BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of the Charges and Complaint Against: **DIETRICH VON FELDMANN, M.D.,** **Respondent.**	**Case No.: 23-31575-1**

FILED
JUN 12 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

ORDER OF SUSPENSION AND NOTICE OF HEARING

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board) hereby **IMMEDIATELY SUSPENDS** the license of Dietrich Von Feldmann, M.D. (Respondent) from the practice of medicine, pursuant to the Board's authority to regulate the practice of medicine in the State of Nevada pursuant to Nevada Revised Statutes (NRS) Chapter 630.

The IC issues this Order of Suspension (Order) based on its determination that Respondent violated a Board Order when he did not satisfy all of the conditions contained in the Board's Findings of Facts, Conclusion of Law, and Order approved by the Board on December 2, 2022, and filed on December 8, 2022.

Prior to the preparation of this Order, Board Staff presented to the IC the following:

1. Respondent is a medical doctor licensed to practice medicine in the State of Nevada (License No. 12002). The Board issued his license on August 17, 2006.

2. On December 2, 2022, Respondent was found to have violated the Medical Practice Act by violating NRS 630.301(4) Malpractice. *See* **Exhibit 1** (Findings of Fact, Conclusions of Law, and Order).

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners is composed of Board members Victor M. Muro, M.D., Chairman, Chowdhury H. Ashan, M.D., Ph.D., FACC, and Ms. Pamela Beal.

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3. Pursuant to NRS 630.352(4)(j), Respondent was ordered unequivocally to submit to a physicial and mental examination to evaluate his competence to practice medicine within six (6) months of the service of the Board Order. *Ibid.*

4. Respondent was ordered to pay of fine of two thousand dollars ($2,000), and costs and expenses actually incurred in the investigation in the amount of eight thousand six hundred and twenty-one dollars, and ninety cents ($8,621.90) within six (6) months of service of the Board Order. *Ibid.*

5. As of the writing of this Order on June 12, 2023, Board staff has received no notification that Respondent has complied with the Board ordered physical and mental examination, nor has the Respondent paid the fine and costs imposed by the Order.

6. NRS 630.3065(2)(a) states in pertinent part that [e]xcept as otherwise provided in NRS 630.2672, knowingly or willfully failing to comply with: (a) [a] regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician, constitutes grounds for initiating disciplinary action.

7. Based on the foregoing, the IC finds that Respondent, Dietrich Von Feldmann, M.D., has willfully and knowingly violated a Board Order and is immediately suspended from the practice of medicine in the State of Nevada. *See* NRS 630.326(1).

ORDER

IT IS HEREBY ORDERED that the License of Dietrich Von Feldmann, M.D. (12002) is immediately **SUSPENDED** until further order of the IC or Board, and Respondent is prohibited from engaging in any acts that constitute the practice of medicine pursuant to NRS 630.020; and

IT IS FURTHER ORDERED that a hearing on this matter is set for the **11th day of July, 2023, at 2:00 p.m.,** at the Board's office located at 9600 Gateway Drive, Reno, Nevada

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89521, to determine whether this suspension may continue, unless the parties mutually agree in writing to a different date and/or time. *See* NRS 630.326(2).

DATED this 12th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: V M Muro MD

VICTOR M. MURO, M.D.
Chairman of the Investigative Committee

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EXHIBIT 1

EXHIBIT 1

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against DIETRICH VON FELDMANN, M.D. Respondent.	**Case No. 22-31575-1**

FILED
DEC - 8 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

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FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This case was presented for adjudication and decision before the Nevada State Board of Medical Examiners (Board), during a regularly scheduled Board meeting on December 2, 2022, located at 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119, video conferenced to 9600 Gateway Drive, Reno, NV 89521. Dietrich Von Feldmann, M.D., (Respondent), was properly served with a notice of the adjudication, including the date, time and location, and was present and not represented by counsel. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law, and Order (FOFCOL) were: Aury Nagy, M.D., Nicola (Nick) M. Spirtos M.D., FACOG, Ms. Maggie Arias-Petrel, Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, Ms. Pamela Beal, Col. Eric D. Wade, and Carl N. Williams, Jr., M.D., FACS. Sophia Long, Esq., Senior Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the Complaint and exhibits admitted at the hearing of this matter, the Hearing Officer's Findings and Recommendations[1], and the transcript of the hearing, made its decision pursuant to its authority and provisions of the Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), NRS Chapter 622A, and NRS Chapter 233B, as applicable.

