COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2019-036

In the Matter of

ADAM P. BECK, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Adam P. Beck, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket Nos. 17-298 and 18-199.

Findings of Fact

1. The Respondent was born in May 1974. He graduated from Loyola University of Chicago, Stritch School of Medicine in 1999 and is certified by the American Board of Ophthalmology.

2. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 217143 since May 7, 2003.

3. The Respondent has also been licensed to practice medicine in New Hampshire since February 2, 2005.

Factual Allegations

Reciprocal Discipline:

4. On October 6, 2017, the Respondent and the State of New Hampshire Board of Medicine ("NH Board") entered into a Settlement Agreement in which the Respondent admitted that if a disciplinary hearing were to take place, Hearing Counsel for the NH Board could present evidence upon which the NH Board could conclude that he engaged in professional misconduct.

5. Specifically, the Respondent admitted that by engaging in the following acts the NH Board could conclude that he was negligent:

a. The Respondent treated Patient A from September 2006 through January 7, 2013 for wet macular degeneration;

b. During the course of his treatment of Patient A he kept inadequate handwritten notes, which at times were illegible and contradicted by the electronic medical record ("EMR");

c. At no time during his treatment of Patient A did he consult with, or refer Patient A to, a glaucoma specialist;

d. Between September 2006 and October 2010, the Respondent administered four Intravitreal injections to Patient A's left eye. The frequency at which the Respondent administered these injections was outside the standard of care;

e. Between January 2011 and May 2011, the Respondent administered hot focal laser treatments to Patient A's left eye. His decision to use hot focal lasers in Patient A's case was outside the standard of care and resulted in the vision in her left eye rapidly deteriorating;

f. In July 2012, the Respondent diagnosed Patient A with wet macular degeneration in her right eye. He subsequently administered a number of injections into her right eye in a manner which was outside the standard of care;

g. The Respondent subsequently performed an unsuccessful surgery on Patient A's right eye which resulted in her suffering a retinal detachment; and

h. The Respondent performed a series of additional surgeries on Patient A in 2012 which were unsuccessful and resulted in her becoming functionally blind.

Patient B:

6. Patient B is a female born in 1934.

7. During 2015 and 2016, Patient B was under the care of the Respondent.

8. In 2016 Patient B saw the Respondent on four separate occasions between January and September for complaints of blurry vision in both eyes.

9. Between January and September 2016 the Respondent diagnosed Patient B with the following conditions: wet macular degeneration, primary open angle glaucoma, peripheral retinal degeneration, dry macular degeneration, posterior vitreous detachment, and glaucoma suspect.

10. On September 28, 2016 the Respondent performed an examination of Patient B's eyes and observed that she had 2+ nuclear scleroses (cataracts) in both eyes.

11. The Respondent failed to diagnose Patient B with having nuclear cataracts or note the diagnosis in her medical record along with all of his other diagnoses.

12. The Respondent failed to inform Patient B that she had nuclear cataracts.

13. The Respondent failed to advise Patient B of the available treatment options for nuclear cataracts and the risks and benefits of each.

14. Patient B learned that she had nuclear cataracts when she obtained a second opinion from a subsequent provider in November 2016.

15. The Respondent's treatment of Patient B fell outside the standard of care because he failed to properly diagnose Patient B with cataracts, record his diagnosis in the medical record, and inform Patient B of same.

16. At each of Patient B's appointments in 2016 the Respondent examined and recorded his observations of the fundus of Patient B's eyes.

17. On January 20, 2016 the Respondent noted that the fundus of both eyes had ischemia.

18. On February 10, 2016 the Respondent noted that the fundus of both eyes had multiple chorioretinal scars, bone spicules and ischemia.

19. On July 13, 2016, the Respondent again recorded in Patient B's medical record the presence of multiple chorioretinal scars in both of her eyes along with pigmentary changes.

20. On September 28, 2016, the Respondent noted that the fundus (periphery only) of both eyes appeared normal and had no tears, breaks, holes or masses.

