

IN THE SUPREME COURT OF THE STATE OF NEVADA

THOMAS A. GOLDENBERG, M.D.,
Appellant,

vs.

GEORGIA WOODARD, INDIVIDUALLY
AND AS THE SURVIVING SPOUSE
AND SUCCESSOR OF HERSCHEL
WOODARD,
Respondent.

No. 57232

GEORGIA WOODARD,
INDIVIDUALLY, AND GEORGIA
WOODARD AS THE SURVIVING
SPOUSE, SUCCESSOR AND
REPRESENTATIVE OF HERSCHEL
WOODARD, DECEASED,
Appellant,

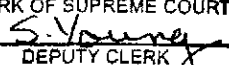
vs.

THOMAS A. GOLDENBERG, M.D.,
Respondent.

No. 58151

FILED

JUN 20 2014

TRACIE K. LINDEMAN
CLERK OF SUPREME COURT
BY 
DEPUTY CLERK

*ORDER AFFIRMING IN PART,
REVERSING IN PART AND REMANDING*

These are consolidated appeals from a judgment following a jury verdict in a professional negligence action. Ninth Judicial District Court, Douglas County; David R. Gamble, Judge.

BACKGROUND

Thomas Goldenberg, M.D. is an obstetrician and gynecologist. In early 2004, Dr. Goldenberg decided to expand his practice by offering colonoscopies. Dr. Goldenberg attended a weekend continuing medical education course in October 2004 and observed a colonoscopy demonstration on a mannequin. Included in the materials provided to Goldenberg at this course were the guidelines published by the American Society of Gastrointestinal Endoscopists, including their requirement that 100 colonoscopies be performed under the supervision of an instructor

before a physician can be evaluated for competence in the procedure. This course was Dr. Goldenberg's only formal training in the colonoscopy procedure.

Although he requested privileges to perform colonoscopies at two different hospitals, both hospitals denied his request due to his lack of demonstrated qualifications to perform the procedure. Dr. Goldenberg eventually obtained a provisional privilege to perform colonoscopies from Lake Tahoe Surgery Center (LTSC) on the condition that he perform the procedures under the supervision of a physician experienced in performing colonoscopies. LTSC later admitted that this decision was a violation of its bylaws, as Dr. Goldenberg's experience did not meet LTSC's credentialing criteria, which require that a physician must have privileges to perform a procedure at a local hospital in order to obtain privileges to perform that procedure at LTSC.

In December 2004, Dr. Goldenberg conducted his annual examination of then 68-year-old Georgia Woodard, and as part of the exam recommended that she undergo a colonoscopy to screen for cancer. Dr. Goldenberg told Ms. Woodard that he could perform her colonoscopy at LTSC. Ms. Woodard testified that Dr. Goldenberg did not disclose to her that he had never performed a colonoscopy on a patient or that he had only conditional privileges to perform the procedure at LTSC with supervision.

Ms. Woodard underwent her colonoscopy at LTSC in March 2005. Although Dr. Goldenberg had previously arranged for a supervising physician to oversee the procedure, the supervising physician was not present at the start of Ms. Woodard's colonoscopy. Dr. Goldenberg initiated the procedure regardless. When Dr. Goldenberg experienced

difficulty advancing the scope through the colon, the supervising physician was summoned and took over the procedure.

Ms. Woodard awoke from the procedure in pain and continued to experience pain over the next week. Despite Dr. Goldenberg's assurances that her condition was improving, Ms. Woodard went to the emergency room in extreme pain and was admitted to the hospital. Subsequent exploratory surgery revealed an instrument-induced half-dollar-size hole in her colon. Ms. Woodard remained in a coma in the intensive care unit for three weeks with a ventilator and feeding tube. The repair of her colon required multiple follow-up surgeries and left Ms. Woodard with a colostomy bag and difficulty walking for many months. After her discharge from the hospital, Ms. Woodard spent two additional weeks in a rehabilitation facility.

