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Finding the Middle Ground: *Acuna v. Turkish* and the New Jersey Supreme Court's Reaffirmation of a Doctor's Role Under the Doctrine of Informed Consent in the Digital Age

Allyson M. Rucinski*

"Google it!" I have heard these words uttered countless times by people looking to obtain information about everything from a TV show, a historical event, or even a medical condition. And while the Internet itself is no longer a novel concept, the impact it is having on the everyday patient is ever evolving. With information readily available at the touch of a button, people are constantly using the Internet to read about their medical conditions, diagnose their symptoms, discover new medical breakthroughs, and even obtain a list of potential medications. The days of a doctor being a patient's primary source for medical information are gone. Today the Internet, in connection with direct-to-consumer advertising, has effectively transformed the "reasonable patient" into an "informed consumer." This new take on the reasonable patient is a far cry from its early twentieth century counterpart that was in existence during the development of the doctrine of informed consent.[1] Historically, the medical community considered patients ignorant of medicine, and accordingly, rested all medical decision-making authority with the doctor.[2] When the courts began to recognize a patient's right to self-determination, however, the issue of who decides what medical treatment a patient should un-

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1. *See* Kathy Seward Northern, *Procreative Torts: Enhancing the Common-Law Protection for Reproductive Autonomy*, 1998 U. ILL. L. REV. 489, 522 (1998).

2. *Id.* at 509-10.

dergo was shifted to the patient.[3] In order to assist patients in making these decisions, the doctrine of informed consent imposed a duty upon doctors to disclose medical treatment information to their patients prior to obtaining consent.[4] Over the years, different standards developed for judging the level of disclosure required for informed consent—from that of a reasonable medical practitioner, to that of a reasonable patient.[5] In addition, a body of law developed in the aftermath of *Roe v. Wade*[6] that focused on the specific informed consent requirements for a woman seeking an abortion.[7] Regardless of whether a doctor is seeking a patient's consent to remove a tumor or to have an abortion, the underlying public policy reasons behind the doctrine of informed consent remain the same today—"to ensure that patients have sufficient facts for making health care decisions."[8]

But if the purpose behind the doctrine of informed consent is to ensure that patients make educated health care decisions, what is the role of the doctor if the "reasonable patient" is now an "informed consumer"? For general medical procedures, many doctors have resorted to computer generated printouts, prepackaged pharmaceutical marketing pamphlets, and website referrals to satisfy the bare minimum duty under the doctrine of informed consent. Conversely, some states have taken it upon themselves to over-legislate in the area of abortion by requiring doctors to make excessive disclosures that are arguably moral, philosophical, or religious in nature. There needs to be a middle ground between these two extremes. The New Jersey Supreme Court provides guidance as to what this middle ground should be in its decision in *Acuna v. Turkish*.[9]

In *Acuna v. Turkish*, the New Jersey Supreme Court was asked to decide what a doctor is—and is not—required to dis-

3. *See* Paul A. Lombardo, *Phantom Tumors and Hysterical Women: Revising our View of the* Schloendorff *Case*, 33 J.L. MED. & ETHICS 791, 791 (2005).

4. *See* Northern, *supra* note 1, at 512-16 (discussing the different disclosure duties placed on doctors under various forms of the informed consent doctrine).

5. *Id.* at 516.

6. 410 U.S. 113 (1973).

7. Linda P. McKenzie, *Federally Mandated Informed Consent: Has Government Gone Too Far?*, 20 J.L. & HEALTH 267, 296-97 (2007).

8. *Id.* at 272.

