[Cite as *Burk v. Fairfield Ambulatory Surgery Ctr., Ltd.*, 2014-Ohio-4062.]

COURT OF APPEALS
FAIRFIELD COUNTY, OHIO
FIFTH APPELLATE DISTRICT

JESSICA L. BURK	:	JUDGES:
	:	
	:	Hon. Sheila G. Farmer, P.J.
Plaintiff-Appellant	:	Hon. John W. Wise, J.
	:	Hon. Patricia A. Delaney, J.
-vs-	:	
	:	Case No. 13-CA-85
	:	
FAIRFIELD AMBULATORY SURGERY CENTER, LTD, DBA RIVER VIEW SURGERY CENTER, ET AL.	:	
	:	
Defendants-Appellees	:	O P I N I O N

CHARACTER OF PROCEEDING:	Appeal from the Fairfield County Court of Common Pleas, Case No. 11CV-722
JUDGMENT:	REVERSED & REMANDED
DATE OF JUDGMENT ENTRY:	September 5, 2014

APPEARANCES:

For Plaintiff-Appellant:

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Delaney, J.

{¶1} Plaintiff-Appellant Jessica L. Burk appeals the November 7, 2013 judgment entry of the Fairfield County Court of Common Pleas granting summary judgment in favor of Defendants-Appellees Fairfield Ambulatory Surgery Center, Ltd., dba River View Surgery Center; LuAnn Kaiser, R.N.; Todd Armen, M.D.; and Fairfield Anesthesia Associates, Inc. on Burk's claim of medical negligence.

FACTS AND PROCEDURAL HISTORY

{¶2} On September 8, 2010, Plaintiff-Appellant Jessica L. Burk went to the Fairfield Ambulatory Surgery Center, Ltd., dba River View Surgery Center ("Surgery Center") for a scheduled outpatient surgical removal of a ganglion cyst from her left wrist. The Surgery Center is not attached to a hospital. Dr. Keith Hollingsworth was to perform the surgery on Burk's wrist.

{¶3} Dr. Todd Armen was scheduled to work as one of the anesthesiologists at the Surgery Center the day of Burk's outpatient surgery. He was assigned as the anesthesiologist for Burk's surgery. On September 8, 2010, Dr. Armen met with Burk before the surgery and conducted an anesthesia preoperative evaluation. He evaluated her as an ASA 1, which meant he found her to be generally healthy and without significant medical problems.

{¶4} Because of the nature of Burk's surgery, Dr. Armen chose to use a regional block called a Bier Block. He would combine the Bier Block with certain sedation and pain medications. For this procedure, the Bier Block involves the placement of an inflatable cuff tourniquet around the patient's forearm and the use of Lidocaine, a regional anesthetic injected into the patient's arm below the tourniquet.

Lidocaine is a drug used as a local anesthetic and as an anti-arrhythmic drug. At high doses, Lidocaine can cause serious arrhythmias.

{¶5} When conducting a Bier Block, Dr. Armen first uses an Esmarch bandage to wrap the patient's arm. The wrap exsanguinates the blood to have a bloodless field at the surgery site. The nurse next places a single cuff tourniquet on the forearm. The tourniquet prevents the escape of the Lidocaine into the systemic circulation. The tourniquet is hooked into the tourniquet machine/generator, which inflates the cuff, monitors the inflation of the cuff, and monitors the duration of the inflation of the cuff. The inflation and deflation of the cuff is controlled by a dial on the generator. If the cuff malfunctions or deflates itself, an alarm sounds. For a normal-sized forearm, the pressure of the cuff is 250 milligrams of mercury. The tourniquet cuff is inflated until the surgical procedure is completed. The nurse present in the operating room can control the inflation or deflation of the cuff pursuant to Dr. Armen's direction. Dr. Armen has the ability to inflate and deflate the cuff himself so that he can perform three or four cycles of deflation and inflation, where he completely deflates the cuff for a period of three to five seconds and then reinflates the cuff to 250 milligrams. Dr. Armen performs the inflation and deflation process to allow the gradual release of the Lidocaine into the systemic circulation so that the patient is not delivered one large bolus of Lidocaine, which could cause a possible toxic reaction.

