OSTROWSKI v. AZZARA
Supreme Court of New Jersey, 1988.

I11 N.J. 429, 545 A.2d 148.

O'HERN, J. This case primarily concerns the legal significance of a medical malpractice claimant's pre-treatment health habits. Although the parties agreed that such habits should not be regarded as evidencing comparative fault for the medical injury at issue, we find that the instructions to the jury failed to draw the line clearly between the normal mitigation of damages expected of any claimant and the concepts of comparative fault that can preclude recovery in a fault-based system of tort reparation. Accordingly, we reverse the judgment below that disallowed any recovery to the diabetic plaintiff who had bypass surgery to correct a loss of circulation in a leg. The need for this bypass was found by the jury to have been proximately caused by the physician's neglect in performing an improper surgical procedure on the already weakened plaintiff.
As noted, the parties do not dispute that a physician must exercise the degree of care commensurate with the needs of the patient as she presents herself. This is but another way of saying that a defendant takes the plaintiff as she finds her. The question here, however, is much more subtle and complex. The complication arose from the plaintiff's seemingly routine need for care of an irritated toe. The plaintiff had long suffered from diabetes attributable, in unfortunate part perhaps, to her smoking and to her failure to adhere closely to her diet. Diabetic patients often have circulatory problems. For purposes of this appeal, we shall accept the general version of the events that led up to the operation as they are set forth in defendant-physician's brief.

On May 17, 1983, plaintiff, a heavy smoker and an insulin-dependent diabetic for twenty years, first consulted with defendant, Lynn Azzara, a doctor of podiatric medicine, a specialist in the care of feet. Plaintiff had been referred to Dr. Azzara by her internist whom she had last seen in November 1982. Dr. Azzara's notes indicated that plaintiff presented a sore left big toe, which had troubled her for approximately one month, and calluses. She told Dr. Azzara that she often suffered leg cramps that caused a tightening of the leg muscles or burning in her feet and legs after walking and while lying in bed. She had had hypertension {abnormally high blood pressure) for three years and was taking a diuretic for this condition.

Physical examination revealed redness in the plaintiff's big toe and elongated and incurvated toenails. Incurvated toenails are not ingrown; rather, they press against the skin. Diminished pulses on her foot indicated decreased blood supply to that area, as well as decreased circulation and impaired vascular status. Dr. Azzara made a diagnosis of onychomycosis (a fungous disease of the nails) and formulated a plan of treatment to debride {trim) the incurvated nail. Since plaintiff had informed her of a high blood sugar level, Dr. Azzara ordered a fasting blood sugar test and a urinalysis; she also noted that a vascular examination should be considered for the following week if plaintiff showed no improvement. Plaintiff next saw Dr. Azzara three days later, on May 20, 1983. The results of the fasting blood sugar test indicated plaintiff's blood sugar was high, with a

reading of 306. The urinalysis results also indicated plaintiff's blood sugar was above normal. At this second visit, Dr. Azzara concluded that plaintiff had peripheral vascular disease, poor circulation, and diabetes with a very high sugar elevation. She discussed these conclusions with plaintiff and explained the importance of better sugar maintenance. She also explained that a complication of peripheral vascular disease and diabetes is an increased risk of losing a limb if the diabetes is not controlled. The lack of blood flow can lead to decaying tissue. The parties disagree on whether Dr. Azzara told plaintiff she had to return to her internist to treat her blood sugar and circulation problems, or whether, as plaintiff indicates, Dr. Azzara merely suggested to plaintiff that she see her internist.

In any event, plaintiff came back to Dr. Azzara on May 31, 1983, and, according to the doctor, reported that she had seen her internist and that the internist had increased her insulin and told her to return to Dr. Azzara for further treatment because of her continuing complaints of discomfort about her toe. However, plaintiff had not seen the internist. Dr. Azzara contends that she believed plaintiff's representations. A finger-stick glucose test administered to measure plaintiff's non-fasting blood sugar yielded a reading of 175. A physical examination of the toe revealed redness and drainage from the distal medial {outside front) border of the nail, and the toenail was painful to the touch. Dr. Azzara's proposed course of treatment was to avulse, or remove, all or a portion of the toenail to facilitate drainage.