9. 930 A.2d 416 (N.J. 2007).

close to a patient seeking an abortion.[10] The court reaffirmed that the common law doctrine of informed consent requires a doctor to *only* disclose material medical information, and it declined to impose a duty on physicians to inform a pregnant patient that an embryo is an existing, living, human being, or that abortion results in the killing of an irreplaceable existing human life.[11] The court also recognized that now, more than ever, with the wealth of information, studies, and knowledge readily available to patients, a doctor is not required to provide a patient with all the possible information available—only the information that is medically material.[12] Although the court limited what a doctor is required to disclose, it in no way diminished a doctor's role. Rather, the court's decision implicitly acknowledged that the informed consumer has created a greater need for the doctor to reemerge as a medical expert. This Note first discusses the origins of the doctrine of informed consent and the evolution of the two standards used today to determine the necessary level of disclosure: the reasonable medical practitioner and the reasonable patient. In addition, this Note addresses how the United States Supreme Court's decision in *Roe v. Wade* has substantially altered the role of the doctrine of informed consent in the area of abortion by expanding and, in many cases, legislating the specific disclosures that must be made by a doctor before performing an abortion. The second part of this Note discusses the New Jersey Supreme Court's decision in *Acuna v. Turkish* and the reasoning employed by the court in finding that a doctor is *only* required to disclose medically material information. Finally, the last section of this Note argues that in the context of an abortion case, the New Jersey Supreme Court's decision in *Acuna* provides guidance as to the

10. Under New Jersey's common law doctrine of informed consent "a physician has a legal duty to disclose to the patient all medical information that a reasonably prudent patient would find material before deciding whether to undergo a medical procedure." *Id.* at 425 (citing Largey v. Rothman, 540 A.2d 504 (N.J. 1988)). *See* discussion *infra* Part II (explaining in detail the doctrine of informed consent).

11. *Acuna*, 930 A.2d at 427-28. *See also Rothman*, 540 A.2d at 508 ("A risk would be deemed 'material' when a reasonable patient, in what the physician knows or should know to be the patient's position, would be 'likely to attach significance to the risk or cluster of risks' in deciding whether to forego the proposed therapy or to submit to it.") (internal citations omitted).

12. *Acuna*, 930 A.2d at 427-28.

level of disclosure a doctor in the digital age must provide under the doctrine of informed consent to a "reasonable patient" turned "informed consumer."

I. The Doctrine of Informed Consent

The doctrine of informed consent derives from the principle that a patient has a right to self-determination—to either permit or refuse medical treatment.[13] Under these auspices, informed consent imposes a two-prong duty on doctors: (1) a duty to disclose information pertaining to treatment, and (2) a duty to obtain a patient's consent prior to administering treatment.[14] The goal of informed consent statutes is to "safeguard a patient's physical well-being"[15] by having doctors and patients "share medical decision-making."[16] Although this information exchange between a doctor and patient seems commonplace today, the recognition of patient autonomy that formed the basis for informed consent within the doctor-patient relationship is relatively new, developing during the twentieth century.[17]

A. *Evolution of the Doctrine of Informed Consent*

Historically, doctors simply dictated a course of treatment to their patients.[18] This paternalistic approach to medicine reflected the perception of the times that the average patient was unable to understand medical science and only doctors possessed the knowledge and experience necessary to treat patients. Therefore, it was the doctors who alone made all of a

13. Douglas Andrew Grimm, *Informed Consent for All! No Exceptions*, 37 N.M. L. Rev. 39, 41-42 (2007).

14. *Id.* at 43.

15. Northern, *supra* note 1, at 510.

16. Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 20 Am. J.L. & Med. 147, 152 (1994).

