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STATE OF MINNESOTA
IN COURT OF APPEALS
A13-0102

Scott Uram,
Appellant,

vs.

Dr. Jeffrey H. Nipper,
Respondent.

Filed July 22, 2013
Affirmed
Connolly, Judge

Hennepin County District Court
File No. 27-CV-11-17120

Jon Hawks, Edina, Minnesota; and

Wilbur W. Fluegel, Fluegel Law Office, Minneapolis, Minnesota (for appellant)

Mark R. Whitmore, Daniel R. Olson, Bassford Remele, A Professional Association, Minneapolis, Minnesota (for respondent)

Considered and decided by Connolly, Presiding Judge; Stoneburner, Judge; and Rodenberg, Judge.

U N P U B L I S H E D   O P I N I O N

CONNOLLY, Judge

Appellant challenges the grant of summary judgment dismissing his three medical-malpractice claims, arguing that the district court erred in dismissing his claim of

misdiagnosis on the ground that appellant's surgery was without harm or danger as a matter of law, his claim of delayed diagnosis on the ground that he failed to prove damages, and his lack-of-informed-consent claim on the ground that it was not properly disclosed. Because we see no error in the district court's dismissal of these claims, we affirm.

FACTS

In December 2008, appellant Scott Uram sustained an injury to his right ring finger. His family doctor referred him to an orthopedic surgeon, respondent Dr. Jeffrey Nipper. Respondent discovered a bony fragment and partial dislocation and recommended surgery to insert a pin and wire to hold the bone in the correct position. Appellant had signed an informed consent form on January 5, 2009; respondent performed the surgery on January 13, 2009.

Ten days later, at a postoperative appointment, respondent discovered that the bone was not in the correct position and further surgery would be necessary. On January 27, respondent began the second surgery but discovered that appellant had an infection, and the surgery could not be completed. Respondent removed the pin and wire, debrided the area, cultured the infection so it could be identified, and prescribed a general antibiotic. On January 30, appellant called the clinic to complain that his finger was hot and painful. By this time, the cultures of appellant's infection were complete, and appellant's family doctor looked at them, identified the infection, and prescribed an antibiotic specific to it. On February 3, appellant, who had previously been a patient at the Mayo clinic, transferred his care to that institution. Doctors at Mayo prescribed a six-

week course of antibiotics against the infection, which healed. But the infection had caused loss of bone and muscle, the distal joint had fused, and appellant could no longer bend the tip of the finger.

In June 2011, a doctor in Atlanta, Georgia, signed an expert's affidavit asserting that respondent had committed medical malpractice. The affidavit stated:

> [I]t was [respondent's] professional opinion and strong recommendation that he [respondent] should proceed with surgery to treat [appellant's] condition.
>
> . . . [I]t is my firm and definite opinion that [respondent] has, in fact, deviated from the standard of good medical care. It is further my opinion that [respondent's] departure from that standard of care was the direct cause of [appellant's] subsequent injuries.
>
> . . . [M]ore specifically, [respondent] was negligent for several reasons, first and foremost:
>
> a. He misdiagnosed [appellant's] condition by determining that [appellant's] injury to his right ring finger consisted of a large bony fragment and that the joint was subluxed.
>
> b. My review of the x-rays in conjunction with the radiologist's report clearly indicate[s] that [appellant] did not have, in any way, a subluxed joint and did not have a large bony fracture. Instead, he had a very small bony fragment of approximately four (4) mm.
>
> c. [Respondent] did not offer an alternative, non-operative treatment of simple splinting, which would have resulted in [an] excellent outcome without any significant surgical risks or residuals.
>
> d. Instead, [respondent] strongly recommended surgical treatment as the only reasonable alternative.
>
> e. Because of the misdiagnosed condition of [appellant], [respondent] proceeded with surgical intervention that was, otherwise, unnecessary.

[S]econdly, the following facts show that [respondent] committed medical malpractice by failing to timely treat [appellant's] infection on his first post-op follow-up visit with [respondent].

a. Although the X-ray taken on January 23, 2009 clearly showed that the bone above the joint had nearly disappeared, having been destroyed by bone/flesh-eating bacteria, [respondent] failed to diagnose it as such and thus failed to inform [appellant].

b. Although these findings were clearly evident, [respondent] did not take any immediate action to deal with this severe infection.

