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**STATE OF MINNESOTA
IN COURT OF APPEALS
A07-1955**

Chase Huisman, a minor child, by his parent
and natural guardian Jodi Schroeder,
Appellant,

vs.

Charles E. Chambers, M. D.,
Defendant,

Owatonna Clinic-Mayo Health System,
Defendant,

Allina Health System
d/b/a Owatonna Hospital, et al.,
Respondents,

Owatonna Anesthesia Services, P. A., et al.,
Respondents.

**Filed December 9, 2008
Affirmed
Hudson, Judge**

Steele County District Court
File No. 74-C5-05-001049

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Considered and decided by Hudson, Presiding Judge; Toussaint, Chief Judge; and Kalitowski, Judge.

UNPUBLISHED OPINION

HUDSON, Judge

In this medical-malpractice action, appellant contends that the district court erred by concluding that the expert-disclosure affidavits did not satisfy the requirements of Minn. Stat. § 145.682 (2006) and by dismissing the medical-malpractice action against respondents, two labor and delivery nurses, a certified nurse anesthetist, and their respective employers. Because the district court did not abuse its discretion, we affirm.

FACTS

In December 1997, appellant Jodi Schroeder began seeing Dr. Charles E. Chambers, M.D., for prenatal care at Owatonna Clinic in Owatonna. On June 11, 1998, Dr. Chambers conducted an ultrasound, which revealed polyhydramnios, an excess of amniotic fluid surrounding Schroeder's baby. The cause of Schroeder's polyhydramnios was idiopathic, or unknown. Polyhydramnios implicates various possible conditions, some of which can threaten the baby's well-being. But Dr. Chambers did not detect any

defects or abnormalities during the ultrasound. Based on this polyhydramnios diagnosis, Dr. Chambers decided to perform an amniocentesis to remove some of the excess fluid and induce labor early.

On June 30, 1998, when her baby was at 37 weeks' gestation, Schroeder was admitted to Owatonna Hospital to have her labor induced. Owatonna Hospital is not a tertiary care facility, and as such, it is not well-equipped to care for infants at high risk for medical complications. At 8:20 a.m., Dr. Chambers performed an artificial rupture of Schroeder's membranes, noting the amount of amniotic fluid released and that the fluid was clear. Schroeder continued to discharge amniotic fluid during the next two hours. Dr. Philip Kaupa, M.D., the baby's physician, visited Schroeder around 9:00 a.m. Later that evening, at 6:22 p.m., Schroeder gave birth to a son, Chase Huisman.

Two labor and delivery nurses, Joan M. Langr, R.N., and Sharon E. Kapp, R.N., were present during labor and delivery and provided care to Schroeder and Chase afterwards. Langr, Kapp, and their employer Allina Health System, d/b/a Owatonna Hospital (Allina), are respondents on this appeal.

After delivery, Dr. Chambers handed Chase to Langr, who took him to a baby warmer. At one minute of life, Chase's heart rate was below 100. Although he was breathing, he was slow to cry, had flaccid tone, limp reflexes, and was blue in color. As a result, he was given an Apgar score of three at one minute of life.¹ The nurses gave Chase oxygen through a mask by bagging; they also gave him medicine to reduce the

¹ An Apgar score evaluates, on a scale from zero to ten, a newborn baby's condition by assessing the heart rate, respiration, tone, reflex, and color. *Tabers Cyclopedic Medical Dictionary* 124 (16th ed. 1989).

effects of some pain relievers that Schroeder took during labor. Chase's condition improved over the next ten minutes, and his Apgar score increased to eight.

Langr and Kapp continued to care for Chase until just before 7:00 p.m., when they took Chase to the nursery because he was exhibiting grunting respirations, nasal flaring, some bluish coloring, and continued hypotonia.² One of them contacted the on-call physician, Dr. Michael S. Schoeneman, M.D., who arrived at 7:00 p.m.

Prior to arriving at the nursery, Dr. Schoeneman ordered blood gases and an x-ray of Chase's chest. He also ordered Shellie Thompson, C.R.N.A., the on-call certified registered nurse anesthetist (CRNA), to come to the hospital to assist with Chase. Thompson was employed by Owatonna Anesthesia Services, P.A. (OAS); she and her employer are the other respondents in this matter.

