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**STATE OF MINNESOTA
IN COURT OF APPEALS
A07-1460**

Jodi Hawkins,
Trustee for the Heirs and Next of Kin of
Bonnie Moore,
Appellant,

vs.

Annie Fontaine, M.D.,
Respondent.

**Filed September 2, 2008
Reversed and remanded
Halbrooks, Judge
Dissenting, Worke, Judge**

Ramsey County District Court
File No. C9-06-4383

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Considered and decided by Worke, Presiding Judge; Halbrooks, Judge; and
Stoneburner, Judge.

UNPUBLISHED OPINION

HALBROOKS, Judge

Appellant challenges the district court's dismissal of a medical-malpractice claim based on the failure to comply with the expert-disclosure statute, arguing that (1) the disclosures are sufficient to make the prima facie showing required by the statute and (2) the district court improperly evaluated and weighed the expert opinions against rebuttal evidence. We reverse and remand.

FACTS

On May 3, 2004, Bonnie Moore was seen in urgent care at the Aspen Medical Group with complaints of trouble breathing, chest tightness, sore throat, runny nose, chills, and fatigue. Some of these symptoms had started 6-8 weeks earlier. The urgent-care physician noted rhonci/rales in Moore's lower left lobe of her lung and reviewed her chest x-ray. The physician diagnosed Moore with pneumonia and prescribed an antibiotic. Moore was also given a work note, authorizing her to return to work on May 5 and instructed to return to the clinic if her condition became worse or to follow-up with her primary physician in 2-3 days if any change occurred.

The following day, Moore returned for follow-up care at Aspen and was seen by respondent Annie Fontaine, M.D. Dr. Fontaine noted in Moore's record that Moore had returned "for a work note" and that she presented with essentially the same symptoms and vital signs as she had the day before. Dr. Fontaine performed a physical exam and, although she was unable to obtain the x-ray for review, noted that Moore had a cough consistent with the pneumonia diagnosis. Dr. Fontaine noted in Moore's treatment record

that she was “having a lot of chest pain with breathing and coughing.” Dr. Fontaine prescribed Vicodin for Moore’s cough and issued an extended work note, authorizing Moore to return to work on May 6. Dr. Fontaine instructed her to return if she developed a high fever, her cough worsened, or she vomited.

The following day, May 5, 2004, Moore was taken to the hospital after suffering from the rapid onset of nausea and vomiting. Shortly after arriving, Moore was pronounced dead. An autopsy concluded that Moore’s death was caused by a massive acute pulmonary embolism that occluded the right and left main branches of the pulmonary artery. Moore’s daughter, appellant Jodi Hawkins, trustee for the heirs and next of kin of Bonnie Moore, filed a complaint, alleging that respondent was negligent in failing to diagnose Moore’s pulmonary embolism. In support of her claim, appellant submitted two expert-witness affidavits pursuant to Minn. Stat. § 145.682 (2006). Dr. Fontaine moved for dismissal, arguing that the affidavits failed to articulate a standard of care or explain how Dr. Fontaine breached the standard of care. Dr. Fontaine maintained that appellant’s expert affidavits failed to satisfy the chain-of-causation requirement because they did not demonstrate how and why Dr. Fontaine’s alleged negligence caused Moore’s untimely death, rather than her death being the result of an unexpected and unfortunate single massive event. In response to the motion, appellant submitted amended expert affidavits. The district court granted Dr. Fontaine’s motion for dismissal. This appeal follows.

DECISION

“When a medical-malpractice claim requires expert testimony to establish a prima facie case, the plaintiff must satisfy the expert-review requirements set forth in Minn. Stat. § 145.682, subd. 2 [(2006)].” *Mercer v. Andersen*, 715 N.W.2d 114, 121 (Minn. App. 2006). Minn. Stat. § 145.682 (2006) is unambiguous and requires strict compliance. *Lindberg v. Health Partners, Inc.*, 599 N.W.2d 572, 576-77 (Minn. 1999). Failure to comply with the expert-review requirements results in mandatory dismissal with prejudice of each cause of action for which expert testimony is necessary. Minn. Stat. § 145.682, subd. 6. We review the dismissal of a medical-malpractice claim for noncompliance with the expert-review statute for an abuse of discretion. *Broehm v. Mayo Clinic Rochester*, 690 N.W.2d 721, 725 (Minn. 2005).

