injury Nos."

9. Entries in the patient record reveals that Patient No. 1 believed she was bipolar based on family history. In addition, Patient No. 1 acknowledged use of crack cocaine while being treated by Licensee. A history of cocaine (crystal meth) use as well as a history of bipolar disorder are both red flags for the potential misuse of medications. Notwithstanding, the patient record contains no referrals of Patient No. 1 for a psychiatric evaluation or consult.

10. Furthermore, the file contains no documented pain history. The pain is limited to just "Pain" with no specificity as to the location of the pain in the hip, any relieving or aggravating factors. Also, there was no documentation of any numerical pain scale. Throughout the medical records, a musculoskeletal physical examination was documented for each visit, but for the most part, the examinations were deemed normal, other than a few references to the patient's "limps". There was no documentation of tenderness, diminished hip range of motion etc. Other than reference to injections by "Dr. Beauchamp", there was no documentation of any nonpharmacologic trials of treatment for hip pain such as physical therapy.

11. Licensee described both Patient No. 1 and her boyfriend as drug abusers. Notwithstanding, only three (3) urine drug screens (UDS) were noted in the medical record, none of which were done during the first 16 months of treatment. Most notable, on June 16, 2016, a UDS was positive for methadone and cocaine. Licensee discontinued the methadone, stating that Patient No.1 "and her boyfriend were quite upset." However, one month later on July 15, 2016, when the patient presented for follow up, a UDS was again taken. Despite the methadone having been previously discontinued, the UDS was positive for methadone, being a red flag as to possible abuse. Instead of declining to provide more controlled substances, Licensee re-prescribed 60 methadone 10 mg, all based on the patient's promise not to abuse drugs again.

12. Patient No. 1's last visit to Licensee occurred on August 15, 2016. The medical record for this date makes no reference to whether a UDS was run. In response to the patient's complaint the "she is in a lot of pain," Licensee increased the dosage of Methadone 10mg from two (2) to three (3) times per day. The Board's medical expert opined that there was no medical justification for the increase in methadone dosage, such conduct deemed non-therapeutic and collectively outside the course of legitimate professional practice.

13. On August 20, 2018, just five (5) days after Licensee issued her last prescription for Patient No. 1 died. A coroner's report attributed death to polysubstance abuse. The Death

Certificate identified the cause of death as respiratory failure, renal failure, sepsis and multidrug overdose.

14. At all times wherein Licensee treated Patient No. 1, said patient was deemed to being treated for Chronic Pain as a term is defined at Title 30, Part 2640, Rule 1.7.A(1) of the *Rules and Regulations Pertaining to the Prescribing, Administering and Dispensing of Medication*. Based on the fact that Patient No. 1 was being treated for Chronic Pain, Licensee was required, yet failed to maintain a Pain Management Contract (same as an Informed Consent Agreement) as required by Rule 1.7(C)(3).

PATIENT NO. 2

15. Based on the medical record for Patient No. 2, said patient was a 35-year-old female initially treated by Licensee on July 25, 2013. For the purpose of the investigation and prescription analysis, a prescription profile was run via the Mississippi Prescription Monitoring Program (MPMP) for a four-year (47-month) period from date of initial visit on July 25, 2013 through June 20, 2017. Licensee terminated the patient on June 20, 2017, stating in the medical record, "I'm not going to see her back." During the approximate four (4) year period of time, Licensee issued to Patient No. 2 prescriptions for the following controlled substances and other medications:

12 prescriptions for approximately 660 Norco 7.5-325 mg
30 prescriptions for approximately 2090 Norco10-325 mg
1 prescription for approximately 30 Methadone HCL 10 mg
1 prescription for approximately 60 Suboxone 2mg-0.5 m SL Films

While the primary complaint was that of back pain, Patient No. 2 often requested narcotics (Norco) based on multiple complaints of pain originating from other sources, including, but not limited to tooth ache, neck pain, facial pain, headaches, eye pain, joint pain, "hurting all over", etc. Of particular significance was the fact that early on Licensee prescribed opioids (Norco) to Patient No. 2 over a period of almost six (6) months based on tooth aches, despite the patient's failure to see a dentist. The frequency and variation of the complaints, and repeated requests for more Norco was such as to put Licensee on notice of drug seeking behavior.

16. Based on the testimony of the medical expert, Dr. Andrew Watson, several concerns regarding Patient No 2 were noted. First, there was never a definitive diagnosis. The patient was noted to have mild scoliosis and the only attempt to render a definitive diagnosis was an entry in the file stating that the patient had back pain "probably from scoliosis." In addition to her complaints of back pain, the patient was noted to have a history of bipolar disorder and depression, which placed her in the high-risk category for abuse of opioids. There was no mention of any review of imaging or ordering of any imaging, including x-rays or MRI's to address the complaints of back pain.