Thompson arrived at the nursery between 7:20 and 7:25 p.m. At 7:30 p.m., Dr. Schoeneman reviewed Chase's x-ray, which revealed that Chase suffered from a congenital diaphragmatic hernia, a condition which causes respiratory problems and prevents the lungs from developing or expanding properly. It is a potentially serious condition and is one of the anomalies associated with polyhydramnios.

Upon learning that Chase had a diaphragmatic hernia, Dr. Schoeneman directed Thompson to intubate Chase. Around 7:35 p.m., Thompson started intubation and attempted twice to intubate Chase, but after each attempt she removed the intubation tube and resumed bagging Chase without any intubation. Thompson called another CRNA,

² Hypotonia is "[r]educed tension in any part" or a decrease or loss of muscle tone. *Stedman's Medical Dictionary* 755 (25th ed. 1990).

Rick Cowell, to assist her. He arrived between 7:50 p.m. and 7:55 p.m. and intubated Chase within a few minutes of his arrival. A respiratory therapist continued bagging Chase after intubation.

Chase's medical team determined that he should be transferred to Minneapolis Children's Hospital for further treatment. Around 8:25 p.m., the neonatal transport team arrived and took over Chase's care. Another chest x-ray was taken, and it revealed a large pneumothorax³ on Chase's chest. Blood gases run at 7:20 p.m. and 8:40 p.m. showed that Chase had severe respiratory acidosis⁴ and was not adequately ventilating. Another test taken at 10:06 p.m. showed metabolic acidosis.⁵

The transport team and Chase left Owatonna Hospital at approximately 10:15 p.m., and arrived at Children's Hospital later that evening. At Children's Hospital, Chase received further medical care, including surgery to repair the diaphragmatic hernia. Chase was hospitalized at Children's Hospital until August 6. Chase was also diagnosed with numerous neurological problems, including cerebral palsy, acquired microcephaly, developmental and speech delays, and mild to moderate mental retardation.

In June 2005, Schroeder, acting as Chase's parent and natural guardian, filed a complaint alleging that Dr. Chambers and Owatonna Clinic; Kapp, Langr, and Allina;

³ A pneumothorax is a collection of air or gas in the pleural cavity. *Tabers Cyclopedic Medical Dictionary* 1430 (16th ed. 1989).

⁴ Respiratory acidosis is "caused by retention of carbon dioxide," and is "due to inadequate pulmonary ventilation or hypoventilation." *Stedman's Medical Dictionary* 15 (25th ed. 1990).

⁵ Metabolic acidosis is defined as "decreased pH and bicarbonate concentration in the body fluids caused either by the accumulation of acids or by abnormal losses of fixed base from the body, as in diarrhea or renal disease." *Stedman's Medical Dictionary* 15 (25th ed. 1990).

and Thompson and OAS were negligent in providing medical care to Chase. According to Schroeder's expert witnesses, Chase's condition was the result of "inadequate oxygenation, build up of carbon dioxide, and the resulting severe acidosis" that Chase suffered shortly after birth.

In support of this contention, Schroeder submitted initial and supplemental expert-disclosure affidavits pursuant to Minn. Stat. § 145.682 from numerous expert witnesses. Kapp, Langr, and Allina and Thompson and OAS moved for dismissal with prejudice, arguing that these affidavits did not meet the statutory requirements. The district court agreed, concluding that the expert-disclosure affidavits submitted in reference to the claims against Kapp, Langr, and Thompson were deficient under Minn. Stat. § 145.682 and that any claims against their respective employers, Allina and OAS, were based solely upon a theory of respondeat superior. Accordingly, the district court dismissed the claims against them. Schroeder settled with the remaining defendants, namely Dr. Chambers and Owatonna Clinic, before trial. This appeal follows, challenging the dismissal of the claims against (1) Kapp, Langr, and Allina, and (2) Thompson and OAS.