Here, the district court determined that the affidavits were deficient as to both the standard of care and causation. The district court found that the affidavits were conclusory in nature and that even if they were sufficient with regard to the standard of care, the experts failed to explain when the embolism developed, the effectiveness of anticoagulant therapy in relation to the development of an embolism, and what facts led to the conclusion that Moore’s death was not the result of a single massive event. The district court also concluded that references to Moore’s medical records, the May 4 symptoms, and autopsy report were insufficient without an explanation as to what they meant in regard to the development of the embolism.

It has been long established that Minn. Stat. § 145.682, subd. 4, requires a plaintiff’s second expert-disclosure affidavit to provide “specific details concerning the[]

experts' expected testimony, including the applicable standard of care, the acts or omissions that plaintiffs allege violated the standard of care and an outline of the chain of causation that allegedly resulted in damage to them." *Sorenson v. St. Paul Ramsey Med. Ctr.*, 457 N.W.2d 188, 193 (Minn. 1990). As the dissent also correctly notes, general or conclusory statements regarding either the applicable standard of care or the causative chain linking its breach to the injury are not sufficiently detailed to meet the statute's requirements. *See Lindberg v. Health Partners, Inc.*, 599 N.W.2d 572, 578 (Minn. 1999) (general statement about familiarity with the proper standard of care is insufficient); *Stroud v. Hennepin County Med. Ctr.*, 556 N.W.2d 552, 556 (Minn. 1996) (conclusory statements regarding causation do not satisfy the statute).

A. Standard of care and breach

In prior cases, the type of statements regarding the standard of care that courts have found lacking include those such as an expert's statement, "I am familiar with the standard and duty of care applicable to doctors, midwives, nurses and other medical personnel in the Twin Cities[.]" *Lindberg*, 599 N.W.2d at 574-75, 78; a statement that the "standard of care is that esophageal trauma should be avoided during surgery"; and that "trauma to the vagus nerve should not occur, either during [surgery] or in aftercare[.]" *Anderson v. Rengachary*, 608 N.W.2d 843, 845 (Minn. 2000).

Here, both of appellant's experts, Walter A. Hinck, M.D., who is board-certified in family medicine, and Peter F. Fedullo, M.D., who is board-certified in internal medicine with subspecialty certificates in critical-care medicine and pulmonary disease, described the standard of care in detail. Dr. Hinck stated:

[I]t was negligent and not reasonable for Dr. Fontaine not to have suspected the possibility of pulmonary embolism and ordered or arranged for objective testing to include an emergent spiral CT scan and/or a D-dimer blood test, either of which would have led to the diagnosis of pulmonary embolism. Ms. Moore had several risk factors for pulmonary embolism, including obesity, relatively recent major orthopedic surgery, positive lupus anticoagulant, questionable recent transient stroke, and use of hormonal replacement therapy. Moreover, her clinical presentation was suggestive of pulmonary embolism, including complaints of shortness of breath and chest pain and evidence of tachypnea. There was no evidence of prior complaints of chest pains associated with her fibromyalgia. The patient's presenting complaint without physical focus, in light of all these things, should have raised a concern in the physician's mind for a differential diagnosis that included pulmonary embolism.

Dr. Fedullo stated in his affidavit:

6. It is my opinion that Dr. Fontaine was negligent in her care and treatment of Bonnie Moore on May 4, 2004. In other words, the care and treatment that she provided to Ms. Moore was not reasonable under all of the circumstances. If she had provided reasonable and appropriate care and treatment, it is my further opinion that Bonnie Moore likely would have fully recovered from her pulmonary embolism with no lasting effects from it.