The consequences and cost of [respondent's] negligence can be seen as follows:

a. [Appellant] suffered significant complications of the surgical treatment, including a severe infection of his finger that could well have been both limb threatening and life threatening.

b. [Appellant] learned that the name of the infection he had was "Enterbacter Aerogenes," one of the most antibiotic resistant strains of bacteria.

c. As a result, [appellant] self referred himself for more specialized treatment and care at the Mayo Clinic in Rochester, MN.

d. [Appellant's] subsequent impairment, complications, and permanent disfigurement were the direct result of [respondent's] departure from the standard of care.

That to summarize in laymen's terms, if [appellant] had been treated by [respondent] in the manner [appellant] would have chosen, had he been properly informed, he would not have elected for any surgery whatsoever. As a result of the unnecessary surgery, [appellant] developed a severe life threatening infection that went untreated by [respondent] for more than four (4) days. As a result of the infection, [appellant] was rushed to the Mayo Clinic in Rochester, Minnesota for emergency treatment of the infection. Although the infection was eventually successfully treated, [appellant] now has permanent disfigurement and a significant loss of use of his right ring finger.

> . . . [N]early all past medical costs as well as all present and future medical treatment costs can be attributed to [respondent's] negligence.

In August 2011, appellant filed the expert's affidavit and brought this action against respondent, alleging that "[his] medical injuries were directly and proximately caused by [respondent's] negligence . . . because the initial surgery where [appellant] obtained the infection was not necessary and never should have been performed." The deposition of appellant's expert was scheduled for May 9, 2012, in Atlanta.

On May 7, 2012, two days before the scheduled deposition, appellant presented respondent with 27 additional theories of malpractice, none of which had been mentioned in his complaint or in his expert's affidavit. Respondent's counsel travelled to Georgia for the expert's deposition, which was also to serve as his trial testimony. On direct examination, over respondent's objection, the expert testified on the newly alleged theories of malpractice. After 40 minutes of cross-examination, the expert said he had a scheduling conflict and left, and the deposition was continued.

On May 22, 2012, appellant filed a revised affidavit from his expert. It differed significantly from the original affidavit. Additions are underlined; deletions are stricken.

> The medical records and deposition testimony from [respondent], as well as the affidavit and deposition testimony from [appellant] that I reviewed indicate that it was [respondent's] professional opinion ~~and strong recommendation~~ that [appellant's] finger required surgery and that he [respondent] should proceed with said surgery ~~to treat [appellant's] condition~~ on January 13, 2009.
>
> . . . That based upon my review of [appellant's] records and his sworn testimony, it is my firm and definite opinion that [respondent] has, in fact, deviated from the

standard of good medical care. It is further my opinion that [respondent's] departure from that standard of care was the direct cause of [appellant's] subsequent injuries.

. . . [M]ore specifically, [respondent] was negligent for several reasons, first and foremost:

~~a. He misdiagnosed [appellant's] condition by determining that [appellant's] injury to his right ring finger consisted of a large bony fragment and that the joint was subluxed;~~

~~b. My review of the x-rays in conjunction with the radiologist's report clearly indicate[s] that [appellant] did not have, in any way, a subluxed joint and did not have a large bony fracture. Instead, he had a very small bony fragment of approximately four (4) mm.~~

a. [Respondent] did not offer an alternative, non-operative treatment of simple splinting, which would have resulted in an excellent outcome without any significant surgical risks or residuals.

~~d. Instead, [respondent] strongly recommended surgical treatment as the only reasonable alternative.~~

b. [Respondent] made the decision to operate because the injury "required" surgery.

c. [Respondent's] failure to advise [appellant] that the operation is hazardous (after admitting to such in his depo. Pg. 72).

d. [Respondent's] failure to advise [appellant] that the operation has an extraordinarily high complication rate, well over 25% and as high as 50% in some recently reported studies.

e. [Respondent's] failure to determine if [appellant] was the type of patient who could NOT tolerate a splint (such as a surgeon or dentist) for the six plus weeks needed to heal.

f. [Respondent's] failure to advise [appellant] of the expected results if he treated him in a splint.

g. [Respondent's] failure to advise [appellant] of the acceptable and successful alternatives to surgery.

h. [Respondent's] failure to advise [appellant] on the initial visit of January 5, 2009 of remodeling of the joint surface despite the alignment of the

fracture (as he has since admitted to in his deposition); hence, there was no justification for doing surgery based on fracture.

i. [Respondent's] failure to advise [appellant] of expected decrease in flexion of the DIP joint if he operated with the K wire used at surgery.

j. [Respondent] advised [appellant] that surgical treatment was required.

