

1 **BEFORE THE BOARD OF MEDICAL EXAMINERS**
2 **OF THE STATE OF NEVADA**

3 * * * * *

4 **In The Matter of Charges and**)
5)
6 **Complaint Against**)
7 **ROBERT FEINGOLD, M.D.,**)
8)
9 **Respondent.**)

Case No. 07-11221-1

FILED

MAR - 2 2011

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: *[Signature]*

10 **FIRST AMENDED COMPLAINT**

11 The Investigative Committee of the Board of Medical Examiners of the state of Nevada,
12 composed, at the time the filing of the First Amended Complaint was approved, of
13 Benjamin J. Rodriguez, M.D., Beverly A. Neyland, M.D., and Mr. Van V. Heffner, and by and
14 through Lyn E. Beggs, General Counsel for the Nevada State Board of Medical Examiners, having
15 a reasonable basis to believe that Robert Feingold, M.D., hereinafter referred to as "Dr. Feingold,"
16 has violated the provisions of NRS Chapter 630, hereby issues its formal First Amended
17 Complaint, stating the Investigative Committee's charges and allegations, as follows:
18

19 1. Dr. Feingold is currently licensed in active status (License No. 7916), and was
20 originally licensed on July 30, 1996, by the Nevada State Board of Medical Examiners, pursuant to
21 the provisions of Chapter 630 of the Nevada Revised Statutes.

22 2. The true identities of the patients at issue in the First Amended Complaint are not
23 disclosed to protect their privacy; however, their identities are disclosed in the Amended Patient
24 Designation served on Dr. Feingold along with a copy of this First Amended Complaint.

25 3. Dr. Feingold ran a weight loss clinic, Medical Reducing, Inc. in Las Vegas, Nevada
26 at all times alleged herein. Medical Reducing, Inc. has an on-site pharmacy, Medical Reducing
27 Pharmacy. Dr. Feingold also provided weight loss treatment for patients through Focus Medical
28 Group.

1 4. Patient A was a forty-year-old male at the time he first presented to Dr. Feingold at
2 Medical Reducing, Inc. on May 3, 2003. He was treated at Medical Reducing, Inc. for weight
3 reduction until June 25, 2004.

4 5. At the time of his initial presentation to Dr. Feingold, Patient A's weight was
5 reported as 239 pounds and he was 68 inches in height, giving him a Body Mass Index (BMI) of
6 36.4, considered obese and exceeding the upper limit of a healthy weight for Patient A by more
7 than 20 percent.

8 6. At the time of Patient A's initial presentation on May 3, 2003, the medical records
9 for Patient A indicate that Dr. Feingold performed a minimal and inadequate medical history and
10 physical. An EKG was performed, as well as lab work, which did not include any testing related to
11 thyroid function.

12 7. During the time that Patient A was treated at Medical Reducing, Inc., he was seen
13 approximately twenty- nine (29) times, and according to his chart, was seen by Dr. Feingold a total
14 of six times, during which minimal records were made regarding Patient A's treatment and care.
15 During the period that Patient A was seen at Medical Reducing, Inc., he was prescribed appetite
16 suppressants, specifically phentermine, and the medical records do not indicate that he was
17 provided with any further medical treatment for weight reduction nor was any type of exercise
18 program or behavior modification recommended. The medical records for Patient A are practically
19 illegible, extremely sparse and contain little information regarding his treatment and care at
20 Medical Reducing, Inc.

21 8. Patient A's lowest recorded weight while being treated at Medical Reducing, Inc.
22 was 220 pounds on August 15, 2003. On December 12, 2003, after a seven-week period in which
23 he was not seen at Medical Reducing, Inc., his weight was 246 pounds and at the time of his last
24 appointment on June 25, 2004, his weight was 244 pounds.

25 9. Patient A was not provided with any information regarding possible side effects,
26 dependency issues, or other possible adverse outcomes of taking the prescribed appetite
27 suppressants. All Patient A's prescriptions for phentermine were dispensed at Medical Reducing
28 Pharmacy.

1 10. Patient B was a thirty-three-year-old female at the time she initially presented to
2 Dr. Feingold at Medical Reducing, Inc. on August 14, 2003. She was treated at Medical Reducing,
3 Inc. for weight reduction and her last noted appointment was May 2, 2005.