17. Northern, *supra* note 1, at 509.

18. *See id.* at 509-10. Indeed, [u]ntil very recently, medical professionals interpreted the ethical injunction to work in the interest of patients to mean that they should make decisions *for* patients. Physicians generally assumed that medicine was primarily a science, that doctors were experts who would know better than patients what was in their interest, and that patients had neither the interest in becoming involved in medical decision-making nor the ability to do so. Doctors promoted benign paternalism. Rodwin, *supra* note 16, at 150-51.

patient's medical decisions.[19] Prior to the twentieth century, there was only limited disclosure as to the nature of the treatment, risks, or alternatives available to a patient.[20] In fact, what little was told to a patient was arguably not intended to facilitate the patient's process of making an educated decision regarding a course of treatment, but rather to assist the doctor in administering the treatment he had selected for the patient.[21] It was not until the twentieth century that the torts of battery and negligence were used to require doctors to give greater disclosure to patients, and to also provide a remedy to patients who did not receive adequate disclosure or who did not consent to a treatment.[22] The case of *Schloendorff v. New York Hospital*[23] is generally credited with establishing the idea of patient autonomy and a patient's right to self-determination in relation to medical decisions.[24] In *Schloendorff*, the patient brought an action for battery against a doctor who failed to obtain her consent prior to performing surgery.[25] In writing the opinion for the court, Judge Cardozo stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[26] This statement by Judge Cardozo is frequently referenced as establishing the origins of informed consent.[27] During the mid-twentieth century, courts shifted away from the tort of battery, to applying the doc-

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19. Northern, *supra* note 1, at 509.

20. Julie Gantz, Note, *State Statutory Preclusion of Wrongful Birth Relief: A Troubling Re-Writing of a Woman's Right to Choose and the Doctor-Patient Relationship*, 4 VA. J. SOC. POL'Y & L. 795, 799 (1997).

21. Northern, *supra* note 1, at 510. *See also* Gantz, *supra* note 20, at 799-800.

22. *See* Northern, *supra* note 1, at 510-11 (citing Natanson v. Kline, 350 P.2d 1093, 1104, *reh'g denied*, 354 P.2d 670 (Kan. 1960) (clarifying original decision)).

23. 105 N.E. 92 (N.Y. 1914). In *Schloendorff*, a female patient brought a medical malpractice suit against her doctor for performing an unauthorized surgery. *See* Lombardo, *supra* note 3, at 791. The doctor had found a tumor on the patient and the patient consented to having the doctor examine the tumor while she was under ether. *Id.* Instead of just examining the tumor, the doctor performed an operation that caused her to suffer leg injuries and lose fingers due to gangrene. *Id.*

24. Lombardo, *supra* note 3, at 791. *See also* Shelly S. Fraser, Note, *Hospital Liability: Drawing a Fine Line with Informed Consent in Today's Evolving Health Care Arena*, 1 IND. HEALTH L. REV. 253, 257 (2004).

25. Lombardo, *supra* note 3, at 793. *See* discussion of facts in *Schloendorff*, *supra* note 23.

26. *Schloendorff*, 105 N.E. at 93.

27. Lombardo, *supra* note 3, at 791.

trine of negligence to actions where a doctor failed to inform the patient of the material risks and benefits of a treatment or any alternatives.[28] In *Natanson v. Kline*, the court set forth a negligence approach to informed consent, by highlighting "that each man is considered to be the master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment[;] . . . the law does not permit [a doctor] to substitute his own judgment for that of the patient by any form of artifice or deception."[29]

The doctrine of informed consent ultimately developed to protect a patient's right to self-determination and to impose on doctors a duty to disclose information pertaining to a patient's treatment prior to obtaining consent.[30] For patients to bring an action in negligence for lack of informed consent, they must show that "(1) [the] 'risk was inherent to the medical or surgical procedure undertaken' and (2) the 'risk was material, in that it could influence a reasonable person's decision to consent to the procedure.'"[31] "A patient must also prove that a reasonable person would not have consented to the procedure if the material risk had been disclosed and that the lack of informed consent is the proximate cause of the injury."[32]

Generally, valid and informed consent requires "capacity, disclosure, and voluntariness."[33] As such, doctors are required to convey information to patients in terms they can understand.[34] Although capacity is traditionally a requirement of valid consent, an exception exists for emergency situations where a patient may lack the capacity to give such consent.[35] In addition, the voluntariness requirement is satisfied so long as a patient's decision is free from "force, coercion or manipula-

28. Northern, *supra* note 1, at 510. *See also* Rodwin, *supra* note 16, at 152.

29. Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960).