~~k. Because of the misdiagnosed condition of [appellant],~~ [Respondent] proceeded with surgical intervention that was, otherwise, unnecessary.

l. [Respondent] failed to obtain a true and honest informed consent because he told [appellant] that surgical treatment was required and then proceeded with unnecessary surgical intervention.

. . . [S]econdly, the following facts show that [respondent] committed medical malpractice ~~by failing to timely treat [appellant's] infection on his first post-op follow-up visit with respondent~~ in performing the open reduction surgery on January 13, 2009.

~~a. Although the X-ray taken on January 23, 2009 clearly showed that the bone above the joint had nearly disappeared, having been destroyed by bone/flesh-eating bacteria, [respondent] failed to diagnose it as such and thus failed to inform [appellant].~~

~~b. Although these findings were clearly evident, [respondent] did not take any immediate action to deal with this severe infection.~~

a. [Respondent's] failure to get an x-ray, after reducing the finger in a splint on January 5, 2009, and before the January 13, 2009 surgery to determine whether the placement of the fracture and/or joint alignment had improved.

b. [Respondent's] failure to obtain an x-ray on the day of surgery, 1/13/09, to check and verify the position of the K-wire, the joint, and the fracture.

c. [Respondent's] failure to insert the K-wire properly at the surgery on 1/13/09 which should have been down the canal of the distal phalanx.

d. [Respondent's] failure to provide the necessary protection in the form of a splint after the surgery on 1/13/09.

Thirdly, the following facts show that [respondent] committed medical malpractice ~~by failing~~ to timely treat [appellant's] infection on his first post-op follow-up visit with [respondent].

a. Although the X-ray taken on January 23, 2009 clearly showed ~~that the bone above the joint had nearly disappeared, having been destroyed by bone/flesh-eating bacteria,~~ severe bone loss above the joint, [respondent] failed to diagnose or suspect it as such and thus failed to treat and inform [appellant].

b. [Respondent] failed to properly interpret the x-ray of 1/23/09.

c. [Respondent] failed to diagnose the condition of probable acute osteomyelit[i]s on the 1/23/09 post-op exam and x-rays.

d. Although these findings were clearly evident, [respondent] did not take any immediate action to deal with this severe infection.

e. [Respondent] failed to urgently return [appellant] to surgery on 1/23, 1/24, 1/25, or 1/26/09.

f. [Respondent] failed to prescribe an antibiotic effective against osteomyelitis on 1/27/09 (not Keflex).

g. [Respondent] failed to follow up on culture results on 1/29/09.

h. [Respondent] failed to follow up on culture results on 1/30/09.

i. [Respondent] failed to follow up on culture results on 1/31/09.

j. [Respondent] failed to follow up on culture results on 2/1/09.

k. [Respondent] failed to diagnose [appellant] with a gram neg. osteomyelitis on 1/29, 1/30, 1/31, or 2/1/09.

l. [Respondent] failed to discontinue an ineffective drug, Keflex, after sensitivities were noted on 1/30/09. As a result, Keflex was not discontinued until [another doctor] did so on February 3, 2009.

The consequences and cost of [respondent's] negligence can be seen as follows:

a. [Appellant] suffered significant complications of the surgical treatment, including a severe

> infection of his finger ~~that could well have been both limb threatening and life threatening.~~
>
> ~~b. [Appellant] learned that the name of the infection he had was "Enterbacter Aerogenes," one of the most antibiotic resistant strains of bacteria.~~
>
> b. ~~As a result~~, [appellant] self referred himself for more ~~specialized~~ proper treatment and care at the Mayo Clinic in Rochester, MN.
>
> c. [Appellant's] subsequent impairment, complications, and permanent injury/disfigurement were the direct result of [respondent's] departure from the standard of proper medical care.
>
> That to summarize in laymen's terms, if [appellant] had been treated by [respondent] in the manner [appellant] would have chosen, and had he been properly informed, [appellant] would not have elected for any surgery whatsoever. As a result of the unnecessary surgery, [appellant] developed a severe life threatening infection that went untreated, then improperly treated by [respondent] ~~for more than four (4) days.~~ As a direct and proximate result of the improper[ly] treated infection, [appellant] was ~~rushed to~~ seen at the Mayo Clinic in Rochester, Minnesota for emergency treatment of the infection. Although the infection was eventually successfully treated, [appellant] now has permanent [disfigurement] and a significant loss of use of his right ring finger, and pain radiating into his hand.
>
> [N]early all of the past medical costs as well as all present and future medical treatment and the costs thereof for [appellant's] right ring finger and hand can be attributed to [respondent's] negligence.