D E C I S I O N

When a medical-malpractice action requires expert testimony to establish a prima facie case, the plaintiff must produce an affidavit identifying each expert whom the plaintiff expects to call 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, subs. 2, 4(a) (2006). The expert-disclosure affidavit required by Minn. Stat. § 145.682, subd. 4(a), must set

forth specific details concerning the experts' expected testimony, including the applicable standard of care; identify the acts or omissions that violated the standard of care; and provide an outline of the chain of causation between the violation of the standard of care and the damage to the plaintiff. *Teffeteller v. Univ. of Minn.*, 645 N.W.2d 420, 428 (Minn. 2002). Plaintiffs must strictly comply with these disclosure requirements. *Broehm v. Mayo Clinic Rochester*, 690 N.W.2d 721, 726 (Minn. 2005). And noncompliance results in "mandatory dismissal with prejudice of each action as to which expert testimony is necessary to establish a prima facie case." Minn. Stat. § 145.682, subd. 6(b) (2006). We review a dismissal under Minn. Stat. § 145.682 (2006) for an abuse of discretion. *Broehm*, 690 N.W.2d at 725.

"The primary purpose of an expert affidavit is to illustrate 'how' and 'why' the alleged malpractice caused the injury." *Maudsley v. Pederson*, 676 N.W.2d 8, 14 (Minn. App. 2004) (citing *Teffeteller*, 645 N.W.2d at 429 n.4). Accordingly, broad and conclusory statements of causation do not satisfy the requirements of the expert-disclosure statute. *Mercer v. Andersen*, 715 N.W.2d 114, 122 (Minn. App. 2006). And affidavits providing simply a "sneak preview" or "general disclosure" of an expert's testimony are inadequate. *Teffeteller*, 645 N.W.2d at 430. Instead, the affidavit must explain how the facts lead to the expert's opinions on malpractice and causation. *Sorenson v. St. Paul Ramsey Med. Ctr.*, 457 N.W.2d 188, 192 (Minn. 1990). To determine whether a particular affidavit satisfies Minn. Stat. § 145.682, courts should consider the entire affidavit, not simply the isolated sentences within it. *See Demgen v. Fairview Hosp.*, 621 N.W.2d 259, 262–63 (Minn. App. 2001) ("[T]he district court

improperly focused on two specific sentences in the affidavit instead of reading the affidavit as a whole.”), *review denied* (Minn. Apr. 17, 2001).

I

Schroeder alleges that the labor and delivery nurses were negligent in providing care to Chase before birth by failing to ensure that the appropriate personnel were present. Schroeder also alleges that the labor and delivery nurses were negligent in providing care to Chase after his birth by failing to recognize that he was not breathing properly and by letting him progress to the point that he suffered from brain damage before intubating him or summoning help. We address each allegation in turn.

A. Standard of care and breach (Kapp, Langr and Allina)

1. Pre-delivery care

Schroeder’s expert affidavits claim that nurses Kapp and Langr should have realized that polyhydramnios could be caused by many conditions, some of which could threaten the infant’s well-being, and therefore, they had an affirmative duty to ensure that proper neonatal support was present in the delivery room, even if Chase’s doctors had not ordered it. In support of that contention, affidavits from two other nurses state, “[T]he nurses had an affirmative duty to take additional steps necessary to have neonatal support there for delivery.” According to Schroeder’s experts, “proper neonatal support” includes

the presence of physicians such as a neonatologist and/or anesthesiologist and/or experienced nurse anesthetists who have expertise in the care of infants with serious respiratory conditions such as [a diaphragmatic hernia]. This experience would include knowledge of when to intubate such infants,

proven skills at intubating infants with respiratory conditions and/or lung abnormalities, proven experience in monitoring the condition of infants with respiratory problems, experience in ventilating infants with fragile and incompletely developed lungs such as Chase, and specialized high frequency ventilators.

The district court concluded, however, that the affidavits misidentified the standard of care, because the nurses did not have a duty to compel the doctors to take additional treatment steps. Minnesota caselaw supports this conclusion.

The Minnesota Supreme Court has expressly “declined to impose a general duty on nurses to compel a physician to take additional treatment steps.” *Wall v. Fairview Hosp. & Healthcare Servs.*, 584 N.W.2d 395, 405 (Minn. 1998); *see also Mercil v. Mathers*, 517 N.W.2d 328, 328 (Minn. 1994) (concluding that nurses did not have “a legal duty to insist or even order the doctors to conduct an on hands examination of the patient” (internal quotation marks omitted)). In general, nurses have a duty to “obey and diligently execute the orders of the physician or surgeon in charge of the patient” unless their orders are obviously negligent or unless an emergency exists, in which case nurses can exercise their own judgment until they can receive instructions from the doctor. *Mesedahl v. St. Luke’s Hosp. Ass’n of Duluth*, 194 Minn. 198, 204, 206, 259 N.W. 819, 822 (1935).