17. The medical record for Patient No. 2 contains a number of warning letters from *SILVERxSCRIPT*, one of which, dated July 13, 2017, warned Licensee of the "unusual medication utilization patterns which may indicate possible drug overutilization and place them [Patient No. 2] at risk for drug induced adverse events." Notwithstanding, the medical record for Patient No. 2 contains no urine drug screens or results of the same. Furthermore, the file does not contain any reference to a Pain Management Contract (Informed Consent Agreement) as required by Board rules and regulations.

18. On June 9, 2017, Patient No. 2 presented to Licensee with a complaint of opioid withdrawal. The patient was requesting to start Suboxone. Pending pre-authorization, she was placed on methadone. However, authorization was thereafter received, and the patient was directed not to fill the Methadone. Patient No. 2 was directed to return on Monday (June 12, 2017) to start the Suboxone. Patient No. 2 failed to present as scheduled but did present June 20, 2017. At that time the patient had been requested that she bring her methadone back so she could be started on Suboxone. The Patient No. 2 claimed that she had flushed the methadone down the toilet. Licensee decided to discontinue use of controlled substances, citing that Patient No. 2 had been "less than honest" and was discharged. It was also noted in the medical record that Patient No.2 had been obtaining controlled substances from other health care providers. Despite Licensee's denial that Patient No. 2 was not a malingerer, the evidence produced during the hearing clearly revealed otherwise.

19. Notwithstanding the fact that Licensee ultimately discharged Patient No. 2, it was the undisputed opinion of the medical expert that there was a lack of any meaningful history, physical examination of abnormalities, imaging, lack of specialist consultation to properly address the patient's pain.

PATIENT NO. 3

20. The third patient record examined was a 33-year-old female initially treated by Licensee on August 24, 2006 with a diagnosis of depression, chronic anxiety and postpartum cardiomyopathy. An October 12, 2007 entry referring to said patient, states "she is thinking she might be bipolar". There was then an eight (8) year gap in treatment, during which time Patient No. 3 was diagnosed with Crohn's disease. Patient No. 3 returned to Licensee on October 24, 2016 with a stated complaint of chronic pain due to Crohn's disease. Licensee noted that the patient had been prescribed controlled substances (Norco and Buprenorphine) by other practitioners. Licensee then treated Patient No. 3 from October 24, 2016 until the doctor-patient relationship was terminated on or about June 19, 2019. During this period of time, Licensee issued to Patient No. 3 prescriptions for the following controlled substances:

31 prescriptions for approximately 2,220 Norco10-325 mg
31 prescriptions for approximately 2,790 Buprenorphine 8 mg SL
8 prescriptions for approximately 390 Alprazolam 1 mg
15 prescriptions for approximately 420 Alprazolam 0.5 mg
1 prescription for approximately 75 Clonazepam 1mg

21. Licensee diagnosed Patient No. 3 with polyarthralgia or polyarthritis secondary to Crohn's disease, despite the fact that on February 8, 2017, a local gastroenterologist described a colonoscopy of Patient No. 3 to be normal and then on January 3, 2018, the same gastroenterologist affirmatively advised Licensee that the patient did not then have Crohn's disease. Despite this, Licensee continued to concomitantly prescribe large quantities of opioids, benzodiazepines and buprenorphine to the patient. Although Patient No. 3 was referred to a physician for her pelvic pain complaints, there was no referral to a rheumatologist to address pain related to autoimmune arthritis. Under such circumstances, a rheumatology evaluation would be warranted.

22. There were approximately sixteen (16) reports or Urine Drug Screens (UDS) in the medical record of Patient No. 3. Greater than 75% of those drug screens were found to be inconsistent because of either absence of the prescribed medication or the presence of medications which were not prescribed by Licensee, including oxycodone and methadone.

23. There is also no clear documentation as to why Patient No. 3 was being treated via concomitant use of Buprenorphine, benzodiazepines and an opioid (Norco). According to the Board expert, the prescription pattern was consistent with non-therapeutic prescribing of controlled substances.

24. On multiple occasions, Licensee was put on notice of possible drug abuse and/or diversion by the patient, including but not limited to, acknowledging that she "took her husband's methadone" (July 17, 2018); stating that the patient's "drug storage container was stolen" prompting her to obtain narcotics "off the streets" (September 16, 2018) and Licensee having to direct the patient not to "peel the label off of her drug test when she takes it" (May 13, 2019). In addition, licensee received advisory notices or inquiries from pharmacies and insurance carriers inquiring as to the rationale for treating Crohn's disease with controlled substances and cautioning against the concomitant use of opioids and benzodiazepines.