7. Venous thromboembolism (venous thrombosis and pulmonary embolism) is a clinical issue that affects all medical and surgical specialties. Regardless of specialty training, under the circumstances present in this case, the standard of care required and requires the physician to consider the diagnosis of pulmonary embolism and to either rule out the possibility of pulmonary embolism through the use of objective testing or to refer to the patient to a practitioner capable of doing so. This is because the diagnosis of pulmonary embolism cannot be confirmed or excluded on the basis of a clinical examination alone; objective testing is the only reliable method to establish or rule out the diagnosis. Dr. Fontaine's care did not comply with this standard of care. It was negligent and not reasonable for Dr. Fontaine not to

have suspected the possibility of pulmonary embolism given Ms. Moore's clinical symptoms and signs (cough, shortness of breath, pleuritic-type chest pain, tachycardia, tachypnea) in the setting of a number of known risk factors for venous thromboembolism including obesity, relatively recent major orthopedic surgery, a positive lupus anticoagulant, and the use of hormonal replacement therapy. The standard of care required Dr. Fontaine to suspect pulmonary embolism and to order objective testing to confirm or rebut that diagnosis. Testing options included D-dimer, ventilation-perfusion scanning, or CT angiography. The fact that the patient had been seen the day before by a different physician who made a diagnosis of pneumonia did not alter the standard of care governing Dr. Fontaine. Dr. Fontaine was obligated to exercise independent thought and responsibility.

In granting respondent's motion, the district court also relied in part on appellant's failure to bring a claim against the urgent-care physician who Moore saw on May 3. It noted that "neither doctor explains why [respondent] . . . would be held to a higher or greater standard of care than the urgent care doctor" appellant saw on May 3. But appellant's failure to bring a suit against the urgent-care physician of May 3 is not determinative. What matters is the standard of care regarding respondent on May 4. Even assuming that it is relevant, Dr. Fedullo specifically stated in his affidavit that "[t]he fact that [Moore] had been seen the day before . . . did not alter the standard of care governing [respondent]."

Both Drs. Hinck and Fedullo discussed in detail what triggered the relevant standard of care (symptoms and health history); the diagnosis that the standard of care required a reasonably prudent physician to reach (suspicion of pulmonary embolism); and what the standard of care required a reasonably prudent physician to do upon arrival at this diagnosis (ordering certain enumerated objective tests to confirm or rebut the

suspicion of pulmonary embolism). This is in stark contrast to the cases noted above, in which conclusory statements in expert affidavits have been held to lack sufficient detail to meet the requirements of Minn. Stat. § 145.682, subd. 4.

B. Causation

Past cases discussing expert affidavits outlining causation in the context of section 145.682 are more numerous than those discussing the standard of care and also more illuminating. Relevant cases have concluded that statements such as the following will not meet the statute's requirements by themselves:

(1) “the departure from the standard of care was a direct cause of [plaintiff’s] second degree burns,” *Mercer v. Andersen*, 715 N.W.2d 114, 123 (Minn. App. 2006);

(2) “there was a failure to diagnose and treat a subarachnoid hemorrhage which ultimately resulted in a complicated hospital course and death,” *Stroud*, 556 N.W.2d at 554;

(3) “[T]he departures from accepted levels of care, as above identified, were a direct cause of [plaintiff’s] death,” *Teffeteller v. Univ. of Minn.*, 645 N.W.2d 420, 429 (Minn. 2002).

The dissent also relies on *Maudsley v. Pederson*, 676 N.W.2d 8 (Minn. App. 2004), to support its conclusion. But the affidavit as to causation in *Maudsley* was just as conclusory as the above-excerpted statements. See *Maudsley*, 676 N.W.2d at 13-14 (“[t]he conclusory statements that generally earlier treatment results in better outcomes

and that every hour counts fail to outline specific details” regarding the causal link between the alleged breach and injury).

Of appellant’s two expert affidavits, only Dr. Fedullo’s affidavit discusses causation. But his affidavit outlines the causative link in a step-by-step manner and, we conclude, in sufficient detail to meet the requirements of Minn. Stat. § 145.682. Dr. Fedullo states in his affidavit:

8. It is my opinion to a reasonable degree of medical certainty Bonnie Moore’s clinical signs and symptoms on May 4 were caused by pulmonary embolism and that objective testing as described above performed on that day would have established the diagnosis of pulmonary embolism. I base this conclusion on the following factors. The autopsy of May 5 disclosed the presence of massive acute pulmonary embolus, saddle type, occluding right and left main branches of pulmonary artery. Pulmonary embolism causes signs and symptoms consistent with those present on May 4, specifically the complaints of worsening shortness of breath with chest pain while breathing and coughing. The fact that the patient experienced worsening symptoms while on antibiotic therapy and that the chest radiograph performed on May 3 was interpreted by the radiologist as negative also evidence the presence of pulmonary embolism on May 4. Finally, the medical literature clearly documents that the overwhelming majority of deaths related to pulmonary embolism are the result of overlooked and often misdiagnosed recurrent events rather than a [] single massive event.