In *Mesedahl*, the Minnesota Supreme Court explained that an order to set a patient on fire would be obviously negligent. *Id.* Although Schroeder’s expert-disclosure affidavits assert that failing to provide “proper neonatal support,” as defined by the affidavits, was obviously negligent, this omission cannot be equated to setting a patient

ablaze. Moreover, even if the nurses had a duty to compel the doctors to take certain treatment steps, on this record, it is far from clear that they had any medical basis for doing so. It is undisputed that the nurses were unaware of the diaphragmatic hernia before Chase's birth and following his delivery. Indeed, Schroeder's own expert-disclosure affidavits explain that Dr. Chambers failed to detect the condition during the ultrasound and it was not diagnosed until nearly an hour after delivery and after Chase left the nurses' care. Furthermore, we note that the affidavits fail to explain how the nurses could have been expected to ensure that certain support, such as high frequency ventilators, were present at the time of Chase's birth when Schroeder's own experts admit that "[n]one of this expertise or equipment was available at Owatonna Hospital[, a non-tertiary care facility,] when Chase was born."

The district court found that the affidavits identified another standard of care for the nurses' pre-delivery conduct, explaining that the nurses had "an affirmative duty to communicate and inquire regarding a plan for delivery." The district court found, however, that the affidavits did not demonstrate a causal link between the nurses' failure to communicate or inquire regarding the plan for delivery and Chase's injuries. Rather than directly challenging this conclusion, Schroeder asserts that the nurses had an affirmative obligation to ensure that the necessary personnel were present, not just a duty to communicate or inquire. But that argument fails for the reason explained above.

2. Post-delivery care

Schroeder next contends that the nurses breached the standard of care by failing to recognize that Chase was not breathing properly and by allowing him to progress to the

point that he suffered brain damage before either intubating him themselves or promptly summoning assistance. In dismissing the claims against Kapp and Langr, the district court explained that since the “affidavits state that the OB Nurses were the care givers for the newborn from delivery at 6:22 p.m. until 7:00 p.m., or for the first 38 minutes of life,” the “conclusory allegation that the claimed breaches ‘were a significant contributing factor to the severity of the hypoxic condition . . . suffered in . . . the first hours of life’” was not specific enough to provide a chain of causation.

The facts in the record and recited by the affidavits reveal that Chase’s condition, as reflected by his Apgar score, improved, at least temporarily, and that the diaphragmatic hernia remained undiagnosed while in the nurses’ care. Chase was, however, blue in color, had grunting respirations, and was flaccid or limp when he was taken to the nursery at 7:00 p.m. and seen by Dr. Schoeneman. Schroeder’s experts opine that the nurses should have recognized that Chase’s condition was deteriorating and that they delayed 10 to 15 minutes before addressing his condition. Careful observation, the experts claim, would have led to earlier intubation. But a delay in diagnosis alone does not prove causation. *Leubner v. Sterner*, 493 N.W.2d 119, 122 (Minn. 1992); *see also Maudsley*, 676 N.W.2d at 13–14 (“The conclusory statements that generally earlier treatment results in better outcomes and that every hour counts fail to outline specific details explaining how and why [a doctor’s] 15- to 17-hour delay in treatment caused [the plaintiff’s] blindness.”). Schroeder’s experts assert that Chase was exhibiting signs of respiratory distress when he arrived at the nursery, and that these signs could not have “develop[ed] suddenly during the 20 second trip to the nursery.” But Schroeder’s experts

do not point to any evidence to support their claim that the nurses should have spotted Chase's problems 10 to 15 minutes before they took him to the nursery or any evidence that the nurses waited 10 to 15 minutes after seeing signs of distress. *See Sorenson*, 457 N.W.2d at 192–93 (explaining that an affidavit that provided “empty conclusions,” such as “the defendants ‘failed to properly evaluate’ and ‘failed to properly diagnose’” fell short of the statute’s requirements).