25. Despite Licensee's denial that Patient No. 3 was not a malingerer, the evidence produced during the hearing clearly revealed otherwise. Licensee ultimately discharged Patient No. 3 due to the drug seeking behavior. Notwithstanding, it was the undisputed opinion of the medical expert that Licensee failed to properly manage the patient, which should have been either terminated or referred to a drug treatment facility much earlier.

CONCLUSIONS OF LAW

1. The Board has jurisdiction in this matter pursuant to Sections 73-25-29, and 73-25-83(a), Mississippi Code of 1972, as amended. Venue is likewise properly placed before the Board to hear this matter in Hinds County, Mississippi.

2. These proceedings were duly and properly convened, and all substantive and procedural requirements under law have been satisfied. This matter is, therefore, properly before the Board.

3. The Board is authorized to license and regulate persons who apply for or hold medical licenses and prescribe conditions under which persons may practice in order to protect the public health, safety and welfare.

4. Based on the evidence and testimony presented, Licensee is guilty of **Counts I, IV and VII** of the Amended Affidavit, that is, guilty of administering, dispensing or prescribing any narcotic drug, or any other drug having addiction-forming or addiction-sustaining liability, otherwise than in the course of legitimate professional practice, all in violation of Miss. Code Ann., § 73-25-29(3).

5. Based on the evidence and testimony presented, Licensee is guilty of **Counts II and V** of the Amended Affidavit, that is, guilty failing to maintain a Pain Management Contract (same as an Informed Consent Agreement) in violation of Title 30, Part 2640, Rule 1.7.C(3) Rules and Regulations Pertaining to the Prescribing, Administering and Dispensing of Medication, all in violation of Miss. Code Ann., §73-25-29(13).

6. Based on the evidence and testimony presented, Licensee is guilty of **Counts III, VI and VIII** of the Amended Affidavit, that is, guilty of unprofessional conduct, which includes, but is not limited to being guilty of any dishonorable or unethical conduct likely to deceive, defraud, or harm the public, all in violation of Miss. Code Ann., §73-25-29(8)(d) and §73-25-83(a).

Based upon the above Findings of Fact and Conclusions of Law, the Board finds the following order to be appropriate under the circumstances.

ORDER

IT IS THEREFORE ORDERED THAT Mississippi Medical license No. 12431, issued to Jean Marie Barker, M. D., is hereby indefinitely suspended.

IT IS FURTHER ORDERED that upon expiration of one (1) year from the date of this order, Licensee shall have the right, but not the obligation, to petition the Board for reinstatement and return to practice, provided that prior to such petition, Licensee shall have successfully completed, (1) a comprehensive clinical competency evaluation in the area of primary care and (2) a multidisciplinary psychiatric evaluation. As to both evaluations, the Board shall provide Licensee with a list of Board approved facilities. Licensee shall execute any and all releases so as to permit the Board to communicate with the facilities and receive directly from the facilities any and all evaluation results. Licensee shall adhere to all treatment and or training recommendations rendered by the aforementioned evaluation facilities.

IT IS FURTHER ORDERED that in the event in the event Licensee chooses to petition for reinstatement of license after expiration of the aforementioned one (1) year, Licensee shall personally appear before the Board and present a plan of practice, consistent with the findings and recommendations of the aforementioned evaluation facilities. Notwithstanding, the Board reserves the right and its sole and absolute discretion to impose any other restriction deemed necessary to protect the public.

IT IS FURTHER ORDERED that Licensee shall reimburse Board for all costs incurred in relation to the pending matter pursuant to Miss. Code Ann. Section 73-25-30. Licensee shall be advised of the total assessment, not to exceed $10,000, by written notification, and shall tender to the Board a certified check or money order within forty (40) days after the date the assessment is mailed to Licensee via US mail to Licensee's current mailing address.

IT IS FURTHER ORDERED that Licensee shall cooperate with the Board, its attorneys, investigators, and other representatives in the investigation and monitoring of Licensee's practice and compliance with the provisions of this Determination and Order.

IT IS FURTHER ORDERED that if Licensee violates the terms of this Determination and Order or further violates the laws, rules and regulations governing the practice of medicine, the Board may take further disciplinary action against Licensee, up to and including revocation of his license.

IT IS FURTHER ORDERED that this Determination and Order shall be public record. It may be shared with other licensing boards (in and out of state), and the public, and may be reported to the appropriate entities as required or authorized by state and/or federal law or guidelines. This action shall be spread upon the Minutes of the Board as its official act and deed.

SO ORDERED this, the 21st day of January, 2021.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

BY: Jeanne Ann Rea, MD, FASA
Jeanne Ann Rea, M.D., President