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[1] The Hearing Officer's Findings and Recommendations were prepared by Patricia Halstead, Esq., who was appointed as Hearing Officer under NRS 630.106 in this matter and presided over the hearing.

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The Board, after due consideration of the record, evidence, and law, and being fully advised in the premises, makes its FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER in this matter, as follows:

FINDINGS OF FACT

I.

Respondent held a license to practice medicine in the State of Nevada issued by the Board from August 17, 2006 to present.

II.

On March 1, 2022, the Investigative Committee filed its formal Complaint in Case No. 22-31575-1, alleging Respondent violated the Medical Practice Act. Respondent was personally served with the Complaint by a USPS Certified mail on March 2, 2022. The Complaint alleges as follows: Count I, a violation of NRS 630.301(4), Malpractice.

Respondent did not answer or file a response to the allegations set forth in the Complaint. Pursuant to NAC 630.460(4), the allegations of the Complaint are deemed generally denied if an answer is not filed.

III.

An Order was filed on March 28, 2022, scheduling the Early Case Conference for the pending matter for April 7, 2022. This Order was served upon Respondent via USPS Certified Mail on March 30, 2022. On April 7, 2022, an Early Case Conference was conducted in this matter. Ian J. Cumings, J.D., Deputy General Counsel was present on behalf of the Investigative Committee (IC) of the Board, with Hearing Officer Patricia Halstead, Esq., Respondent did not participate.

In compliance with NAC 630.465, a Scheduling Order was filed April 14, 2022, setting dates for the Prehearing Conference, scheduled for May 5, 2022, with the formal hearing calendared to commence on June 21, 2022, at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521 video conferenced to the Board's Las Vegas Office, located at 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119.

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Respondent was served this Order via USPS Certified Mail on April 18, 2022, at his address of record.

An Order Setting Status Conference was then filed on May 2, 2022, setting a status conference for May 5, 2022, among the parties to reschedule Prehearing and Hearing dates. A copy of this Order was sent via US Regular Mail to Respondent on May 3, 2022. An Order Re-Setting Status Conference was then filed May 5, 2022, resetting the previously scheduled status conference to May 12, 2022. A copy of this Order was sent via US Regular Mail to Respondent on May 5, 2022. An Order Continuing Status Conference setting the third continuation of the scheduled status conference was filed May 13, 2022, setting the new date for a status conference to June 3, 2022. A copy of this Order was sent via US Regular Mail to Respondent on May 13, 2022.

A status conference was held June 3, 2022, at 10:00 a.m., at which Respondent's counsel at the time Lyn E. Beggs, Esq., appeared telephonically on behalf of Respondent. Ms. Beggs stated that Respondent had not been responsive to her attempts to contact him and therefore she was unable to provide legal counsel and notified the parties she would withdraw following the status conference.

Following the status conference on June 3, 2022, an Order Vacating Scheduling Order and Setting Status Conference was filed June 3, 2022. A copy of this Order was sent to Respondent via US Regular Mail on June 6, 2022.

An Amended Scheduling Order was filed June 27, 2022, setting dates for the Prehearing Conference, scheduled for July 19, 2022, with the formal hearing calendared to commence on August 24, 2022. A copy of this Order was sent to Respondent June 27, 2022, via US Regular Mail.

The Prehearing Conference was held telephonically as noticed and ordered, at which time, legal counsel for the IC, Ian J. Cumings, J.D., Deputy General Counsel appeared. Respondent appeared telephonically without legal counsel. Respondent was timely and properly served with the Prehearing Conference Statement and the mandated Prehearing Disclosures in accordance with

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NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and the requirements of due process. Respondent did not provide any Prehearing Disclosures or a Prehearing Statement.