9. The standard of care upon the objective confirmation of the diagnosis of pulmonary embolism would have required that Bonnie Moore be administered anticoagulant therapy intravenously to halt the progression of thrombosis and prevent the subsequent development of life threatening pulmonary embolism. It is my opinion, based on the medical literature as well as my training and experience in Internal Medicine, Pulmonary Medicine and Critical Care Medicine, that the subsequent cardiopulmonary arrest and death would have been avoided if Ms. Moore had been hospitalized and

appropriately treated with anticoagulant therapy. The medical literature conclusively demonstrates that the mortality rate associated with pulmonary embolism, assuming the diagnosis is made and effective therapy initiated, is in the range of 2% with the exception of patients who initially present with hemodynamic compromise, which was not the case with Ms. Moore.

The purpose of Minn. Stat. § 145.682 is to “readily identify[] meritless lawsuits at an early stage of the litigation.” *Broehm*, 690 N.W.2d at 725. This is done by requiring a plaintiff, in reasonable detail, to allege facts establishing a prima facie case. The legislature, in enacting the statute, did not declare “that all medical malpractice claims are against public policy,” and the statute should not be interpreted to require disclosure of facts or circumstances beyond those described above in *Sorenson* and its progeny. See *Demgen v. Fairview Hosp.*, 621 N.W.2d 259, 264, 266 (Minn. App. 2001) (refusing to extend Minn. Stat. § 145.682 to require explanation of “the sequence of biological facts that led to death”). Because we conclude that appellant’s expert affidavits are sufficient to establish a prima facie case under Minn. Stat. § 145.682, we reverse and remand for trial on the merits of the claim.

Reversed and remanded.

WORKE, Judge (dissenting)

I respectfully dissent. The purpose of the expert-review statute is to dismiss meritless claims at an early stage of litigation. *Broehm v. Mayo Clinic Rochester*, 690 N.W.2d 721, 725 (Minn. 2005). The plaintiff is required to identify each expert whom the plaintiff plans to call to testify at trial with respect “to the issues of malpractice or causation, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion.” Minn. Stat. § 145.682, subd. 4 (2006). To comply with the expert-review statute, plaintiffs must set forth “specific details concerning their experts’ expected testimony, including the applicable standard of care, the acts or omissions that plaintiffs allege violated the standard of care and an outline of the chain of causation that allegedly resulted in damage to them.” *Sorenson v. St. Paul Ramsey Med. Ctr.*, 457 N.W.2d 188, 193 (Minn. 1990). Broad or conclusory statements of causation are insufficient. *Lindberg v. Health Partners, Inc.*, 599 N.W.2d 572, 578 (Minn. 1999).

In *Maudsley v. Pederson*, this court determined that a general statement in an affidavit was not sufficient to satisfy the strict standard for expert affidavits. 676 N.W.2d 8, 14 (Minn. App. 2004). Maudsley’s expert’s affidavit provided that it was more likely than not that had treatment for post-operative eye surgery been initiated one day earlier, Maudsley would not have lost the vision in her right eye, and that, generally, the earlier an infection is treated, the better the outcome. *Id.* at 13. This court held that the affidavit failed to provide specificity on causation and failed to detail a chain of causation explaining how and why delayed treatment caused the loss of vision. *Id.* at 13, 14.

Conversely, in *Demgen v. Fairview Hosp.*, this court held that the expert's affidavit met the statutory requirements. 621 N.W.2d 259, 266 (Minn. App. 2001), *review denied* (Minn. Apr. 17, 2001). In *Demgen*, a pregnant woman sought care after noticing decreased fetal movement, and after receiving care, she delivered a stillborn child. *Id.* at 260-61. The affidavit stated that (1) the standard of care required a nurse to immediately involve a doctor; (2) the standard of care required a fetal-acoustical-stimulation test or a bedside ultrasound; (3) the ultrasound would have revealed the presence of abnormally low amniotic fluid levels; (4) the combination of findings required an immediate caesarean section; (5) failure to administer the appropriate tests delayed such procedure; (6) had such procedure been timely performed a live birth would have resulted; and (7) if the applicable standard of care had been followed, the baby would have been delivered prior to the cessation of cardiac activity. *Id.* at 263-64. This court determined that the affidavit was "detailed and exhaustive," easily putting the defendant on notice of the doctor's medical opinion on negligence, causation, and the standard of care. *Id.* at 265.