30. Northern, *supra* note 1, at 510.

31. Fraser, *supra* note 24, at 258.

32. *Id.*

33. Grimm, *supra* note 13, at 40. For a patient to have capacity, she must be able to "understand both the information presented and its relevance, and be able to appreciate the reasonably foreseeable consequences of her decision." *Id.* at 40-41.

34. *Id.* at 41.

35. *Id.* at 42, 65.

tion."[36] This includes when a patient voluntarily waives his or her right to informed consent.[37]

The requirement that is most often a source of contention is the proscribed level of disclosure. Typically, a doctor is required to disclose to a patient all pertinent information relating to medical or surgical treatment.[38] Treatment encompasses "all the steps taken to effect a cure of an injury or disease, including examination and diagnoses as well as application of remedies."[39] Informed consent, however, is presumed in situations that are "only diagnostic and are minimally invasive."[40] Some medical professionals believe that a doctor's obligation to disclose information to his patient is satisfied when he provides:

> (1) A description of the recommended treatment or procedure; (2) a description of the risks and benefits of the recommended procedure, with special emphasis on risks of death or serious bodily disability; (3) a description of the alternatives, including other treatments or procedures, together with the risks and benefits of these alternatives; (4) the likely results of no treatment; (5) the probability of success, and what the physician means by success; (6) the major problems anticipated in recuperation, and the time period during which the patient will not be able to resume his or her normal activities; and (7) any other information generally provided to patients in this situation by other qualified physicians.[41]

Conversely, there are cases where a doctor may not be required to disclose all information to a patient under a therapeutic privilege,[42] including cases where "disclosure may be harmful to the patient."[43]

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36. *Id.* at 41.

37. *Id.* at 42, 65.

38. *Id.* at 40, 67.

39. *Id.* at 41.

40. *Id.* at 65-66. These include "situations such as drawing blood, taking a temperature, or conducting routine physical exams." *Id.* at 65.

41. *Id.* at 43-44.

42. *Id.* at 42.

43. *Id.* at 65.

B. *Different Standards under Informed Consent*

Two primary standards have evolved to adjudge the appropriate level of disclosure required for informed consent: (1) the reasonable medical practitioner standard, and (2) the reasonable patient standard. Initially, negligence actions based on lack of informed consent were analyzed using the reasonable medical practitioner standard. This standard based the amount and type of information a doctor must disclose on what a reasonable medical practitioner would do under the same or similar circumstances.[44] Under this approach, physicians breached their duty when their disclosures fell below an acceptable standard established by fellow physicians.[45] Typically, a doctor had to "disclose collateral hazards of proposed treatment, as well as alternative modalities of therapy."[46] This was the dominant standard used by courts until the seminal case of *Canterbury v. Spence*[47] in 1972.

The court in *Canterbury v. Spence* adopted a new standard —the reasonable patient standard—for determining whether adequate disclosure had been made.[48] Under this objective standard, a doctor must disclose "what a reasonable person would find material to the decision to undergo treatment."[49] As such, a doctor is not required to disclose all the risks of a particular treatment, just those that are material.[50] "A risk is material when a reasonable patient, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether to forgo the proposed therapy or to submit to it."[51] In adopting this standard, the court recognized the inadequacies of

44. Northern, *supra* note 1, at 512.

45. *Id.*

46. *Id.*

47. 464 F.2d 772 (D.C. Cir. 1972). *Canterbury* was not the first case to announce a patient standard, but it is the leading case on the matter. Heyward H. Bouknight, III, Note, *Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence*, 60 WASH. & LEE L. REV. 1515, 1524-25 (2003).

48. *Canterbury*, 464 F.2d at 786-87.