4 11. At the time of her initial presentation to Dr. Feingold, Patient B weighed 218
5 pounds and was 65 inches in height, giving her a Body Mass Index (BMI) of 37.4, considered
6 obese and exceeding the upper limit of a healthy weight for Patient B by more than 20 percent.

7 12. At the time of Patient B's initial presentation, her medical records indicate that
8 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was
9 performed, as well as lab work, which did not include any testing related to thyroid function or to
10 test for pregnancy.

11 13. Between August 2003 and May 2005, Patient B was seen approximately twenty-
12 seven (27) times, and according to her chart, was seen by Dr. Feingold a total of five times, during
13 which minimal records were made regarding Patient B's treatment and care. During the period that
14 Patient B was seen at Medical Reducing, Inc., she was prescribed appetite suppressants,
15 specifically phentermine, and the medical records do not indicate that she was provided with any
16 further medical treatment for weight reduction nor was any type of exercise program or behavior
17 modification recommended. The records for Patient B are practically illegible and extremely
18 sparse and contain little information regarding her treatment.

19 14. Patient B's lowest recorded weight while treated at Medical Reducing, Inc. was 180
20 pounds on February 11, 2004. Patient B was sporadically seen between February 2004 and August
21 2005.

22 15. Patient B was not provided with any information regarding possible side effects,
23 dependency issues, the potential of birth defects in unborn children, or other possible adverse
24 outcomes, of taking the prescribed appetite suppressants. All of Patient B's prescriptions for
25 phentermine were dispensed at Medical Reducing Pharmacy.

26 16. Patient C was a twenty-six-year-old female at the time she initially presented to
27 Dr. Feingold at Medical Reducing, Inc. on January 2, 2004. She was treated at Medical Reducing,
28 Inc. for weight reduction until September 2005.

1 17. At the time of her initial presentation to Dr. Feingold, Patient C weighed 190
2 pounds and was 65 inches in height, giving her a Body Mass Index (BMI) of 31.6, considered
3 obese and exceeding the upper limit of a healthy weight for Patient C by more than 20 percent

4 18. At the time of Patient C's initial presentation, her medical records indicate that
5 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was
6 performed, as well as lab work, which did not include any testing related to thyroid function or to
7 test for pregnancy.

8 19. Between January 2005 and June 2005, Patient C was seen approximately twenty-
9 two (22) times at Medical Reducing, Inc., and according to her chart, was seen by Dr. Feingold a
10 total of four times, during which minimal records were made regarding Patient C's treatment and
11 care. During the period that Patient C was seen at Medical Reducing, Inc., she was prescribed
12 appetite suppressants, specifically phentermine, and her medical records do not indicate that she
13 was provided with any further medical treatment for weight reduction nor was any type of exercise
14 program or behavior modification recommended. The records for Patient C are practically illegible
15 and extremely sparse and contain little information regarding her treatment.

16 20. Patient C's lowest recorded weight while treated at Medical Reducing, Inc. was
17 166.5 pounds on June 21, 2004. Patient C's last recorded weight was 170 pounds on June 1, 2005.

18 21. Patient C was not provided with any information regarding possible side effects,
19 dependency issues, the potential of birth defects in unborn children, or other possible adverse
20 outcomes, of taking the prescribed appetite suppressants. All of Patient C's prescriptions for
21 phentermine were dispensed at Medical Reducing Pharmacy.

22 22. Patient D was a thirty-six-year-old female at the time she initially presented to
23 Dr. Feingold at Medical Reducing, Inc. on May 26, 2004. She was treated at Medical Reducing,
24 Inc. for weight reduction through July 2005.

25 23. At the time of her initial presentation to Dr. Feingold, Patient D weighed 189
26 pounds and was 68 inches in height, giving her a Body Mass Index (BMI) of 28.7, considered
27 overweight, and exceeding the upper limit of a healthy weight for Patient D by more than 20
28 percent.

1 24. At the time of Patient D's initial presentation, her medical records indicate that
2 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was
3 performed, as well as lab work, which did not include any testing related to thyroid function or to
4 test for pregnancy.