Following the Prehearing a Second Amended Scheduling Order was filed July 19, 2022, setting the new Hearing date for August 17, 2022. A copy of this Order was sent to Respondent July 20, 2022, via US Regular Mail.

IV.

On August 17, 2022, as duly noticed and ordered, a hearing was held before the Hearing Officer to receive evidence and to hear arguments of both parties. Legal counsel for the Investigative Committee, Ian J. Cumings, J.D., Deputy General Counsel appeared, along with Respondent, without legal counsel, and Hearing Officer Halstead. Mr. Cumings presented the IC's case, offered documentary evidence and presented witness testimony. Exhibits 1 through 20, were marked and admitted into evidence.

The Hearing Officer provided the Findings and Recommendations, filed October 12, 2022. This matter was scheduled for final adjudication on December 2, 2022, at a regularly scheduled Board meeting.

The notice of the adjudication was sent via USPS Certified Mail on October 26, 2022, and was picked up from the post office by Respondent on October 29, 2022, at 2:42 p.m.

A copy of the adjudication materials along with a copy of the Hearing Officer's Findings and Recommendation were mailed via Fed Ex 2-Day, and were delivered on Respondent's address of record on November 16, 2022, at 1:48 p.m.

V.

Pursuant to NRS 622A.300(5)(a), the Findings and Recommendations of the Hearing Officer are hereby approved by the Board in their entirety, with modification to the discipline, and are hereby specifically incorporated and made part of this Order by reference and are attached hereto as **Exhibit 1.**

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VI.

In accord with the Findings and Recommendations, the Board hereby finds that each count set forth in the Complaint, and as recapitulated in Paragraph II above, have been established by a preponderance of the evidence.

VII.

If any of the foregoing Findings of Fact is more properly deemed a Conclusion of Law, it may be so construed.

CONCLUSIONS OF LAW

I.

The Board has jurisdiction over Respondent and the Complaint, and an adjudication of this matter by the Board members as set forth herein is proper.

II.

Respondent was timely and properly served with the Complaint, and all notices and orders in advance of the hearing and adjudication thereon, in accordance with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and all legal requirements of due process.

III.

With respect to the allegations of the Complaint, the Board concludes that Respondent has violated NRS 630.301(4), Malpractice, as alleged in Count I. Accordingly, Respondent is subject to discipline pursuant to NRS 630.352.

IV.

The Board finds that, pursuant to NRS 622.400, recovery from Respondent of reasonable attorneys' fees and costs incurred by the Board as part of its investigation and disciplinary proceedings against Respondent is appropriate. The Board has reviewed the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees, and the Board finds them to be the actual fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent, and finds them to be reasonable, necessary, and actually incurred based on: (1) the abilities, training, education, experience, professional standing and skill demonstrated by Board staff and attorneys; (2) the character of the

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work done, its difficulty, its intricacy, its importance, the time and skill required, the responsibility imposed and the prominence and character of the parties where, as in this case, they affected the importance of the litigation; (3) the work actually performed by the Board's attorneys and staff, and the skill, time and attention given to that work; and (4) the product of the work and benefits to the Board and the people of Nevada that were derived therefrom.

V.

If any of the foregoing Conclusions of Law is more properly deemed a Finding of Fact, it may be so construed.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause appearing therefore,

IT IS HEREBY ORDERED that:

1. Respondent has violated the Medical Practice Act, as alleged in the Complaint, as follows: one (1) count of NRS 630.301(4).

2. Pursuant to NRS 630.352(4)(e), the Board shall administer a written public reprimand to Respondent.

3. Pursuant to NRS 630.352(4)(j), Respondent shall submit to a physical and mental examination testing his competence within six (6) months of service of this Order, the cost of which to be borne by the Respondent.