In my opinion, a review of the record here supports the district court's determination that the affidavits were deficient. The affidavits provide: (1) the standard of care requires assessment of more serious conditions through the use of objective testing; (2) objective testing is the only reliable method to establish or rule out a pulmonary embolism; (3) the standard of care requires the physician to order objective testing considering the risk factors and symptoms or referral to a specialist; (4) there is more responsibility on a physician in a clinical setting where a patient's chart is available

than in an urgent care setting; and (5) the physician's diagnosis from the previous day did not alter the standard of care. But the affidavits fail to establish why respondent should be held to a higher standard of care than Moore's initial attending physician or why respondent's care was deficient.

Regarding causation, the affidavit provides that (1) Moore's symptoms were caused by pulmonary embolism; (2) objective testing would have established that diagnosis; (3) following the diagnosis Moore would have been administered anticoagulant therapy; (4) anticoagulant therapy would have prevented Moore's death because medical literature demonstrates that the mortality rate associated with pulmonary embolism that is diagnosed and effectively treated is in the range of 2%; and (5) medical literature demonstrates that the majority of deaths related to pulmonary embolism are the result of overlooked recurrent events rather than a single massive event. But the affidavit does not explain how anticoagulant therapy would have caused Moore to have overcome the pulmonary embolism. The affidavit also does not demonstrate when Moore developed the embolism or that it was not a single massive event that developed after respondent saw Moore. The record shows that Moore's symptoms were significantly different on the day she died in comparison to her symptoms when she presented and was seen by respondent on May 4.

Our role is to review the district court's findings and conclusions under an abuse-of-discretion standard. When reviewing a close case for an abuse of discretion, this court must not reweigh the evidence, but rather, defer to the district court's ruling. *See Haefele v. Haefele*, 621 N.W.2d 758, 763 (Minn. App. 2001) (stating that under the abuse-of-

discretion standard we do not reweigh the evidence and instead give due deference to a district court's broad discretion to evaluate testimonial and documentary evidence), *review denied* (Minn. Feb. 21, 2001). Because I agree that the affidavits are deficient in establishing the appropriate standard of care and causation, I conclude that the district court did not abuse its discretion in dismissing the claim for failure to comply with Minn. Stat. § 145.682.

The majority determines that the affidavits meet the necessary requirements because the disclosure is not required to be highly detailed. But the affidavit must contain more than just the facts found in the hospital or clinic record. *Stroud v. Hennepin County Med. Ctr.*, 556 N.W.2d 552, 555 (Minn. 1996). And the affidavit must provide more than a “sneak preview” or “general disclosure” of an expert’s testimony. *Teffeteller v. Univ. of Minn.*, 645 N.W.2d 420, 430 (Minn. 2002) (quotation omitted). At a minimum, the affidavit must provide “meaningful disclosure” of the expert’s trial testimony. *Id.* (quotation omitted). The disclosure must include *specific details* regarding standard of care, the manner in which the standard of care was violated, and the chain of causation between the standard-of-care violation and the damages. *Sorenson*, 457 N.W.2d at 193. Thus, the majority is incorrect in asserting that the affidavits are not required to be detailed. And this court has stated that in medical-malpractice actions it is improper for a district court to rely on rebuttal affidavits and discovery evidence, such as medical records, when weighing and analyzing the adequacy of expert affidavits. *Demgen*, 621 N.W.2d at 266. Here, the district court made adequate findings that support

the dismissal that did not rely on evidence outside of the material provided in the affidavits.

Finally, the majority asserts that the district court should have chosen another alternative to dismissal—that appellant should have been permitted to clarify or cure any ambiguity in the disclosures. But appellant submitted two affidavits from each expert, which provided ample opportunity to offer the necessary evidence; therefore, in my view, the appropriate outcome under the statute was dismissal.