5 25. Between May 2004 and May 2005, Patient D was seen at Medical Reducing, Inc.
6 approximately twenty-seven (27) times, and according to her chart, was seen by Dr. Feingold a
7 total of eight times, during which minimal records were made regarding Patient D's treatment and
8 care. During the period that Patient D was seen at Medical Reducing, Inc., she was prescribed
9 appetite suppressants, specifically phentermine, and the medical records do not indicate that she
10 was provided with any further medical treatment for weight reduction nor was any type of exercise
11 program or behavior modification recommended. The records for Patient D are practically illegible
12 and extremely sparse and contain little information regarding her treatment.

13 26. Patient D's lowest recorded weight while being treated at Medical Reducing, Inc.
14 was 157 pounds on March 16, 2005.

15 27. Patient D was not provided with any information regarding possible side effects,
16 dependency issues, the potential of birth defects in unborn children, or other possible adverse
17 outcomes, of taking the prescribed appetite suppressants, which were dispensed at Medical
18 Reducing Pharmacy.

19 28. Patient E was a thirty-four-year-old female at the time she initially presented to
20 Dr. Feingold at Medical Reducing, Inc. on January 4, 2005. She was treated at Medical Reducing,
21 Inc. for weight reduction only through February 14, 2005.

22 29. At the time of her initial presentation to Dr. Feingold, Patient E weighed 142
23 pounds and was 64 inches in height, giving her a Body Mass Index (BMI) of 24.4, considered a
24 healthy weight.

25 30. At the time of Patient E's initial presentation, her medical records indicate that
26 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was
27 performed, as well as lab work, which did not include any testing related to thyroid function or to
28 test for pregnancy.

1 31. During the time that Patient E was treated at Medical Reducing, Inc., she was seen
2 only four times, and according to her chart, was only seen by Dr. Feingold once. During the period
3 that Patient E was seen at Medical Reducing, Inc., she was prescribed appetite suppressants,
4 specifically phentermine, although not medically indicated, and her medical records do not
5 indicate that she was provided with any further information regarding alternatives to appetite
6 suppressants or any other medical treatment for weight reduction nor was any type of exercise
7 program or behavior modification recommended. The records for Patient E are practically illegible
8 and extremely sparse and contain little information regarding her treatment.

9 32. Patient E was not provided with any information regarding possible side effects,
10 dependency issues, the potential of birth defects in unborn children, or other possible adverse
11 outcomes, of taking phentermine. All of Patient E's phentermine prescriptions were dispensed at
12 Medical Reducing Pharmacy.

13 33. Patient F was a thirty-five-year-old female at the time she initially presented to
14 Dr. Feingold at Medical Reducing, Inc. on October 29, 2004. She was treated at Medical
15 Reducing, Inc. for weight reduction until February 21, 2005.

16 34. At the time of her initial presentation to Dr. Feingold, Patient F weighed 130
17 pounds and was 61 inches in height giving her a Body Mass Index (BMI) of 24.6, considered a
18 healthy weight.

19 35. At the time of Patient F's initial presentation, her medical records indicate that
20 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was
21 performed, as well as lab work, which did not include any testing related to thyroid function or to
22 test for pregnancy.

23 36. During the time that Patient F was treated at Medical Reducing, Inc., she was seen
24 approximately sixteen (16) times, and according to her chart, was seen by Dr. Feingold a total of
25 four times, during which minimal records were made regarding Patient F's treatment and care.
26 During the period that Patient F was seen at Medical Reducing, she was prescribed appetite
27 suppressants, specifically Didrex, although not medically indicated. Didrex is considered an FDA
28 pregnancy category X drug. Patient F's medical records do not indicate that she was provided with

1 any further information regarding alternatives to appetite suppressants or any other medical
2 treatment for weight reduction nor was any type of exercise program or behavior modification
3 recommended. The records for Patient F are practically illegible and extremely sparse and contain
4 little information regarding her treatment.

5 37. Patient F was not provided with any information regarding possible side effects,
6 dependency issues, the potential of birth defects in unborn children, or other possible adverse
7 outcomes, of taking Didrex. All of Patient F's Didrex prescribed by Dr. Feingold were dispensed
8 at Medical Reducing Pharmacy.