4. Pursuant to NRS 630.352(4)(k), Respondent, if found competent to practice medicine, shall complete twelve (12) hours of Continuing Medical Education relating to the management of surgical patients with potential colon perforation within six (6) months of a finding of competency. The aforementioned hours of Continuing Medical Education shall be in addition to the requirements that are regularly imposed upon Respondent as a condition of licensure in the State of Nevada pursuant to NAC 630.153(1).

5. Pursuant to NRS 630.352(4)(h), Respondent is hereby ordered to pay a fine of two thousand dollars ($2,000.00) per violation of the Medical Practice Act, for a total fine in the amount of two thousand dollars ($2,000.00) within six (6) months of service of this Order.

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6. Respondent is hereby ordered to reimburse the Board the reasonable and necessary costs and expenses actually incurred in the investigation and prosecution of this case in the amount of eight thousand six hundred and twenty-one dollars, and ninety cents ($8,621.90) within six (6) months of service of this Order. The Board, and/or its designee, are granted the authority to collect any and all funds due under this Order.

IT IS SO ORDERED.

DATED this 8th day of December, 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

AURY NAGY, M.D.
President of the Board

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CERTIFICATION

I certify that the foregoing is the full and true original **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** on file in the office of the Board of Medical Examiners in the matter of **DIETRICH VON FELDMANN, M.D.**, Case No. 22-31575-1.

I further certify that Aury Nagy, M.D., is the President of the Nevada State Board of Medical Examiners and that full force and credit is due to his official acts as such; and that the signature to the foregoing ORDER is the signature of said Aury Nagy, M.D.

IN WITNESS THEREOF, I have hereunto set my hand in my official capacity as Secretary-Treasurer of the Nevada State Board of Medical Examiners.

DATED this 8th day of December, 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Maggie Arias-Petrel

MAGGIE ARIAS-PETREL
Secretary-Treasurer and Public Member of the Board

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EXHIBIT 1

EXHIBIT 1

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and

Complaint Against

DIETRICH VON FELDMANN, M.D.,

Respondent.

Case No. 22-31575-1

FINDINGS AND RECOMMENDATION

TO: Ian Cumings, J.D.
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Dietrich Von Feldmann, M.D.
7696 Stone Bluff Way
Reno, NV 89523

1. Introduction

This matter was heard in the Reno office of the Nevada State Board of Medical Examiners (the "Board") on August 17, 2022. Present were Ian Cumings, J.D. on behalf of the Investigative Committee (the "IC"), Respondent Dietrich Von Feldmann, M.D. ("Respondent") representing himself, and the undersigned hearing officer. The IC submitted exhibits 1-20, which were admitted by stipulation. Appearing on behalf of the IC was David Shih, M.D. who was properly sworn as was Respondent who testified on his own behalf. No other witnesses were called.

2. Allegations

The Complaint alleges a single count of Malpractice, a violation of NRS 630.301(4), which is premised upon the allegation that Respondent failed to order an immediate abdominal radiograph to exclude the possibility of colon perforation when Patient A, an 80 year old male;

complained of severe pain on June 20, 2018, after a colonoscopy performed by Respondent. IC Exhibit 1. The malpractice claim further alleges that Respondent failed to recognize and appreciate the gravity of the free air in Patient A's right upper quadrant, which suggested a colon perforation and warranted immediate surgical evaluation. Id. No answer was filed by Respondent although Respondent denied the allegations by way of his hearing testimony.

3. Witnesses and Testimony

In support of the IC allegations, the IC called David Shih, M.D. Dr. Shih testified as to his credentials, which are partially reflected in IC Exhibit 18. Transcript of Hearing Proceedings ("TR"), pp. 10-13. Dr. Shih was then directed to the circumstances underlying the Complaint with regard to which he testified that, based upon his review of the medical records provided by the IC, Respondent "did not act upon the standard of care." TR pp. 14-15. In so concluding, Dr. Shih testified as to the medical records, which he indicated provide as follows.