{¶6} On September 8, 2010, Burk presented in the operating room. Present in the operating room were Dr. Hollingsworth, Dr. Armen, and circulating nurse LuAnne Kaiser. The estimated length of the surgery to remove the cyst from Burk's left wrist was 15 minutes.

{¶7} Dr. Armen placed the Bier Block on Burk's left arm. The tourniquet cuff was inflated to 250 milligrams at 11:31 a.m. The recorded time was based on the clock in the operating room. Nurse Kaiser did not recall noticing anything wrong with the tourniquet cuff at the time it was placed on Burk's arm. Dr. Armen administered to Burk the common dosage of Lidocaine for a Bier Block in the amount of 30 ml, 0.5 percent. He also gave Burk sedation and pain medications through her I.V. including Diprivan, Fentanyl, Bupivacaine, and Versed. A blood pressure cuff and pulse oximeter were placed on her right arm. Burk received oxygen through nasal cannula.

{¶8} During the surgery, Dr. Armen was stationed near Burk's head. Dr. Armen had full view of the monitors that monitored her blood pressure, heart activity, and oxygen saturation levels. Dr. Armen charted those levels throughout the surgery. The pulse oximeter is also monitored through an audible alert. The pulse oximeter beeps when it registers a heart rate and the tone of the beep corresponds to the saturation. The blood pressure monitor, pulse oximeter, and EKG have audible alarms that sound if the patient is in distress.

{¶9} Nurse Kaiser was seated at a desk in the operating room, but in a position where she could observe the patient. She was working on charting the notes of the surgery. At the end of the 15 minute surgery, Dr. Hollingsworth was seated to the left of the patient and Dr. Armen was at the head of the patient. Nurse Kaiser looked at Burk's face and it appeared to be colored a dusky blue. Nurse Kaiser wasn't sure if the blue drapes were causing Burk's face to look blue, so she stood up and came around the patient to look at the patient, the monitor, and to speak to Dr. Armen. When she came to Dr. Armen, Nurse Kaiser observed that Dr. Armen was not looking at Burk's face. She

observed Dr. Armen looking in a different direction at an electronic device in his hand. When she came to the patient, Nurse Kaiser said to Dr. Armen that Burk did not look good. Nurse Kaiser saw Dr. Armen immediately start investigating Burk's status.

{¶10} Dr. Armen checked the monitor and noticed the heart rate with a low number for heart rate. He watched Burk's heart rate go from the 50s to 18 to 20 and then to zero. This occurred at approximately 11:45 a.m. No alarms from the monitors sounded. Dr. Armen expected the alarms to sound. It was later determined from a GE representative that the alarm for asytole does not happen for two minutes after the event. Dr. Armen did not know if that would explain why the blood pressure monitor alarm did not sound. When the event happened, the blood pressure cuff was inflated and the oxygen saturation monitor had gone down correspondingly because it was on the same arm. When the blood pressure cuff deflated, the oxygen saturation tone did not return back, alerting Dr. Armen that the patient was in distress. Dr. Armen had set the pulse oximeter threshold amount at 50 percent.

{¶11} Dr. Armen immediately began mask ventilation of Burk. Nurse Kaiser called a code to get assistance in the operating room. Dr. Armen injected Burk with epinephrine. A nurse arrived in the room and began chest compressions on Burk. Within two minutes, at 11:47 a.m., Burk had a heart rate with a sinus rhythm. Dr. Armen intubated Burk at 11:52 a.m. because Burk was not breathing independently. An EMS squad reported to the operating room and transferred Burk to the Fairfield Medical Center.

{¶12} At the time Burk had the asystolic event, Dr. Armen and Nurse Kaiser did not observe the status of the tourniquet cuff to determine if it was inflated or deflated.