9 38. On December 17, 2004, Patient F's husband contacted Medical Reducing, Inc.,
10 alleging that Patient F was seeing other providers for medications and that she was abusing it.

11 39. Dr. Feingold made no effort to access Patient F's Patient Utilization Report or to
12 address these allegations in any way and continued to prescribe Didrex to Patient F. Dr. Feingold
13 made no effort to address Patient F's prescription drug abuse or make any appropriate referrals
14 after initially being contacted regarding her drug usage.

15 40. On March 2, 2005, Medical Reducing, Inc. was contacted by the Prescription
16 Controlled Substance Abuse Prevention Task Force regarding Patient F's drug usage and on
17 March 4, 2005, Dr. Feingold ceased prescribing Didrex to Patient F based on this report.

18 41. Patient G was a twenty-seven-year-old female at the time she initially presented to
19 Dr. Feingold at Medical Reducing, Inc. on October 4, 2007. She was treated at Medical Reducing,
20 Inc. for weight reduction until June 29, 2009.

21 42. At the time of her initial presentation to Dr. Feingold, Patient G weighed 216.5
22 pounds and was 65 inches in height, giving her a Body Mass Index (BMI) of 36, considered obese,
23 and exceeding the upper limit of a healthy weight for Patient G by more than 20 percent.

24 43. At the time of Patient G's initial presentation, her medical records indicate that
25 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was
26 performed, as well as lab work, which did not include any testing related to thyroid function or to
27 test for pregnancy. Subsequent lab work completed in 2009 did test thyroid function.

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1 44. During the time that Patient G was treated at Medical Reducing, Inc., she was seen
2 approximately sixty-five (65) times, and according to her chart, was seen by Dr. Feingold on a
3 total of ten occasions, during which minimal records were made regarding Patient G's treatment
4 and care. During the period that Patient G was seen at Medical Reducing, Inc., she was prescribed
5 appetite suppressants, specifically phentermine and Tenuate, and the medical records do not
6 indicate that she was provided with any further medical treatment for weight reduction nor was
7 any type of exercise program or behavior modification recommended. The records for Patient G
8 are practically illegible and extremely sparse and contain little information regarding her
9 treatment.

10 45. Patient G's lowest recorded weight while being treated at Medical Reducing, Inc.
11 was 193 pounds in June 2009. Patient G's last recorded weight was 194 pounds on June 29, 2009.

12 46. Patient G was not provided with any information regarding possible side effects,
13 dependency issues, the potential of birth defects in unborn children, or other possible adverse
14 outcomes, of taking the prescribed appetite suppressants, all of which were dispensed at Medical
15 Reducing Pharmacy.

16 47. Patient H was a twenty-six-year-old female at the time she initially presented to
17 Dr. Feingold at Medical Reducing, Inc. on May 20, 2006. She was treated at Medical Reducing,
18 Inc., for weight reduction with a final appointment on July 31, 2009.

19 48. At the time of her initial presentation to Dr. Feingold, Patient H weighed 166
20 pounds and was 63 inches in height, giving her a Body Mass Index (BMI) of 29.4, considered
21 overweight, and exceeding the upper limit of a healthy weight for Patient H by more than 20
22 percent.

23 49. At the time of Patient H's initial presentation, her medical records indicate that
24 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was
25 performed, as well as lab work, which did not include any testing related to thyroid function or to
26 test for pregnancy.

27 50. During the time that Patient H was treated at Medical Reducing, Inc., she was seen
28 approximately twenty-eight (28) times, and according to her chart, was seen by Dr. Feingold on a

1 total of seven occasions, during which minimal records were made regarding Patient H's treatment
2 and care. During the period that Patient H was seen at Medical Reducing, Inc., she was prescribed
3 appetite suppressants, specifically phentermine and phendimetrazine, and the medical records do
4 not indicate that she was provided with any further medical treatment for weight reduction. On
5 May 21, 2006, there is a brief entry that appears that Patient H was informed to increase exercise;
6 however no further behavior modification was recommended. The records for Patient H are
7 practically illegible and extremely sparse and contain little information regarding her treatment.

8 51. Patient H's lowest recorded weight while treated at Medical Reducing, Inc. was
9 149 pounds on May 12, 2008. Patient H was sporadically seen between May 2008 and February
10 2009 and was seen for the final time on July 31, 2009, at which time her last recorded weight was
11 176 pounds.