Thereafter, Ms. Woodard filed a complaint against Dr. Goldenberg and LTSC, alleging various tort claims.¹ Following an eight-day trial, the jury found against Dr. Goldenberg and LTSC on claims of professional negligence and fraud, awarding Ms. Woodard \$610,000 in economic damages and \$1 million in noneconomic damages. The jury apportioned 80 percent of Ms. Woodard's total damages to negligence and 20 percent to fraud. From this, the jury apportioned 40 percent of the negligence liability to Dr. Goldenberg.

Dr. Goldenberg filed several post-trial motions, including a motion to reduce the noneconomic professional negligence damages to an aggregate cap of \$350,000 before apportioning liability between Dr.

¹Ms. Woodard's husband Herschel also filed a loss of consortium claim. Herschel died in 2010, and Ms. Woodard has been substituted in his place for these consolidated appeals.

Goldenberg and LTSC pursuant to NRS 41A.035. The district court denied this motion, concluding that although NRS 41A.035 limits noneconomic damages per *action* to \$350,000, the limit applied separately against each defendant.

DISCUSSION

Dr. Goldenberg argues on appeal that the district court erred by (1) upholding the jury's finding of fraud against him, (2) ruling that NRS 41A.035's \$350,000 damages cap applies separately to each defendant, and (3) refusing to reduce or offset the damages awarded against him.²

Dr. Goldenberg's appeal

Dr. Goldenberg argues on appeal that the district court erred by finding that Ms. Woodard's fraud claim does not fall within NRS Chapter 41A's definition of professional negligence. He further argues

²Ms. Woodard also filed a cross-appeal in which she raised various constitutional challenges to NRS 41A.035's noneconomic damages cap. Because NRS 41A.035 was not triggered under the district court's apportionment of her noneconomic damages and because Ms. Woodard does not point to any arguments made to the district court or any district court ruling on the constitutionality of NRS 41A.035, Ms. Woodard is not aggrieved by the district court's judgment. We therefore lack jurisdiction over this portion of Ms. Woodard's cross-appeal. NRAP 3A(a); *Ford v. Showboat Operating Co.*, 110 Nev. 752, 756, 877 P.2d 546, 549 (1994) ("A party who prevails in the district court and who does not wish to alter any rights of the parties arising from the judgment is not aggrieved."). Both parties also raised numerous arguments in their appeals that they failed to properly preserve or develop for appellate review, and we decline to address those arguments on appeal. *Old Aztec Mine, Inc. v. Brown*, 97 Nev. 49, 52, 623 P.2d 981, 983 (1981) (providing that this court need not address issues raised for the first time on appeal); *Edwards v. Emperor's Garden Rest.*, 122 Nev. 317, 330 n.38, 130 P.3d 1280, 1288 n.38 (2006) (explaining that this court need not consider claims that are not cogently argued or supported by relevant authority).

that there is no evidence in the record that he made any representations regarding his ability to perform Ms. Woodard's colonoscopy and that his representation that he could perform the procedure was not fraudulent because he intended to have a supervising physician assist him at the time he made the representation.

Fraud as a separate claim from professional negligence

In resolving this issue, this court must first address whether the district court properly found that Ms. Woodard's fraud claim fell outside of NRS Chapter 41A's definition of professional negligence. Although this court has not previously addressed the issue, California courts have concluded that intentional tort claims do not fall within that state's Medical Injury Compensatory Reform Act (MICRA) when the allegations of an intentional tort claim are "qualitatively different than professional negligence." *Unruh-Haxton v. Regents of Univ. of Cal.*, 76 Cal. Rptr. 3d 146, 155 (Ct. App. 2008) (citing *Perry v. Shaw*, 106 Cal. Rptr. 2d 70 (Ct. App. 2001)). NRS Chapter 41A is closely aligned with MICRA, which defines professional negligence in nearly identical language as NRS 41A.015, which defines professional negligence as "a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death." See Cal. Civ. Proc. Code § 364(f)(2) (West 2009) (defining professional negligence as a "negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death"); *State ex rel. Harvey v. Second Judicial Dist. Court*, 117 Nev. 754, 763, 32 P.3d 1263, 1269 (2001) (holding that a statute derived from a sister state is presumably adopted with the construction given it by the sister state's courts).

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