After the asystolic event, the tourniquet cuff was observed to be deflated. Dr. Armen did not know when the tourniquet cuff was deflated. He did not deflate the tourniquet cuff and he did not instruct Nurse Kaiser to deflate the tourniquet cuff. Nurse Kaiser did not deflate the tourniquet cuff and did not know who deflated the tourniquet cuff. Dr. Armen stated he believed it was inflated at the time of the asystolic event because the surgeon's field was bloodless throughout the procedure and the bandages were being placed on the patient when she became asystolic. Nurse Kaiser did not believe the cuff prematurely deflated because she did not recall hearing noises indicating that it prematurely deflated. After the asystolic event and before Burk was transferred, Nurse Kaiser needed to complete the patient chart. Nurse Kaiser went to the tourniquet machine/generator and noted the monitor reported the cuff was inflated for 15 minutes. Based on the monitor, Nurse Kaiser charted that the cuff was deflated at 11:46 a.m. because it was inflated at 11:31 a.m. pursuant to the clock in the operating room.

{¶13} Burk was admitted to the Fairfield Medical Center and remained there until September 17, 2010. She was then transferred to the Ohio State University Medical Center for inpatient rehabilitation. She remained at that facility until October 1, 2010.

{¶14} On July 28, 2011, Burk filed a medical negligence claim against Fairfield Ambulatory Surgery Center, Ltd., dba River View Surgery Center; LuAnn Kaiser, R.N.; Todd Armen, M.D.; and Fairfield Anesthesia Associates, Inc. She alleged the Defendants-Appellees failed to meet the standard of care on September 8, 2010. As a result of their failure to meet the standard of care, Burk claimed she suffered an arrhythmia, anoxic brain injury and memory and speech deficits.

{¶15} Burk's expert, Dr. Mark Dershwitz, was deposed on February 28, 2013. Appellees Dr. Armen and Fairfield Anesthesia Associates, Inc. filed a motion for summary judgment and Appellees Nurse Kaiser and Fairfield Ambulatory Surgery Center also filed a motion for summary judgment. In their motions, Appellees argued that while Dr. Dershwitz identified alleged failures in the standard of care, Dr. Dershwitz's testimony failed to create a genuine issue of material fact to show that a breach of the standard of care and/or the alleged failure of the standard of care was the proximate cause of Burk's alleged injuries.

{¶16} The trial court granted Appellees' motions for summary judgment on November 7, 2013. It is from this decision Burk now appeals.

ASSIGNMENT OF ERROR

{¶17} Burk raises one Assignment of Error:

{¶18} "THE TRIAL COURT ERRED IN HOLDING THAT APPELLEES ARE ENTITLED TO SUMMARY JUDGMENT FOR THE REASON THAT GENUINE ISSUES OF MATERIAL FACT REMAIN."

ANALYSIS

SUMMARY JUDGMENT STANDARD OF REVIEW

{¶19} Burk's sole Assignment of Error argues the trial court erred in granting summary judgment in favor of Appellees. We refer to Civ.R. 56(C) in reviewing a motion for summary judgment which provides, in pertinent part:

> Summary judgment shall be rendered forthwith if the pleading, depositions, answers to interrogatories, written admissions, affidavits, transcripts of evidence in the pending case and written stipulations of fact,

> if any, timely filed in the action, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. * * * A summary judgment shall not be rendered unless it appears from such evidence or stipulation and only from the evidence or stipulation, that reasonable minds can come to but one conclusion and that conclusion is adverse to the party against whom the motion for summary judgment is made, such party being entitled to have the evidence or stipulation construed most strongly in the party's favor.

{¶20} The moving party bears the initial responsibility of informing the trial court of the basis for the motion, and identifying those portions of the record before the trial court, which demonstrate the absence of a genuine issue of fact on a material element of the nonmoving party's claim. *Dresher v. Burt,* 75 Ohio St.3d 280, 292, 662 N.E.2d 264 (1996). The nonmoving party then has a reciprocal burden of specificity and cannot rest on the allegations or denials in the pleadings, but must set forth “specific facts” by the means listed in Civ.R. 56(C) showing that a “triable issue of fact” exists. *Mitseff v. Wheeler,* 38 Ohio St.3d 112, 115, 526 N.E.2d 798, 801 (1988).

{¶21} Pursuant to the above rule, a trial court may not enter summary judgment if it appears a material fact is genuinely disputed. *Vahila v. Hall,* 77 Ohio St.3d 421, 429, 674 N.E.2d 1164 (1997), citing *Dresher v. Burt,* 75 Ohio St.3d 280, 662 N.E.2d 264 (1996).