12 52. Patient H was not provided with any information regarding possible side effects,
13 dependency issues, the potential of birth defects in unborn children, or other possible adverse
14 outcomes, of taking the prescribed appetite suppressants, all of which were dispensed at Medical
15 Reducing Pharmacy.

16 53. Patient I was a thirty-three-year-old female at the time she presented to
17 Dr. Feingold at Medical Reducing, Inc. on October 7, 2005. Her records indicate that she had been
18 seen at Medical Reducing, Inc. at some time in the past. She was treated at Medical Reducing, Inc.
19 for weight reduction until September 18, 2006, but then was not seen again until January 12, 2007.
20 She was then treated until a last appointment on October 8, 2008.

21 54. At the time of her presentation to Dr. Feingold on October 7, 2005, Patient I
22 weighed 175 pounds and was 70 inches in height giving her a Body Mass Index (BMI) of 25.1,
23 considered overweight, but did not exceed the upper limit of a healthy weight for Patient I by more
24 than 20 percent.

25 55. At the time of Patient I's presentation on October 7, 2005, her medical records
26 indicate that Dr. Feingold performed a minimal and inadequate medical history and physical. An
27 EKG was performed, but the medical record does not indicate that any lab work was performed in
28 October 2005, prior to Patient I being prescribed appetite suppressants.

1 56. At the time Patient I returned to Medical Reducing, Inc., on January 12, 2007, her
2 weight was 149, giving her a BMI of 21.4, considered a healthy weight. No labs were completed at
3 this time; however she did have lab work completed a few days later by another physician which
4 did include thyroid function testing.

5 57. During the time that Patient I was treated at Medical Reducing, Inc., between
6 October 2005 and October 2008, she was seen approximately sixty-three (63) times, and according
7 to her chart, was seen by Dr. Feingold on a total of nine occasions, during which minimal records
8 were made regarding Patient I's treatment and care. During the period that Patient I was seen at
9 Medical Reducing, Inc., she was prescribed appetite suppressants, specifically phentermine and
10 phendimetrazine, although not medically indicated. Her medical records do not indicate that she
11 was provided with any further medical treatment for weight reduction nor was any type of exercise
12 program or behavior modification recommended. The records for Patient I are practically illegible
13 and extremely sparse and contain little information regarding her treatment.

14 58. Patient I's lowest recorded weight while being treated at Medical Reducing, Inc.
15 was 144 pounds on August 13, 2008. Patient I's last recorded weight on October 8, 2008 was 170
16 pounds.

17 59. Patient I was not provided with any information regarding possible side effects,
18 dependency issues, the potential of birth defects in unborn children, or other possible adverse
19 outcomes, of taking the prescribed appetite suppressants, all of which were dispensed at Medical
20 Reducing Pharmacy.

21 60. Patient J was a twenty-five-year-old female at the time she initially presented to
22 Dr. Feingold at Medical Reducing, Inc. on May 9, 2005. During her course of treatment at Medical
23 Reducing, Inc., she was not seen between August 2008 and August 2009 due to a pregnancy.

24 61. At the time of her initial presentation to Dr. Feingold, Patient J weighed 212
25 pounds and was 66 inches in height, giving her a Body Mass Index (BMI) of 34.2, considered
26 obese and exceeding the upper limit of a healthy weight for Patient J by more than 20 percent.

27 62. At the time of Patient J's initial presentation, her medical records indicate that
28 Dr. Feingold performed a minimal and inadequate medical history and physical. An EKG was

1 performed, as well as lab work, which did not include any testing related to thyroid function or to
2 test for pregnancy. Subsequent lab work was performed in January 2007, which did include testing
3 for thyroid function. In June 2008, a pregnancy test was performed which was negative, and in
4 August 2008 more lab work was completed which included thyroid function testing but no
5 pregnancy test.