On May 28, 2012, appellant's expert's deposition was concluded in Georgia. On June 13, 2012, the district court issued an order limiting the expert's testimony to the issues disclosed in his original affidavit, excluded the expert's testimony on informed consent because that issue had not been disclosed in that affidavit, denied appellant's

motion to amend the pleadings, and noted that another district court judge had been assigned to the case.

On June 29, 2012, counsel for respondent wrote to the second district court judge, stating that (1) the trial testimony of appellant's expert, which was being offered by deposition, had been completed; (2) in respondent's opinion, appellant's expert's testimony was not sufficient for the case to go to a jury; (3) the parties agreed that, in the interests of judicial economy, the court should resolve this issue prior to trial under Rule 56 of the Minnesota Rules of Civil Procedure; (4) appellant also asked the court to reconsider his motion to amend the pleadings; and (5) respondent sought attorney fees incurred when appellant's expert unilaterally terminated the first session of his deposition, necessitating a second trip to Georgia for respondent's attorney.

Following a hearing in August, the district court issued an order in November 2012 denying appellant's motion to amend the complaint, granting respondent's motion for summary judgment, dismissing the complaint with prejudice, and awarding respondent $1,000 in attorney fees.

Appellant challenges the dismissal of his medical-malpractice claims based on misdiagnosis of his injury, delayed diagnosis of his infection, and lack of informed consent.

D E C I S I O N

1. Misdiagnosis of the injury

A prima facie case of medical malpractice requires expert testimony showing: (1) the standard of care in the particular community relative to the patient's condition,

(2) that the defendant departed from this standard, and (3) that the departure was a direct cause of the plaintiff's injuries. *Plutshack v. Univ. of Minn. Hosps.*, 316 N.W.2d 1, 5 (Minn. 1982). "[A] moving party is entitled to summary judgment when there are no facts in the record giving rise to a genuine issue for trial as to the existence of an essential element of the nonmoving party's case." *DLH, Inc. v. Russ*, 566 N.W.2d 60, 71 (Minn. 1997) (quotation omitted). "[T]he mere existence of a scintilla of evidence" in the nonmoving party's position is not sufficient to survive summary judgment. *Id.* (quotation omitted).

In his original affidavit, appellant's expert opined that respondent was first negligent when "[h]e misdiagnosed [appellant's] condition by determining that [appellant's] injury to his right ring finger consisted of a large bony fragment and that the joint was subluxed." This language was stricken from the second affidavit, as was the phrase "Because of the misdiagnosed condition of [appellant]" that had started the sentence "[Respondent] proceeded with surgical intervention that was, otherwise, unnecessary." Thus, when the expert revised his affidavit, he removed the claim of misdiagnosis that he gave as the reason why appellant's surgery was unnecessary.

On this point, the expert's deposition testimony contradicts his original affidavit and corroborates his second affidavit. He testified:

> [T]he mere act of doing the surgery is not malpractice. . . . I'm not saying that doing the surgery per se is outside the standard of care.
>
> . . . .
>
> [I]t's not that one is not allowed to do an operation for this [i.e., appellant's condition], okay, in order to meet the standard of care. It is allowed to do the operation.

> . . . .
> [Appellant] meets the indications for a surgeon that wants to do the surgery. He does meet those indications. I don't think there's any dispute about that.

Thus, the record supports the district court's finding that "[appellant] is not able to sustain the theory that [respondent] misdiagnosed [appellant] and, because of this misdiagnosis, proceeded with a surgical intervention that was otherwise unnecessary."

Appellant argues that the "[m]isdiagnosis [c]laim [p]resented a [h]arm from the [p]ain of [s]urgery [c]ompared to the [i]nconvenience of [s]plinting" and that this comparison creates a genuine issue of material fact to be resolved by a jury. But appellant does not provide expert evidence that respondent violated any standard of care by performing surgery, regardless of whether surgery was more painful than splinting, and appellant's expert repeatedly conceded that performing the surgery did not violate the standard of care.