Patient A saw Respondent for a colonoscopy on June 20, 2018, at which time Respondent "found there were a cecal polyp, an ascending colon polyp, and a marked left-sided diverticulosis." TR pp. 15-16. According to the medical records, per Dr. Shih, Respondent removed the polyps via a procedure called endoscopic mucosal resection, one complication of which is perforation. TR 16-17. Dr. Shih described the procedure as entailing the injection of a solution to raise the polyp, after which a snare, coupled with electrocautery, is utilized. TR 16. The site, as treated by Respondent, was then subject to a hot biopsy with forceps where the polyp was not already completely removed. Id.

The medical records indicate that during the evening following the procedure, Patient A was suffering from abdominal pain that prompted a call to the hospital. TR 18. Respondent prescribed analgesics based upon the belief that Patient A had post polypectomy coagulation necrosis syndrome. Id. According to Dr. Shih, Patient A's complaint should have triggered an order by Respondent for abdominal imaging, which Respondent failed to order. TR 19.

The following morning, June 21, 2018, Patient A presented at an emergency room and a CT scan was ordered by another physician. TR 20. The CT scan showed a large amount of free air in Patient A's upper right quadrant and a few foci of gas in the porta hepatitis. The transverse

colon was also mildly dilated, diverticulitis was evident, and there was also evidence of a cyst. TR 21. Per Dr. Shih, the presence of the free air would not typically be seen and is most indicative of a bowel perforation, which could be life threatening and lend itself to fecal leakage that could cause sepsis. TR 21-22.

Per Dr. Shih's review of the medical records, Respondent reviewed the CT and maintained that the free air was attributable to post polypectomy coagulation necrosis syndrome; however, Dr. Shih was repeatedly adamant that "[b]y definition, there is no free air in the condition called post polypectomy coagulation syndrome." TR 22. The free air, according to Dr. Shih, distinguished post polypectomy coagulation syndrome from a bowel perforation, in that a bowel perforation causes free air whereas there is no free air in post polypectomy coagulation syndrome. TR 22-23.

Noting the free air as shown from the CT scan, it was Respondent's suggestion that a needle be placed in Patient A's abdomen to release the air, which, according to Dr. Shih, is not appropriate. TR 24. The medical records also indicate that Respondent had considered a gastrografin enema, which, according to Dr. Shih, could worsen a perforation. TR 24-25. What should instead have been done, according to Dr. Shih, was an urgent surgical consultation. TR 25.

Suspecting a bowel perforation, the then treating physician ordered a surgical consult. TR 25-28. TR 29-30. The surgeon ultimately removed the right colon due to damage from massive distension and extensive air within the soft tissue surrounding the colon that the right colon could not recover from. Id. Part of Patient A's omentum also needed to be removed due to the perforation. Id.

Dr. Shih opined that he believed Patient A would not have survived absent the surgery and was adamant throughout his testimony that, when Patient A reached out post- procedure, Respondent should have directed Patient A to immediately go to urgent care or an emergency room to address the likelihood of a perforation. TR 31-32. According to Dr. Shih, Respondent's failure to do so was below the standard of care and constituted malpractice. TR 32.

Respondent questioned Dr. Shih, touching upon Dr. Shih's educational timeline predating his residency (TR 33-34); the number of colonoscopies Dr. Shih has performed (TR 35); and how Dr. Shih would have treated Patient A, as to which Dr. Shih testified that he would not have done a hot biopsy touchup as it increases the risk of perforation and that he would have attributed the post-procedure complaints to a perforation (TR 35-36, 43). Dr. Shih was also clear that he would not have ordered a gastrografin enema and that it would be "contra" to do so in that it could exacerbate a tear. TR 37-38, 41.

On redirect, Dr. Shih reiterated his experience with post coagulation necrosis syndrome and the number of colonoscopies he has performed both solo and with fellows. TR 38-40. Dr. Shih also reiterated that when there is a complaint of pain after a colonoscopy, abdominal imaging should be undertaken. TR 40.

Respondent was permitted recross, during which Dr. Shih noted that the surgeon described a serosal tear, indicating that the tear was complete through the colon wall from the inside of the colon wall through the outside of the colon wall. TR 42-43. At nine (9) centimeters, Dr. Shih described the tear as big and complete. Id.