49. Bethany J. Spielman, *Managed Care Regulation and the Physician-Advocate*, 47 DRAKE L. REV. 713, 724 (1999).

50. Northern, *supra* note 1, at 516.

51. *Id.* at 515-16.

a reasonable medical practitioner standard in achieving patient autonomy.

> In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision.[52]

Jurisdictions are split on which of the two standards to apply.[53] The majority of jurisdictions that employ a reasonable medical practitioner standard are also those that have statutorily regulated the level of disclosure required for informed consent.[54]

C. *Informed Consent and Abortion*

In the case of *Roe v. Wade*, the United States Supreme Court recognized a right of personal privacy under the Constitution, which "encompass[ed] a woman's decision whether or not to terminate her pregnancy."[55] While the Court held that a woman has a right to an abortion, it also noted that this right is not absolute.[56] The right is subject to a certain amount of regulation by the states to advance their legitimate interests in "protecting maternal health," "maintaining medical standards," and "protecting potential life."[57] States have used this language, however, as an opportunity to regulate abortion in a manner unlike any other medical procedure.[58] Specifically, states have attempted to increase the amount of information that a doctor is required to disclose to a woman before she can consent to an

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52. *Canterbury*, 464 F.2d at 786.

53. Fraser, *supra* note 24, at 257.

54. Northern, *supra* note 1, at 512.

55. 410 U.S. 113, 152-53 (1973).

56. *Id.* at 154-55.

57. Jeffrey A. Van Detta, *Constitutionalizing* Roe*,* Casey*, and* Carhart*: A Legislative Due-Process Anti-Discrimination Principle that Gives Constitutional Content to the "Undue Burden" Standard of Review Applied to Abortion Control Legislation*, 10 S. CAL. REV. L. & WOMEN'S STUD. 211, 222 (2001).

58. *Id.* at 246.

abortion.[59] Shortly after *Roe v. Wade* was decided, the Supreme Court in *Planned Parenthood of Central Missouri v. Danforth*[60] saw the first attempt by the states to expand the doctrine of informed consent in an abortion context. In *Danforth*, the Supreme Court upheld the constitutionality of a Missouri abortion statute that required a woman to certify her consent to an abortion procedure in writing.[61] The statute provided that "a woman, prior to submitting to an abortion during the first 12 weeks of pregnancy, must certify in writing her consent to the procedure and that her consent is informed and freely given and is not the result of coercion."[62] The Court recognized that while this requirement is unique to abortion, it is appropriate because the decision to abort "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences."[63]

In 1980, two additional challenges to existing abortion laws were presented to the courts. Each challenge sought to further expand informed consent requirements by requiring a doctor to give specific disclosures to patients seeking to obtain an abortion. The United States District Court for the District of North Dakota in *Leigh v. Olson*[64] and the United States Court of Appeals for the Seventh Circuit in *Charles v. Carey*,[65] applied the principles articulated by the Supreme Court in *Danforth*. Each court found certain provisions of the respective abortion laws to be unconstitutional.[66]

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59. Pennsylvania, in particular, has repeatedly attempted to enact statutory disclosures that a doctor must make before being able to perform an abortion. See the National Abortion and Reproductive Rights Action League, *U.S. Supreme Court Decisions Concerning Reproductive Rights 1965-2007*, Dec. 1, 2007, www.prochoiceamerica.org/assets/files/Courts-SCOTUS-Choice-Cases.pdf, for a list of Supreme Court decisions concerning reproductive rights, including four cases involving Pennsylvania statutes.

60. 428 U.S. 52 (1976).

61. *Id.* at 58-60.

62. *Id.* at 65.

63. *Id.* at 66-67. The Court also noted that the only other Missouri statute that required this type of consent for a general medical or surgical procedure was for "persons committed to the Missouri State chest hospital . . . or to mental or correctional institutions." *Id.* at 66 n.6.

64. 497 F. Supp. 1340 (D.N.D. 1980).