Because appellant did not produce expert evidence on one element of the misdiagnosis claim, i.e., that respondent violated the standard of care by performing surgery based on a misdiagnosis, the district court did not err in granting summary judgment dismissing appellant's misdiagnosis claim.

2. Delay in diagnosing infection

The district court concluded that the delayed-diagnosis-of-the-infection claim fails because appellant did not show what injury was caused by the delay. Appellant challenges this conclusion, arguing that his expert's affidavits show causation. But the expert's affidavits do not support this argument.

Appellant's expert originally stated that the January 23, 2009, x-ray "clearly showed that the bone above the joint had nearly disappeared, having been destroyed by bone/flesh eating bacteria" and that the failure to timely diagnose the infection caused "a severe infection of [appellant's] finger that could well have been both limb threatening and life threatening." His second affidavit revised this to state that the x-ray clearly showed "severe bone loss above the joint" and that the failure to timely diagnose caused "a severe infection of [appellant's] finger." Thus, the bone loss had already occurred before January 23, when appellant argues it should have been diagnosed; it could not have been the result of a failure to diagnose the infection that day.

The district court relied on *Maudsley v. Pederson*, 676 N.W.2d 8, 14 (Minn. App. 2004) (affirming dismissal of medical malpractice case on the basis of an inadequate expert's affidavit). In *Maudsley*, the expert's affidavit stated:

> It is more likely than not that if treatment had been initiated on June 27, rather than June 28, [plaintiff] would not have lost the vision in her right eye. . . . When infections are present, it is generally true that better outcomes are the result of earlier treatment; in fact every hour counts.

Id. at 10. When asked to supplement his affidavit "because it lacked specific information regarding causation," the *Maudsley* expert added a sentence: "It is more likely than not that if treatment had been initiated on June 27, 1999, that [plaintiff] would have recovered from the infection and had the vision she had at the time surgery was performed on June 17, 1999." *Id.* Neither the original nor the supplemented affidavit was deemed adequate:

> 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 [the doctor's] 15- to 17-hour delay in treatment caused [the plaintiff's] blindness. As the district court correctly noted, a delay in diagnosis is not enough; if it were, expert testimony on causation would not be necessary.

Id. at 14.

As in *Maudsley*, appellant's expert's affidavits failed to do more than point out that earlier treatment is preferable; they did not identify why or how treating appellant's infection on January 27 instead of on January 23 or 24 caused appellant's injuries to any significant extent.[1] *See DLH*, 566 N.W.2d at 71 ("[T]he mere existence of a scintilla of evidence" in the nonmoving party's position is not sufficient to survive summary judgment). Thus, the district court did not err in dismissing the delayed diagnosis claim.

3. Informed consent claim

The first district court judge assigned to this case issued an order stating that "the testimony of [appellant's expert] shall be limited to the issues disclosed in his [original] Affidavit . . . filed [in support of the complaint]" and that "[appellant's expert] cannot

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[1] Appellant relies on three unpublished cases, *Karedla v. Obstetrics & Gynecology Assocs. P.A.,* A11-1423, 2012 WL 2077894 (Minn. App. June 11, 2012); *Kramer v. St. Cloud Hosp*., A11-1187, 2012 WL 360415 (Minn. App. Feb. 6, 2012), and *Kuhne v. Allina Health System*, A09-1826, 2010 WL 2363406 (Minn. App. June 15, 2010), *review denied* (Minn. Aug. 24, 2010), to argue that "Cases have Rejected the Application of *Maudsley* in these Circumstances." As unpublished decisions of this court, *Karedla, Kramer,* and *Kuhne* have no precedential value. *See Dynamic Air, Inc. v. Bloch*, 502 N.W.2d 796, 800 (Minn. App. 1993). Moreover, all three are distinguishable because all three involved expert affidavits that adequately addressed causation. *See Karedla*, 2012 WL 2077894 at *7-*8; *Kramer*, 2012 WL 360415 at *10; *Kuhne*, 2010 WL 2363406 at *7.

testify regarding issues of informed consent." But appellant's expert did testify on the issue of informed consent, and appellant moved to amend the complaint by adding a claim for failure to obtain informed consent. The second district court judge denied the motion on two grounds: (1) the claim was untimely, having been submitted "well after the close of discovery" and after "the trial testimony of [appellant's] expert has occurred and [respondent] has brought[] what is[,]in essence[,] a motion for directed verdict"; and (2) the claim could not survive summary judgment.