6 63. Between May 2005 and August 2008, Patient J was seen approximately sixty (60)
7 times, and according to her chart, was seen by Dr. Feingold on a total of seven occasions, during
8 which minimal records were made regarding Patient I's treatment and care. During this period that
9 Patient J was seen at Medical Reducing, Inc., she was prescribed appetite suppressants,
10 specifically phentermine and Didrex among others. Didrex is a FDA pregnancy category X drug.
11 Her medical records do not indicate that she was provided with any further medical treatment for
12 weight reduction nor was any type of exercise program or behavior modification recommended.
13 The records for Patient J are practically illegible and extremely sparse and contain little
14 information regarding her treatment.

15 64. Patient J's lowest recorded weight while being treated at Medical Reducing, Inc.
16 between May 2005 and August 2008 was 179 pounds on September 21, 2005.

17 65. There is a note on August 29, 2008 from Dr. Feingold to discontinue Didrex, which
18 would coincide with the date of Patient J's pregnancy, but there is no other information to indicate
19 that Patient J was provided with any information regarding possible side effects, dependency
20 issues, the potential of birth defects in unborn children, or other possible adverse outcomes, of
21 taking the prescribed appetite suppressants, all of which were dispensed at Medical Reducing
22 Pharmacy.

23 66. Patient J returned to Medical Reducing, Inc., where she once again began to receive
24 Didrex for weight loss.

25 67. In addition to Medical Reducing, Inc., Dr. Feingold also worked at Focus Medical
26 Group, where he also focused his practice on weight loss.

27 68. Patient K was a thirty-three-year-old female at the time she presented to
28 Dr. Feingold at Focus Medical Group on June 23, 2008.

1 69. At the time of her initial presentation to Dr. Feingold, Patient K weighed 171.8
2 pounds and was 65 inches in height, giving her a Body Mass Index (BMI) of 28.5, considered
3 overweight and exceeding the upper limit of a healthy weight for Patient K by just under 20
4 percent.

5 70. At the time of Patient K's initial presentation, her medical records indicate that
6 Dr. Feingold performed a minimal and inadequate medical history and physical and gave an
7 impression of exogenous obesity. There is no EKG in the records and no indication that one was
8 performed. There is a note to follow up with the patient for lab work, but there is no further
9 information in the chart that any labs were ever completed or noted.

10 71. During the time that Patient K was treated at Focus Medical Group between June
11 2008 and July 2009, she was seen approximately thirty-five (35) times; however it is unclear from
12 her chart how many times she was seen by Dr. Feingold. There are, however, copies of seven
13 prescriptions in the chart written by Dr. Feingold for appetite suppressants for Patient K. Other
14 than Patient K's progress note in the chart dated June 23, 2008, there are no other entries regarding
15 Patient K's treatment and care other than her weight and what medications/injections were
16 administered or prescribed during her visits. During the period that Patient K was seen at Focus
17 Medical Group, she was prescribed appetite suppressants, specifically phentermine, among others.
18 Her medical records do not indicate that she was provided with any further medical treatment for
19 weight reduction nor was any type of exercise program or behavior modification recommended.
20 The records for Patient K are practically illegible and extremely sparse and contain little
21 information regarding her treatment.

22 72. Patient K's lowest recorded weight while being treated at Focus Medical Group
23 was 148 pounds in May 2009.

24 73. Patient K's medical record does not indicate that she was provided with any
25 information regarding possible side effects, dependency issues, the potential of birth defects in
26 unborn children, or other possible adverse outcomes, of taking the prescribed appetite
27 suppressants. All of Patient K's prescriptions for appetite suppressants were dispensed by
28 Dr. Feingold.

1 74. Patient L was thirty-two-year-old female at the time she presented to Dr. Feingold
2 at Focus Medical Group on February 4, 2008. She was then treated for weight loss until
3 April 20, 2009.

4 75. At the time of her initial presentation to Dr. Feingold, Patient L weighed 147
5 pounds and was 66 inches in height, giving her a Body Mass Index (BMI) of 23.7, considered a
6 healthy weight.

7 76. At the time of Patient L's initial presentation, her medical records indicate that
8 Dr. Feingold performed a minimal and inadequate medical history and physical and gave an
9 impression of exogenous obesity although Patient L's BMI clearly did not indicate that she was
10 obese. There is no EKG in the records and no indication that one was performed. There is also no
11 indication that any lab work was performed.