65. 627 F.2d 772 (7th Cir. 1980).

66. *Leigh*, 497 F. Supp. at 1352; *Charles*, 627 F.2d at 784.

The district court in *Leigh v. Olson* found a North Dakota statute, which, similar to *Danforth*, required a patient to certify her consent to an abortion in writing, to be unconstitutional. Specifically, the court took issue with the statutory requirement that a doctor put forth specific information that is of questionable truth and validity.[67] The disclosures at issue in the statute required a doctor to inform a patient of:

> c. The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.
> d. The immediate and long-term physical dangers of abortion, psychological trauma resulting from abortion, sterility and increases in the incidence of premature births, tubal pregnancies and stillbirths in subsequent pregnancies, as compared to the dangers in carrying the pregnancy to term.
> . . .
> f. Alternatives to abortion such as childbirth and adoption and information concerning public and private agencies that will provide the woman with economic and other assistance and encouragement to carry her child to term including, if the woman so requests, a list of the agencies and the services available from each.[68]

The court ruled that these disclosures imposed a direct burden on a woman's ability to obtain an abortion.[69]

Similarly, in *Charles v. Carey*, the Seventh Circuit considered the constitutionality of the Illinois Abortion Law of 1975, which also tried to expand the information requirements for doctors treating patients seeking an abortion. This statute made it a Class B misdemeanor if a doctor failed to inform a patient at least 24-hours before a procedure of the medical risks associated with that procedure; the probable gestational age of the fetus; the availability of state materials that depicted the different characteristics of a fetus at different gestational stages; and that a fetus is capable of feeling pain, as well as methods to control fetal pain.[70] The court held that these re-

67. *Leigh*, 497 F. Supp. at 1345.
68. *Id.* at 1344 (citing N.D. CENT. CODE § 14-02.1-02(4) (1979)).
69. *Id.* at 1345-46.
70. *Charles*, 627 F.2d at 781-82.

quirements posed an obstacle to a woman's ability to obtain an abortion and that the information regarding fetal pain was "medically meaningless, confusing, medically unjustified, and contraindicated, causing cruel and harmful stress to patients."[71]

Despite the limitations that courts appeared to be imposing on the disclosures required of a doctor before performing an abortion, the direction of informed consent took a dramatic turn when the United States Supreme Court decided the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[72] In *Casey*, the Supreme Court determined the constitutionality of the Pennsylvania Abortion Control Act of 1982.[73] Although the Court emphasized in its decision that it was not overruling *Roe v. Wade*, it did apply a different test—the undue burden test—in determining whether the Pennsylvania statute was constitutional.[74] Specifically, the undue burden test requires a determination of whether a "state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[75]

In *Casey*, the following provisions of the Pennsylvania Abortion Control Act were being challenged: (1) the informed consent provision that required a 24-hour waiting period prior to an abortion;[76] (2) the parental notification requirement for minors seeking an abortion; (3) the spousal notification requirement for married women; and (4) the reporting requirements

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71. *Id.* at 784.

72. 505 U.S. 833 (1992).

73. *Id.* at 844 (addressing the challenge to the Pennsylvania Abortion Control Act of 1982, 18 PA. CONS. STAT. §§ 3203-3220 (1982) (amended 1989)).

74. *Id.* at 846, 876.

75. *Id.* at 877.

76. *Id.* at 881. The 24-hour waiting period required that, except in cases of emergencies, a physician must provide a patient with certain information at least 24 hours prior to performing an abortion. *Id.* (discussing the Pennsylvania Abortion Control Act of 1982, 18 PA. CONS. STAT. § 3205 (1990)). This information included "the nature of the procedure, the health risks of the abortion and of childbirth, and the 'probable gestational age of the unborn child'" as well as notifying the woman "of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion." *Id.* Before a woman could have an abortion she had to certify in writing that this information was made available to her. *Id.*

for facilities providing abortion services.[77] In applying the undue burden test, the Court found that only the spousal notification requirement of the Act failed the test. The Court upheld the other informed consent provisions noting that "[i]f the information the State requires to be made available to the woman is *truthful and not misleading*, the requirement may be permissible."[78] The standard set forth in *Casey*—that the information be "truthful and not misleading"—has provided a large window of opportunity for states to require specific disclosures by doctors in cases of abortion.