MEDICAL NEGLIGENCE

{¶22} It is well settled that, "in order to establish medical malpractice, it must be shown by a preponderance of evidence that the injury complained of was caused by the

doing of some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar conditions or circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done under like or similar conditions and circumstances, and that the injury complained of was the direct and proximate result of such doing or failing to do some one or more of such particular things." *Bruni v. Tatsumi*, 46 Ohio St.2d 127, 346 N.E.2d 673, 675 (1976), paragraph one of syllabus. Summarized, a prima facie case of medical malpractice consists of a showing that: (1) the physician deviated from the ordinary standard of care exercised by other physicians, *i.e.* the physician was negligent, and (2) such deviation was the proximate cause of the patient's injury. *Egleston v. Fell*, 6th Dist. No. L-95-127, 1996 WL 50161, *2 (Feb. 9, 1996) citing *Bruni*, 46 Ohio St.2d 127, paragraph one of syllabus.

{¶23} It is well settled in Ohio that in order to prevail in a medical malpractice claim, a plaintiff must demonstrate through expert testimony that, among other things, the treatment provided did not meet the prevailing standard of care and the failure to meet the standard of care caused the patient's injury. *Ramage v. Central Ohio Emergency Services, Inc.*, 64 Ohio St.3d 97, 102, 1992-Ohio-109, 592 N.E.2d 828; *Hoffman v. Davidson*, 31 Ohio St.3d 60, 62, 508 N.E.2d 958 (1987). Proof of the recognized standards must necessarily be provided through expert testimony. This expert must be qualified to express an opinion concerning the specific standard of care that prevails in the medical community in which the alleged malpractice took place, according to the body of law that has developed in this area of evidence. *Bruni* at 131-132. However, there is an exception made to this general rule where an element of

medical malpractice is “within the comprehension of layman and requires only common knowledge and experience to understand and judge it * * *.” *Egleston v. Fell*, 6th Dist. Lucas No. L-95-127, 1996 WL 50161 (Feb. 9, 1996) citing *Bruni* at 130.

{¶24} Burk's expert was Dr. Mark Dershwitz. He is on the faculty of the University of Massachusetts Medical School where he has an appointment in the Department of Anesthesiology and the Department of Biochemistry and Molecular Pharmacology. Dr. Dershwitz also does clinical work as an anesthesiologist.

{¶25} During the deposition of Dr. Dershwitz, Dr. Dershwitz provided four opinions as to the deviation of the standard of care. Dr. Dershwitz testified as to the first deviation: "So the first deviation from the standard of care, I cannot ascribe to an individual or an entity of any kind. I will let the jury decide that. But I believe beyond a reasonable degree of medical certainty that the tourniquet deflated prematurely in this case. And I can hypothesize a number of different routes by which that could have happened, but I am unable to choose between the potential etiologies." (Depo., p. 52). The premature release of the tourniquet caused the Lidocaine to be introduced into Beck's system, which caused an arrhythmia and the cessation of breathing. (Depo., p. 86).

{¶26} Dr. Dershwitz's opinion as to the second deviation of the standard of care was: "My second standard of care criticism is, and again, I do not know to whom to attribute this, but it appears that no alarms made noise during this case. And if that is the case, as several witnesses have testified, then either the equipment was defective or the alarms were disabled. But either of those possibilities represents a deviation from the standard of care." (Depo., p. 52-53).

{¶27} Dr. Dershwitz testified that his third standard of care opinion was that, "Dr. Armen testified that he set the alarm for the oximeter at 50 percent. That cutoff or threshold value for an oximetry alarm is below the standard of care." (Depo., p. 53).

{¶28} Dr. Dershwitz testified the fourth standard of care deviation was, "[f]rom the anesthesia record, there is no indication that Dr. Armen measured and recorded the patient's end-tidal carbon dioxide or the patient's respiratory rate. And even under regional anesthesia or monitored anesthesia care, both of those are requirements for monitoring." (Depo., p. 53).