The IC rested its case, after which Respondent testified on his own behalf. Respondent was adamant that he believed Patient A was suffering from post coagulation necrosis syndrome and that he would not have ordered a surgical consult. TR 45. Respondent believes that there was only a superficial tear (which he called a "cat scratch"), from which air was permitted to escape via micro perforations, and that Patient A could have been treated with antibiotics and pain medication, with the needle procedure to relieve the free air. TR 45-49, 52-53, 63-66. According to Respondent, he did not believe the surgeon's perforation determination because the surgeon did not note fecal spillage (as opposed to the pathologist who did). TR 48-49. Respondent also did not believe Patient A with regard to the pain level reported by Patient A given that Patient A ate cookie; Respondent believed Patient A slept through the night or at least stayed home through the night and did not go to the emergency room until next day (TR 49, 57-58); and Respondent noted that Patient A had a history of abdominal pain (TR 59-60). Respondent also did not believe that the perforation described by the surgeon had anything to do with Patient A's symptoms and

continued to assert that the colon injury was superficial. TR 55. Respondent further testified that he thinks that there was no perforation when Patient A was transported to Renown by Care Flight, which he claimed was supported by the pathology report, which is Exhibit 17. TR 60, 62. Under cross-examination, Respondent continued to maintain that Patient A was suffering from post coagulation necrosis syndrome and not a perforation. TR 67-68.

The IC called Dr. Shih in rebuttal. Dr. Shih reiterated that the distinction between post polypectomy coagulation syndrome and a perforation is free air – free air indicating a perforation – and that the surgeon documented a tear and that the pathologist documented was transmural, meaning that the tear had gone through the whole bowel wall of the colon. TR 70, 74-76, 79-80, 82. Dr. Shih further reiterated that the most likely source of the free air in Patient A's upper right quadrant was due to either the endoscopic mucosal resection or the hot biopsy forceps. TR 72. Dr. Shih also took issue with Respondent's claim that the surgeon's failure to note fecal spillage countered the surgeon's finding of a tear given the fact that Patient A had not eaten in preparation for the colonoscopy performed by Respondent, preparation noted as adequate for the procedure; and, therefore, the two pieces of crackers that Patient A had eaten would not have rendered sufficient bowel content to extravasate. TR 72-81. To the extent fecal matter was addressed on the pathology report, Dr. Shih testified that it supports that there was a perforation with leakage otherwise it would not have been noted as present and, therefore, Respondent's reliance upon the pathology report is misguided. TR 81, 88.

4. Findings

Given the pain as reported by Patient A, the noted free air, the surgical intervention, the resulting surgical procedure, and the pathology report, there can be no doubt that Patient A was suffering from a colon perforation and that Respondent should have considered the likely chance of a perforation as opposed to being committed to an erroneous conclusion that Patient A was suffering from post coagulation necrosis syndrome. To discard the intervention of other physicians who recognized the issue and to disregard their conclusions upon such intervention, which is what one would have to do to accept Respondent's position as raised in his defense, is unreasonable. Even in light of the medical records reflecting the perforation and the explanation

thereof by Dr. Shih, Respondent remained adamant that he would not have considered the possibility of a perforation nor ordered a surgical consult, specifically stating at the close of the proceedings "I would have done everything the same way if I would have a case like that again." TR 99.

5. Recommendation

For the reasons set forth above, inclusive of the credible testimony provided by Dr. Shih, I find that the IC met its burden of proof in relation to Count 1 of the Complaint against Respondent (the only count alleged), and I respectfully recommend that the Board confirm that Respondent committed malpractice as set forth in the Complaint.

DATED this 12th day of October 2022.

By: 

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing FINDINGS AND RECOMMENDATION addressed as follows:

Ian Cumings, J.D.
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Dietrich Von Feldmann, M.D.
7696 Stone Bluff Way
Reno, NV 89523

DATED this 12th day of October, 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title