After *Casey*, some states attempted to exploit the opportunity presented by the Court's reformulated test. For example, South Dakota passed a law requiring additional disclosures by a doctor before a patient can give informed consent for an abortion.[79] The constitutionality of South Dakota's statute was challenged in *Planned Parenthood Minnesota v. Rounds*.[80] Specifically, the statute required a physician "before performing an abortion and as a precondition to informed consent, [to] advise the patient that 'the abortion will terminate the life of a whole, separate, unique, living human being' and that 'by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated.'"[81] Although the outcome of these cases have varied, many states since *Roe v. Wade* have sought to use the doctrine of informed consent as a means of requiring a

77. *Id.* at 844.

78. *Id.* at 882 (emphasis added).

79. 2005 S.D. Sess. Laws 1166, *available at* 2005 SD H.B. 1166 (N.S.) (Westlaw).

80. Planned Parenthood Minn. v. Rounds, 467 F.3d 716, 727 (8th Cir. 2006), *reh'g en banc granted, opinion vacated* (Jan. 9, 2007). The United States Court of Appeals for the Eighth Circuit originally upheld the lower court's preliminary injunction because the majority of the panel found that the compelled disclosures "could . . . violate both the First Amendment rights of physicians and the due process rights of women seeking [an] abortion." *Id.* The Eighth Circuit, sitting *en banc*, subsequently vacated and remanded the original district court opinion. Planned Parenthood Minn. v. Rounds, 530 F.3d 724 (8th Cir. 2008), *vacating and remanding on reh'g en banc*, 375 F. Supp. 2d 881 (D.S.D. 2005). On remand, the plaintiffs and defendants both filed for summary judgment. Both motions were granted in part and denied in part. Planned Parenthood Minn. v. Rounds, No. Civ. 05-4077-KES, 2009 WL 2600753 (D.S.D. Aug. 20, 2009).

81. Acuna v. Turkish, 930 A.2d 416, 425 (N.J. 2007) (citing S.D. CODIFIED LAWS §§ 34-23A-10.1(1)(b), (d) (2005)).

substantially greater level of disclosure than that required for most medical procedures.[82] While scholars and individuals may disagree as to the "true purpose" behind these informed consent statutes,[83] what has become clear is that they can be used as a legislative tool to try to impose a duty on doctors to disclose information that is beyond the requirements of the original doctrine of informed consent.

II. Statement of the Case: *Acuna v. Turkish*

In *Acuna v. Turkish*, the New Jersey Supreme Court was faced with determining the scope of informed consent under New Jersey common law. New Jersey courts employ a reasonable prudent patient standard for determining the amount of disclosure doctors must provide to their patients.[84] Specifically, the court was presented with the question of whether, "under the common law duty to obtain informed consent, a physician is required to advise a woman, who is in the sixth to eighth week of pregnancy, that an abortion procedure will kill not just a potential life, but an actual existing human being."[85] The court in this case made it clear that doctors are only required to provide their patients seeking an abortion with *material medical information*.[86] The court held that there is no duty for a physician to inform a pregnant patient that an embryo is an existing, living, human being, or that an abortion results in the killing of a life.[87] The plaintiff, Rosa Acuna, filed a malpractice action against her obstetrician-gynecologist, Dr. Sheldon Turkish,[88] claiming that he failed to provide her with information sufficient to gain her

82. Van Detta, *supra* note 57, at 246-47.

83. Although state informed consent laws are frequently passed with the stated purpose of ensuring that a woman has made a decision regarding an abortion based on all information available, opponents argue that these measures are actually designed to limit or prohibit women from exercising their right to an abortion. *See id.*

84. *Acuna*, 930 A.2d at 425. The reasonably prudent patient standard is an objective standard that requires a doctor to disclose "what a reasonable person would find material to the decision to undergo treatment." Spielman, *supra* note 49, at 724.