BREACH

{¶29} Appellees argue that Burk cannot establish the first element necessary to establish a medical malpractice: breach of the standard of care. Appellees state that while Dr. Dershwitz testified it was his opinion the tourniquet cuff deflated prematurely and the Lidocaine entered Burk's system as a single bolus, Dr. Dershwitz could not identify which party committed the negligent act. Dr. Dershwitz testified, "[s]o the first deviation from the standard of care, I cannot ascribe to an individual or an entity of any kind. I will let the jury decide that. But I believe beyond a reasonable degree of medical certainty that the tourniquet deflated prematurely in this case." (Depo. p. 52). He further stated:

> A. That is correct. All I can say is that the tourniquet deflated earlier than was intended, and that fact in and of itself was a deviation from the standard of care.
>
> Q. By someone?
>
> A. By someone or something or some combination of things.

Q. Of which you cannot specify?

A. I cannot ascribe blame, if you wish, or a degree of probability or anything like that.

(Depo., p. 127). Appellees argue that because Dr. Dershwitz cannot ascribe negligence to one person, Burk cannot establish a breach of the standard of care.

{¶30} Dr. Dershwitz opined that the premature deflation of the tourniquet caused the release of the Lidocaine into Burk's system. Both Dr. Armen and Nurse Kaiser testified in their depositions as to their use of the tourniquet cuff on the day of Burk's surgery. Neither Dr. Armen nor Nurse Kaiser had any recollection of how the tourniquet cuff came to be deflated. Dr. Armen stated that the nurse placed the tourniquet cuff on the patient's arm. Dr. Armen then explained the participation of the doctor and the nurse in the use of the tourniquet cuff:

Q. So the nurse would know that you prefer the single cuff for this particular procedure?

A. Correct. She knew I preferred the single cuff on the forearm.

Q. And that tourniquet that is placed is also hooked onto a monitor?

A. It's hooked onto the tourniquet machine. It monitors the degree of inflation of the cuff and the duration of the inflation of the cuff.

Q. And is there a variance of what the inflation rate of the cuff is?

A. Yes. You set what that inflation level is.

Q. And who determines that?

A. I do.

Q. And you tell the nurse?

A. Yes.

* * *

Q. Okay. And does that cuff then stay inflated until the procedure is finished?

A. Yes. Until I give the okay for it to be decreased.

Q. Okay. That was my question. Who then controls the inflation and deflation of the cuff?

A. The nurse generally controls the inflation and deflation depending on how I order it to be deflated and inflated. Often -- more often than not, I physically deflate it myself because I do a cycle deflation when I do that, where I deflate it for a period of three to five seconds and reinflate it and do that cycle three to four times.

Q. Okay. So if the nurse -- you said -- you indicated that the nurse normally controls the inflation and deflation, meaning physically she is the one that would press the button for it to go down and press the button for it to go up? Is it a button that goes down?

A. It's a dial, button.

Q. So she's the one that would at your request --

A. Yes.

Q. -- order --

A. She would ask me if I want the tourniquet inflated and to what I want the tourniquet inflated or what I want the tourniquet deflated or when I want it deflated.

Q. All right. So without your instruction or order, the nurse will not deflate or inflate the cuff.

A. That's my general understanding.

Q. And that's how you prefer to practice?

A. Correct.

Q. So in terms of when the cuff is deflated or inflated, that is within your control? * * * I'm talking generally.

A. Generally, yes.

Q. All right. And you indicated typically that you -- or that you typically will physically actually control the deflation yourself with the dial, correct?

A. Correct.

(Depo. p. 62-66).

{¶31} Nurse Kaiser testified to her experience with the tourniquet cuff:

Q. All right. Who typically deflates the tourniquet cuff and the end of a procedure?

A. That would be the circulator under the direction of the anesthesiologist.

Q. So, typically if things had happened according to plan in this case, Dr. Armen at some point in time would have said okay to let the cuff down?

A. Correct.

Q. How physically do you do that then? How physically is it done?

A. I dial it down on the generator.

Q. And is there a timeframe over which the cuff deflates or you can just dial it down?

A. It can be done all at once, or it can be done it steps.

Q. How do you, what is the preference of how you do it?

A. I do it under the direction of the anesthesiologist.

Q. So, he will tell you go ahead and let it down at once or do it in steps?

A. He will tell me go ahead and let it down, he or she. Some anesthesiologists prefer just to do it themselves in steps, there is a button that they can push and just let it down in increments.