B. Causation (Kapp, Langr and Allina)

Schroeder relies on affidavits from several experts in an attempt to outline causation. Dr. Donald K. Nelms, M.D., explains that the tests conducted on Chase showed that he was not adequately ventilating, because he had severe respiratory acidosis at 7:20 p.m. and 8:40 p.m. and metabolic acidosis at 10:06 p.m. This “inadequate ventilation,” according to Nelms’s affidavit, “leads to respiratory acidosis, which leads to metabolic acidosis, which leads to damage to the brain and other organs,” and Chase’s neurological injuries were due to “inadequate oxygenation, build up of carbon dioxide, and the resulting severe acidosis.” Likewise, Dr. Jeffrey L. Wener, M.D., notes that “[i]nadequate resuscitation leads to inadequate oxygenation, which leads to hypoxia and acidosis.”

The affidavits stress that time was of the essence in treating Chase. Dr. Nelms, for instance, asserts that “[t]he continued presence of inadequate ventilation caused continuing harm to [Chase]. The longer the condition continued, the more organ damage, including brain damage, occurred due to the passage of time.” Another expert, Dr. Audrius V. Plioplys, M.D., contends that “Chase would have avoided the severe

hypoxic event from which he suffered and which caused the brain damage with its associated conditions from which he suffers today” if he had received proper resuscitation at birth and afterwards, explaining that “[e]very minute of inadequate resuscitation causes additional damage. This is a cumulative event. Very simply, if you decrease the time during which the resuscitation is inadequate, then you decrease the amount of brain damage.” And Dr. Philip L. Glick, M.D., similarly asserts that Chase’s injuries worsened as time passed, stating that “[w]ith each passing minute of ineffective ventilation, hypoxia and acidosis worsen, causing damage to the lungs, brain and other organs.” He explains that

care of an infant with diaphragmatic hernia should begin with the first breath. With every breath that the infant takes before diagnosis and/or adequate treatment is achieved, the infant’s condition worsens. Proper and timely resuscitation of Chase would have avoided the severe hypoxic insult that he sustained at Owatonna Hospital in the first hours of life.

Although these statements explain how inadequate ventilation or resuscitation contributed to Chase’s injuries, they do not explain with specificity how the nurses’ actions or omissions after delivery caused Chase’s injuries. *See Sorenson*, 457 N.W.2d at 193 (requiring that the affidavits provide “specific details concerning their experts’ expected testimony, including . . . an outline of the chain of causation”); *Maudsley*, 676 N.W.2d at 14 (requiring that the affidavits provide an outline of the chain of causation with “specific details”). Statements like “every minute . . . causes additional damage” are not sufficient to satisfy the requirements of Minn. Stat. § 145.682. *See Maudsley*, 676

N.W.2d at 13–14 (stating that affidavit that included statement that “every hour counts” is insufficient to satisfy the strict standard for expert affidavits).

In sum, the expert-disclosure affidavits do not identify an applicable standard of care for the nurses’ pre-delivery conduct. Even assuming that the affidavits establish an applicable standard of care for the nurses’ post-delivery conduct and a breach of that standard of care, they are still inadequate under Minn. Stat. § 145.682 because they do not provide a chain of causation. Accordingly, the district court did not abuse its discretion by dismissing the claims against Kapp, Langr, and Allina.

II

The district court dismissed the claims against Thompson and OAS because the expert-disclosure affidavits failed to establish a causal link between Thompson’s actions or omissions and Chase’s injuries. In doing so, the court explained:

None of the affidavits provide any factual link, or show how the experts arrive at the conclusion, to link Thompson’s actions prior to [Chase] receiving the highest level of respiratory care available in Owatonna, a non-tertiary care center, at approximately 8 p.m. and the first diagnosis of metabolic acidosis at 10:06 p.m.

On appeal, Schroeder again points to the affidavits discussed above to establish a chain of causation. The experts assert that, under the applicable standard of care, Thompson should have intubated Chase within several minutes of her arrival between 7:20 p.m. and 7:25 p.m., but that she breached that standard of care when she did not start intubation until 7:35 p.m., made two attempts at intubation, and then resumed bagging Chase without the intubation. They also claim that Thompson should have called

Cowell, a more-experienced CRNA, when she learned that Chase had a diaphragmatic hernia, but that she inexcusably delayed in calling the more-experienced personnel. According to the affidavits, had Thompson called Cowell sooner, Chase would have been intubated 10 or 15 minutes earlier. After Cowell intubated Chase, Dr. Nelms claims that Thompson continued to breach the standard of care by writing her report while a less-experienced respiratory therapist bagged the baby, explaining that Chase suffered a pneumothorax as a result. And Dr. Nelms also claims that Thompson breached the standard of care when she allowed Cowell to place a medical IV after he intubated, while she wrote her report.