12 77. During the time that Patient L was treated at Focus Medical Group between
13 February 2008 and April 2009, she was seen approximately thirty-seven (37) times, and was seen
14 by Dr. Feingold at least three times, as there are minimal chart entries from Dr. Feingold,
15 including Patient L's initial visit. There are also copies of seven prescriptions in the chart written
16 by
17 Dr. Feingold for phentermine for Patient L. Other than Patient L's progress note in the chart dated
18 February, 2008, and two subsequent brief notes written by Dr. Feingold on February 18, 2008 and
19 March 3, 2008, there are no other entries regarding Patient L's treatment and care other than her
20 weight and what medications/injections were administered or prescribed during her visits. During
21 the period that Patient L was seen at Focus Medical Group, she was prescribed appetite
22 suppressants, specifically phentermine, although not medically indicated. Her medical records do
23 indicate that she was told to increase her exercise; however, there is no indication she was
24 provided with any further medical treatment or behavior modification was recommended. The
25 records for Patient L are practically illegible and extremely sparse and contain little information
26 regarding her treatment.

27 78. Patient L's lowest recorded weight while being treated at Focus Medical Group was
28 130 pounds in August 2008. Patient L's last recorded weight was 139.4 pounds on April 20, 2009.

1 79. Patient L's medical record does not indicate that she was provided with any
2 information regarding possible side effects, dependency issues, the potential of birth defects in
3 unborn children, or other possible adverse outcomes, of taking the prescribed appetite
4 suppressants. All of Patient L's prescriptions for appetite suppressants prescribed by Dr. Feingold
5 were also dispensed by him.

6 **Count I**

7 80. Nevada Revised Statute Section 630.306(2)(b) provides that conduct which is a
8 violation of the standards of practice established by regulation of the Board is grounds for
9 discipline.

10 81. Dr. Feingold violated Nevada Administrative Code 630.205(1), a standard of
11 practice, in his prescribing of appetite suppressants for Patients A-L, in that he failed to prescribe
12 them as part of a program of medical treatment that included dietary restrictions, modification of
13 behavior and exercise.

14 82. Dr. Feingold's failure to comply with NAC 630.205(1) thus constitutes a violation
15 of Section 630.306(2)(b) of the Nevada Revised Statutes.

16 83. By reason of the foregoing, Dr. Feingold is subject to discipline by the Nevada
17 State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

18 **Count II**

19 84. Nevada Revised Statute Section 630.306(2)(b) provides that conduct which is a
20 violation of the standards of practice established by regulation of the Board is grounds for
21 discipline.

22 85. Dr. Feingold failed to comply with Nevada Administrative Code 630.205(1), a
23 standard of practice, in his prescribing of appetite suppressants for patients E, F, I and L, when he
24 prescribed appetite suppressants to these patients when such a prescription was not medically
25 indicated as set forth in NAC 630.205(1)(a) or NAC 630.205(1)(b).

26 86. Dr. Feingold's failure to comply with NAC 630.205 thus constitutes a violation of
27 Section 630.306(2)(b) of the Nevada Revised Statutes.

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1 87. By reason of the foregoing, Dr. Feingold is subject to discipline by the Nevada
2 State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

3 **Count III**

4 88. Nevada Revised Statute Section 630.306(2)(b) provides that conduct which is a
5 violation of the standards of practice established by regulation of the Board is grounds for
6 discipline.

7 89. Dr. Feingold failed to comply with Nevada Administrative Code 630.205(4), a
8 standard of practice, in his prescribing of appetite suppressants for Patients A-L, in that he failed
9 to perform adequate medical histories and physicals or conduct adequate studies to determine
10 whether any contraindications to the use of appetite suppressants existed.

11 90. Dr. Feingold's failure to comply with NAC 630.205 thus constitutes a violation of
12 Section 630.306(2)(b) of the Nevada Revised Statutes.

13 91. By reason of the foregoing, Dr. Feingold is subject to discipline by the Nevada
14 State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

15 **Count IV**

16 92. Nevada Revised Statute Section 630.3062(1) provides that the failure to maintain
17 timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care
18 of a patient is grounds for discipline.

19 93. Dr. Feingold's records regarding Patients A-L are practically illegible, contain
20 minimal information regarding the diagnosis, treatment and care of the patients and are not
21 accurate and complete records.