Q. Do you ever get instructions to do it in increments, to let it down in increments?

A. I haven't. I have only watched it.

Q. So, when you get instruction in your practice, you have been only involved in the dialing down to let it down all at once?

A. Correct.

Q. Do you know Dr. Armen's preference from when you have worked with him, what your experience is?

A. He prefers to let it down in increments.

Q. And do it himself?

A. And do it himself. do that part as far as deflating.

(Depo., p. 91-93).

{¶32} Burk proposes that the alternative liability doctrine applies to determine the negligence of Dr. Armen or Nurse Kaiser. The alternative liability doctrine has been summarized as follows:

The classic illustration of the theory of alternative liability is *Summers v. Tice* (1948), 33 Cal.2d 80, 199 P.2d 1. In that case, the plaintiff and two defendants were hunting quail. The plaintiff proceeded up a hill such that the relative positions of the three hunters formed a triangle. The defendants' view of the plaintiff was unobstructed, and they knew the plaintiff's location. One of the defendants flushed a quail, which rose into the air and flew between the plaintiff and the two defendants. Both defendants fired their weapons, but instead of firing in the direction of the quail, they both shot in the plaintiff's direction. The plaintiff was injured when birdshot struck his eye and face. The evidence adduced demonstrated that both defendants were negligent in shooting in the plaintiff's direction but failed to demonstrate which defendant's gun was the source of the shot that injured the plaintiff.

On appeal, the court upheld the judgment in favor of the plaintiff and against both defendants, even though it remained undetermined which defendant's negligence was the proximate cause of the plaintiff's injuries. The court reasoned that when the negligence of both defendants is established but it cannot be established which person's negligence caused the plaintiff's injuries, there exists a " 'practical unfairness of denying the injured person redress simply because he cannot prove how much damage each did, when it is certain that between them they did all.' " *Summers,* supra, at 85–86, 199 P.2d 1, quoting Wigmore, Select Cases on the Law of Torts Section 153. The court went on to state that, in such

situations, " 'let [the negligent defendants] be the ones to apportion [the damage] among themselves.' " *Id*., at 86, 199 P.2d 1, quoting Wigmore, supra.

The *Summers* court further discussed the rationale for application of the doctrine of alternative liability as follows:

> "When we consider the relative position of the parties and the results that would flow if plaintiff was required to pin the injury on one of the defendants only, a requirement that the burden of proof on that subject be shifted to defendants becomes manifest. They are both wrongdoers—both negligent toward plaintiff. They brought about a situation where the negligence of one of them injured the plaintiff, hence it should rest with them each to absolve himself if he can. The injured party has been placed by defendants in the unfair position of pointing to which defendant caused the harm. If one can escape the other may also and plaintiff is remediless. Ordinarily defendants are in a far better position to offer evidence to determine which one caused the injury." *Id*.

Thus, even in its nascent form, the doctrine of alternative liability shifted only the burden of proof of causation away from the plaintiff in situations where two defendants acted negligently toward him or her, and the negligence of only one of the tortfeasors could have caused the plaintiff's injuries. Our research reveals that Ohio courts apply the doctrine of alternative liability in the same manner; that is, to shift the burden of

> proof of causation when the negligence of two parties has been established. In Ohio, the doctrine has never been broadened to shift the burden of proof of *negligence,* as appellant herein is requesting this court to do.

Peck v. Serio, 155 Ohio App.3d 471, 2003-Ohio-6561, 801 N.E.2d 890, ¶ 7-10 (10th Dist.).