Dr. Azzara says that prior to performing the removal procedure she reviewed with Mrs. Ostrowski both the risks and complications of the procedure, including nonhealing and loss of limb, as well as the risks involved with not treating the toe. Plaintiff executed a consent form authorizing Dr. Azzara to perform a total removal of her left big toenail. The nail was cut out. (Defendant testified that she cut out only a portion of the nail, although her records showed a total removal.)

Two days later, plaintiff saw her internist. He saw her four additional times in order to check the progress of the toe. As of June 30, 1983, the internist felt the toe was much improved. While plaintiff was seeing the internist, she continued to see Dr. Azzara, or her associate, Dr. Bergman. During this period the toe was healing slowly, as Dr. Azzara said one would expect with a diabetic patient.

During the time plaintiff was being treated by her internist and by Dr. Azzara, she continued to smoke despite advice to the contrary . Her internist testified at the trial that smoking accelerates and aggravates peripheral vascular disease and that a diabetic patient with vascular disease can by smoking accelerate the severity of the vascular disease by as much as fifty percent. By mid-July, plaintiffs toe had become more painful and discolored.

At this point, all accord ceases. Plaintiff claims that it was the podiatrist's failure to consult with the patient's internist and defendant's failure to establish by vascular tests that the blood flow was sufficient to heal the wound, and to take less radical care, that left her with a non-healing, pre- gangrenous wound, that is, with decaying tissue. As a result, plaintiff had to undergo immediate bypass surgery to prevent the loss of the extremity. If

left untreated, the pre-gangrenous toe condition resulting from the defendant's nail removal procedure would have spread, causing loss of the leg. The plaintiffs first bypass surgery did not arrest the condition, and she underwent two additional bypass surgeries which, in the opinion of her treating vascular surgeon, directly and proximately resulted from the unnecessary toenail removal procedure on May 31, 1983. In the third operation a vein from her right leg was transplanted to her left leg to increase the flow of blood to the toe.

At trial, defense counsel was permitted to show that during the pre- treatment period before May 17, 1983, the plaintiff had smoked cigarettes and had failed to maintain her weight, diet, and blood sugar at acceptable levels. The trial court allowed this evidence of the plaintiff's pre-treatment health habits to go to the jury on the issue of proximate cause. Defense counsel elicited admissions from plaintiff's internist and vascular surgeon that some doctors believe there is a relationship between poor self-care habits and increased vascular disease, perhaps by as much as fifty percent. But no medical expert for either side testified that the plaintiffs post-treatment health habits could have caused her need for bypass surgery six weeks after defendant's toenail removal. Nevertheless, plaintiff argues that defense counsel was permitted to interrogate the plaintiff extensively on her post-avulsion and post-bypass health habits, and that the court allowed such evidence of plaintiffs health habits during the six weeks after the operation to be considered as acts of comparative negligence that could bar recovery rather than reduce her damages. The jury found that the doctor had acted negligently in cutting out the plaintiffs toenail without adequate consideration of her condition, but found plaintiffs fault (fifty-one percent) to exceed that of the physician (forty-nine percent). She was therefore disallowed any recovery. On appeal the Appellate Division affirmed in an unreported decision. We granted certification to review plaintiff's claims. We are told that since the trial, the plaintiff's left leg has been amputated above the knee. This was foreseen, but not to a reasonable degree of medical probability at the time of trial.

The court noted the factual complexities of the case and concluded that "the instructions to the jury in this case did not adequately separate or define the concepts that were relevant to the disposition of the plaintiff's case". The case was remanded for a new trial.