22 94. By reason of the foregoing, Dr. Feingold is subject to discipline by the Nevada
23 State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

24 **Count V**

25 95. Nevada Revised Statute Section 630.301(4) provides that malpractice is grounds
26 for discipline.

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1 96. Nevada Administrative Code Section 630.040 defines malpractice as the failure of
2 a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used
3 under similar circumstances.

4 97. Dr. Feingold failed to use the reasonable care, skill or knowledge ordinarily used in
5 similar circumstances when he failed to discuss with Patients B-L the risks associated with taking
6 appetite suppressants during pregnancy nor did he test for or ask about pregnancy status prior to
7 prescribing appetite suppressants, especially those known to be FDA pregnancy category X drugs.

8 98. Dr. Feingold's failure to provide Patients B-L with the accepted standard of care
9 constitutes malpractice as defined by Section 630.040 of the Nevada Administrative Code, and
10 thus he has violated Section 630.301(4) of the Nevada Revised Statutes.

11 99. By reason of the foregoing, Dr. Feingold is subject to discipline by the Nevada
12 State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

13 **Count VI**

14 100. Nevada Revised Statute Section 630.301(4) provides that malpractice is grounds
15 for discipline.

16 101. Nevada Administrative Code Section 630.040 defines malpractice as the failure of
17 a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used
18 under similar circumstances.

19 102. Dr. Feingold failed to use the reasonable care, skill or knowledge ordinarily used in
20 similar circumstances when he failed to address the allegations of Patient F's possible drug abuse
21 and when he failed to take any action to address said drug abuse after being contacted by the
22 Controlled Substance Abuse Prevention Task Force regarding Patient F.

23 103. Dr. Feingold's failure to provide Patient F with the accepted standard of care
24 constitutes malpractice as defined by Section 630.040 of the Nevada Administrative Code, and
25 thus he has violated Section 630.301(4) of the Nevada Revised Statutes.

26 104. By reason of the foregoing, Dr. Feingold is subject to discipline by the Nevada
27 State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

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Count VII

105. Nevada Revised Statute Section 630.306(7) provides that the continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for discipline.

106. Dr. Feingold's actions and omissions as described above in his prescribing of appetite suppressants for Patients A-L shows a continual failure to exercise the skill or diligence as described by Nevada Revised Statute Section 630.306(7).

107. By reason of the foregoing, Dr. Feingold is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners give Dr. Feingold notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in Section 630.339 of the Nevada Revised Statutes within twenty (20) days of service of the First Amended Complaint;

2. That the Nevada State Board of Medical Examiners set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Nevada State Board of Medical Examiners determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act (Nevada Revised Statutes Chapter 630) committed by Dr. Feingold; and

4. That the Nevada State Board of Medical Examiners make, issue and serve on Dr. Feingold its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

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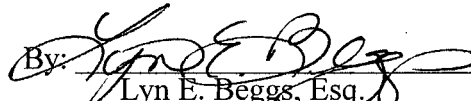
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5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 1st day of March, 2011.

THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 
Lyn E. Beggs, Esq.
General Counsel and Attorney for the Investigative Committee

VERIFICATION

STATE OF NEVADA)
 : ss.
COUNTY OF CLARK)

BENJAMIN J. RODRIGUEZ, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the First Amended Complaint against Dr. Feingold herein; that he has read the foregoing First Amended Complaint; and that based upon information discovered in the course of the investigation into complaints against Dr. Feingold, he believes that the allegations and charges in the foregoing First Amended Complaint against Dr. Feingold are true, accurate, and correct.

DATED this 1st day of March, 2011.

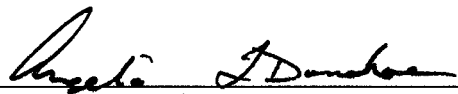

BENJAMIN J. RODRIGUEZ, M.D.

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 2nd day of March 2011; I served a file copy of the FIRST AMENDED COMPLAINT & AMENDED PATIENT DESIGNATION by mailing via USPS certified return receipt mail to the following:

Tracy Singh, Esq.
Law Offices of Tracy Singh, LLC
8635 West Sahara Ave., #437
Las Vegas, NV 89117

Dated this 2nd day of March 2011.



Angelia L. Donohoe
Legal Assistant

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