{¶33} The alternative liability doctrine does not relieve Burk of her burden to prove that Dr. Armen and/or Nurse Kaiser breached the standard of care. Burk must still establish the negligence of either Dr. Armen or Nurse Kaiser. In this case, Dr. Dershwitz correctly stated that it is up to a jury as fact finder to determine the negligent party. Dr. Dershwitz testified it was a breach of the standard of care for the tourniquet cuff to prematurely deflate. Dr. Armen and Nurse Kaiser both testified that the nurse inflates the tourniquet cuff at the direction of the anesthesiologist. The nurse has a dial that controls the inflation. Dr. Armen and Nurse Kaiser both testified that it is Dr. Armen's practice that he physically controls the deflation of the tourniquet cuff so that it is deflated in increments to control the release of the Lidocaine. Nurse Kaiser testified that she has no recollection of the tourniquet cuff improperly deflating. There was no testimony by Dr. Armen or Nurse Kaiser that the particular tourniquet cuff system used during Burk's surgery operated on a timer.

{¶34} Dr. Dershwitz gave his expert opinion as to the negligent act, the premature deflation of the cuff. Nurse Kaiser and Dr. Armen both testified they had control over the instrument, which could have caused the tourniquet cuff to deflate. Reviewing the Civ.R. 56 evidence in a light most favorable to the non-moving party, we

find there is a genuine issue of material fact to be determined by the fact finder whether Dr. Armen or Nurse Kaiser was negligent.

PROXIMATE CAUSE

{¶35} Dr. Armen and Fairfield Anesthesia Associates, Inc. argued in their motion for summary judgment that while Dr. Dershwitz may have had opinions as to the deviations from the standard of care, Dr. Dershwitz's testimony gave only limited opinions on causation. Dr. Dershwitz testified:

> Q. * * * But first as a matter of reasonable degree of medical probability, what causation opinions do you hold?
>
> A. I believe that an elevated blood concentration of lidocaine was the proximate cause of the patient's arrhythmia.
>
> Q. Okay. Any others?
>
> A. I don't think so.
>
> Q. Okay. In terms of harm to the patient, did the patient suffer any deficits -- we'll just say acute deficits now as a result of the arrhythmia?
>
> A. Well, certainly the patient had an acute derangement in physiology by suffering a cardiopulmonary arrest. I am certainly not going to give expert opinions on whether or not those derangements in physiology that occurred acutely had any medium or long-term effect on her, because that is outside my area of expertise.
>
> * * *

(Depo., p. 85-86; 152-153).

{¶36} In her complaint, Burk stated that her injuries were, inter alia, cardiac arrest, anoxic brain injury, and memory and speech deficits. Dr. Dershwitz testified only to his opinion as to the causation of Burk's arrhythmia. Dr. Dershwitz also had no causation testimony as to his other standard of care opinions.

{¶37} Dr. Armen argues that because there is no expert testimony as to the proximate cause of Burk's other injuries, Burk's claim for medical negligence must fail. Dr. Armen is correct that expert testimony is required to establish a causal link between the alleged negligent act and the injury sustained. *Bruni* at 130. At the summary judgment stage of the proceedings, the standard is to consider the facts in a light most favorable to the non-moving party to determine whether there is a genuine issue of material fact for trial. Burk argues she will present the testimony of Burk's treating physicians at trial to establish Burk's other claimed injuries. Dr. Armen testified that Burk did not immediately regain consciousness after Dr. Armen resuscitated her nor was she breathing independently. The record shows that Burk was hospitalized for 23 days after she suffered the arrhythmia. From September 8, 2010 to September 17, 2010, Burk was hospitalized at Fairfield Medical Center. On September 17, 2010, Burk was transferred to the Ohio State University, Dodd Hall, for continued rehabilitation. She remained at Dodd Hall until October 1, 2010 when she was discharged to home. Considering the Civ.R. 56 evidence in a light most favorable to the non-moving party, we find there is a genuine issue of material fact whether the elevated concentration of Lidocaine in Burk's system was the proximate cause of Burk's arrhythmia which then caused Burk to suffer further injuries resulting in a lengthy hospitalization and medical expenses.

CONCLUSION

{¶38} Accordingly, we find upon our de novo review there are genuine issues of material fact as to whether Dr. Armen and/or Nurse Kaiser fell below the standard of care and caused Burk to suffer injuries on September 8, 2010.

{¶39} Burk's sole Assignment of Error is sustained.

{¶40} The judgment of the Fairfield County Court of Common Pleas is reversed and the matter is remanded for further proceedings consistent with this opinion and law.

By: Delaney, J.,

Farmer, P.J., and

Wise, J., concur.