"Generally, the decision to permit or deny amendments to pleadings is within the discretion of the district court and will not be reversed absent a clear abuse of discretion." *Johns v. Harborage I, Ltd.*, 664 N.W.2d 291, 295 (Minn. 2003). But "[w]hether the district court has abused its discretion in ruling on a motion to amend may turn on whether it was correct in an underlying legal ruling," which we review de novo. *Doe v. F.P.*, 667 N.W.2d 493, 500-01 (Minn. App. 2003), *review denied* (Minn. Oct. 21, 2003).

Appellant's complaint alleged only that "[his] medical injuries were directly and proximately caused by [respondent's] negligence because the initial surgery where [appellant] obtained the infection was not necessary and never should have been performed." Claims of "[n]egligent nondisclosure and negligent care and treatment can overlap at times, but they are different causes of action." *Russell v. Johnson*, 608 N.W.2d 895, 899 (Minn. App. 2000), *review denied* (Minn. June 27, 2000). Thus, appellant's pleaded claim of negligent care and treatment was not sufficient to put respondent on notice of a claim of negligent nondisclosure.

Appellant's argument to the contrary was addressed in *Bigay v. Garvey*, 575 N.W.2d 107, 109 (Minn. 1998) (rejecting the view that an original claim of negligent care and treatment in performance of surgery and an amended claim of negligent nondisclosure both arose from the same general conduct and occurrence that caused the injury and were "based on a common factual transaction").

> [The] original complaint contained nothing to put the defendants on notice that a negligent nondisclosure claim might be asserted. The original complaint focuses only on the defendants' actions in performing the surgery itself; it makes no mention of [the surgeon's] actions in presurgery consultations, when [the patient's] consent was obtained.

Id. at 110.

Amendment of claims is generally permitted, unless the party opposing amendment can establish some sort of prejudice. *Envall v. Ind. Sch. Dist. No. 704*, 399 N.W.2d 593, 597 (Minn. App. 1987), *review denied* (Minn. Mar. 25, 1987). But here, as the district court noted, the trial testimony of appellant's expert had been taken; respondent had, in effect, moved for a directed verdict; and "[i]t would [have been] highly prejudicial to force [respondent] to have to try this case over again by allowing [appellant] to simply amend the complaint and allege whole new theories of malpractice." The district court did not abuse its discretion in denying the motion to amend as untimely.

Nor did it abuse its discretion by denying the motion to amend because the proposed claim could not survive summary judgment. *See Bebo v. Delander*, 632 N.W.2d 732, 740 (Minn. App. 2001) (holding that a motion to amend is properly denied

when the claim to be added could not survive summary judgment), *review denied* (Minn. Oct. 16, 2001). A claim for negligent nondisclosure requires a plaintiff "to demonstrate that a reasonable person in the plaintiff's position would have refused the treatment had he been informed of the undisclosed risk." *Reinhardt v. Colton*, 337 N.W.2d 88, 96 (Minn. 1983) (quotation omitted).

Before the surgery, appellant and respondent both signed a "Verification of Informed Consent For Treatment." It provided in relevant part:

> I [appellant] have had a chance to talk with the doctor [respondent] about the procedure:
> - What it is and what it involves.
> - How it may help me (benefits).
> - The most likely and serious ways it might harm me (risks).
> - The possible long-term effects.
> - Other choices for treatment and their risks and benefits.
> - What will probably happen if I say no.
> - How I might feel right away afterward and how quickly I am expected to recover[.]
> - What medicines I may need, including some that may control my pain and others that may sedate me or make me sleepy.

Appellant testified that, at his first meeting with respondent, he asked for a splint because he planned to leave on a trip, and respondent told him, "[N]o, we have to have surgery. If you don't do it by then, [i.e., when you return from the trip] your finger will be dysfunctional, it won't do anything." Thus, appellant knew of the possibility of treating his injury with a splint and knew of the risks of surgery when he chose to have surgery.

Appellant also testified that, when he spoke to one of the doctors at Mayo, he said, "I understand medicine is a practice, I understand things happen, I understand one percent of the people get infections . . . ." Appellant did not testify that, if respondent had told him that the surgery could result in infection, he would not have had the surgery.

The district court did not abuse its discretion in denying appellant's motion to amend the complaint to add a negligent-nondisclosure claim or in dismissing the malpractice claims based on misdiagnosis and delayed diagnosis.

Affirmed.