21. The Respondent's notes regarding the results of the fundus examinations of the periphery are inconsistent and are insufficient to enable another health care provider to provide proper diagnosis and treatment as required by 243 C.M.R. 2.07(13)(a).

22. The Respondent's care of Patient B fell outside the standard of care because he failed to accurately document the fundus examinations.

23. The Respondent did not provide Patient B with a complete copy of her medical record as requested in writing on April 26, 2017 as required by 243 C.M.R. 2.07(13)(b).

Conclusion of Law

A. The Respondent has violated 243 CMR 1.03(5)(a)12, in that he has been disciplined in another jurisdiction in any way by the proper licensing authority for reasons substantially the same as those set forth in G.L. c. 112, § 5 or 243 CMR 1.03(5), specifically he has:

1. Engaged in conduct which places into question the physician's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions in violation of 243 CMR 1.03(5)(a)3; and
2. Failed to maintain adequate medical records in violation of 243 CMR 2.07(13)(a).

B. The Respondent has violated G.L. c. 112, § 5, eighth par. (c) and 243 CMR 1.03(5)(a)3 by engaging in conduct that places into question the Respondent's competence to practice medicine, including gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond

its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

C. The Respondent has violated 243 CMR 2.07(13)(a) by failing to maintain a medical record which is adequate to enable the licensee to provide proper diagnosis and treatment.

D. The Respondent has violated 243 CMR 2.07(13)(b) by failing to provide, upon a patient request, a copy of the patient's medical record to a patient, other licensee or other specifically authorized person, in a timely manner.

Sanction and Order

The Respondent is hereby reprimanded. The Respondent agrees that the following permanent practice restrictions will be placed on his Massachusetts license, certificate number 217143:

1. The Respondent shall not use a laser for any extrafoveal choroidal neovascular membrane treatment except in the limited circumstances in which such treatment is medically necessary; such justification is documented in the medical record; the benefits outweigh the risks; and reasonable and appropriate informed consent has been provided to the patient regarding the risks and benefits of the use of a laser, including the possibility of tissue destruction and vision loss; and

2. The Respondent shall not perform Intravitreal Kenalog injections on any glaucoma patients except in the limited circumstances in which such treatment is medically necessary; such justification is documented in the medical record; the benefits outweigh the risks; and reasonable and appropriate informed consent has been provided to the patient regarding the risks and benefits of the use of an intravitreal Kenalog injection, including the possibility of tissue destruction and vision loss; and

3. For a period of one year from the effective date of this Consent Order, in patients with glaucoma and wet macular degeneration in which either an intravitreal Kenalog injection or more than one incisional glaucoma surgical procedure in a six month period is deemed medically necessary, the Respondent shall document a physician to physician conversation with another ophthalmologist or glaucoma specialist in the medical record and shall abide by the judgment of such ophthalmologist or glaucoma specialist if it differs from his own; and;

4. Further, the Respondent agrees to a non-disciplinary practice audit by Lifeguard Services. The audit must include the following: 1) the evaluator must watch the Respondent operate for one day – the cases shall be picked by the evaluator; 2) the evaluator must watch the

Respondent at his clinical practice for one day ;; and 3) random chart review – charts picked by the evaluator. Should Lifeguard Services make any recommendations as a result of their audit, the Respondent shall then enter into a Board approved Probation Agreement for 5 years, including the standard terms, that incorporates all of the Lifeguard recommendations.

Execution of this Consent Order

Complaint Counsel, the Respondent, and the Respondent's counsel agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel, the Respondent, and the Respondent's counsel are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order, in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which he practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts

Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated for the duration of the permanent practice restriction and Probation Agreement, if applicable. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

Adam P. Beck, M.D.
Licensee

7/17/19
Date

Sean Capplis, Esq.
Attorney for the Licensee

signed by SMH
7/17/19
Date

Gloria Brooks, Esq.
Complaint Counsel

7/17/19
Date

So ORDERED by the Board of Registration in Medicine this 17 day of July, 2019.

Candace Lapidus Sloane, MD

Candace Lapidus Sloane, M.D.
Board Chair