According to Schroeder's expert witnesses, these breaches "caused considerable delay in achieving adequate resuscitation, which was a significant factor that contributed to the neurological damages suffered by Chase in the first hours of life." Dr. Nelms asserts that Thompson's breaches "significantly caused and/or contributed to Chase Huisman's severe hypoxic and acidotic state." And Dr. Glick states that Thompson's breaches "were a significant contributing factor to the severity of the hypoxic condition that was suffered by Chase in the first hours of his life," explaining that "inadequate resuscitation leads to inadequate oxygenation, which leads to hypoxia and acidosis." As explained above, the other affidavits indicate how inadequate ventilation or resuscitation led to Chase's neurological problems.

Minnesota courts have held that certain statements on causation do not satisfy the requirements of Minn. Stat. § 145.682. For instance, in *Mercer*, we held that a single statement that "the departure from the standard of care was a direct cause of [plaintiff's]

second degree burns” was insufficient. 715 N.W.2d at 123. And in *Teffeteller*, the Minnesota Supreme Court held that a statement that, “[T]he departures from accepted levels of care, as above identified, were a direct cause of [the patient’s] death,” was also inadequate, noting that they failed to explain “‘how’ and . . . ‘why’ the malpractice caused the injury.” 645 N.W.2d at 429, 429 n.4.

We acknowledge that the affidavits in this case do not treat the issue of causation as summarily as the affidavits in *Teffeteller* and *Mercer*, but they still fall short of providing a sufficient chain of causation. Schroeder vigorously asserts that Thompson should have intubated Chase sooner. But her expert affidavits admit that Thompson started intubation at 7:35, shortly after the diaphragmatic hernia diagnosis by Dr. Schoeneman. Thompson attempted to intubate the infant twice, removed the intubation tube and resumed bagging Chase. Schroeder’s experts point out that Thompson testified that she removed the intubation tube because she believed that her bagging was more effective than intubation in Chase’s case. They assert simply that, “This is not successful intubation,” but do not explain why Thompson’s efforts were not an effective means for ventilating the infant. More specifically, the affidavits do not explain why removing the tube and resuming bagging was not sufficient, and thus, it is not clear how Thompson’s actions caused the injury. We, therefore, cannot say that the district court abused its discretion by concluding that the affidavits did not establish the requisite chain of causation.

Likewise, although the affidavits allege that Thompson should have called Cowell sooner, they do not indicate that Thompson, a CRNA, lacked the skills or training to care for infants with diaphragmatic hernias. Dr. Nelms asserts that Thompson should not have written her report while a less-experienced respiratory therapist bagged Chase and while the more-experienced CRNA, Cowell, placed an IV. His affidavit asserts that Chase suffered a pneumothorax because he was bagged too forcefully by a less-experienced respiratory therapist and that this pneumothorax aggravated his condition. However, the affidavit again does not explain how the pneumothorax led ultimately to Chase's severe neurological problems. Moreover, the mere fact that one person may have more experience does not mean that another person is incompetent.

Finally, we note that the affidavits allege that Thompson's breaches "caused considerable delay" and were "a significant factor that contributed to [Chase's] neurological damages." Such statements are too broad and conclusory to satisfy Minn. Stat. § 145.682. *See Maudsley*, 676 N.W.2d at 13–14 (concluding that an affidavit was not sufficiently specific on causation where the expert's statement stated only that it was more likely than not that the plaintiff would not have lost vision in her right eye had treatment for post-operative eye surgery been initiated a day earlier and that, generally, the earlier an infection is treated, the better the outcome).

Because the affidavits do not provide a sufficient chain of causation between Thompson's alleged breach of the applicable standard of care and Chase's injuries, the district court did not abuse its discretion by concluding that the expert-disclosure affidavits were inadequate and by dismissing the claims against Thompson and OAS.

Affirmed.