85. *Acuna*, 930 A.2d at 424.

86. *Id.* at 427-28.

87. *Id.*

88. *Id.* at 418. At the time of the consultation, Dr. Turkish had been practicing medicine for more than thirty years. *Id.* at 419.

consent prior to performing an abortion.[89] When Ms. Acuna first went to see Dr. Turkish she was complaining of abdominal pains and headaches.[90] At that time, she was twenty-nine years old, married, and the mother of two daughters under the age of three.[91] After performing an ultrasound, Dr. Turkish informed Ms. Acuna that she was approximately six to eight weeks pregnant.[92]

There was some discrepancy over the conversations that ensued after Dr. Turkish informed Ms. Acuna that she was pregnant. First, Ms. Acuna claimed that because of a kidney disorder she had been suffering from since high school, Dr. Turkish told her that unless she had an abortion she would die in three months due to kidney complications.[93] Dr. Turkish denied making such a statement; however, his assistant remembered that Ms. Acuna mentioned "'she wanted to end the pregnancy because she had two small children at home' and that her pregnancy was 'too soon after the birth of her second child.'"[94] Second, Ms. Acuna recounted that she asked the doctor "if it was the baby in there" and the doctor replied, "don't be stupid, it's only blood."[95] Although Dr. Turkish could not remember his exact conversation with Ms. Acuna, he believed that if she had asked that question, he would have responded that "'a seven-week pregnancy is not a living human being' but rather it 'is just tissue at this time.'"[96]

In light of Dr. Turkish's comments and after discussing the matter with her husband, Ms. Acuna agreed to have a termina-

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89. *Id.* at 418. Ms. Acuna filed an eleven-count complaint against Dr. Turkish, his medical group, and an unidentified nurse, which was originally dated April 8, 1998. *Id.* at 420 n.6. The complaint consisted of wrongful death and survival claims on behalf of her unborn child, negligent infliction of emotional distress, negligence, and lack of informed consent claims on her behalf. *Id.* at 420. All of the other claims had been dismissed or addressed throughout the litigation, so that the only claim put before the New Jersey Supreme Court was the issue of informed consent. *Id.* at 423.

90. *Id.* at 418.

91. *Id.* at 419. Dr. Turkish had been her regular obstetrician-gynecologist for five years and had also delivered Ms. Acuna's youngest daughter. *Id.*

92. *See id.*

93. *Id.*

94. *Id.* at n.3 (internal brackets omitted).

95. *Id.* at 419.

96. *Id.*

tion of pregnancy ("TOP") performed.[97] She signed a consent form for the TOP that included a statement that the doctor had "explained all of the risks and complications to [the patient]."[98] That same day, a vacuum aspiration was performed to terminate the pregnancy.[99] Unfortunately, Ms. Acuna suffered an "incomplete abortion" and she was taken to the hospital a few weeks later, where doctors performed a dilatation and curettage procedure.[100] Ms. Acuna claims that when she asked a nurse what had happened "[t]he nurse replied that the doctor had left parts of the baby inside of you."[101] Although the procedure did not actually remove any fetal parts—only chorionic villi, the lining of the uterus—this statement greatly upset Ms. Acuna.[102] She decided to conduct research on her own after the procedure had been performed to determine what had happened and the nature of her pregnancy at that point. She ultimately concluded "that the abortion procedure killed a human being."[103] As a result, she suffered from depression and was eventually diagnosed with post-traumatic stress disorder.[104]

The basis of Ms. Acuna's claim that Dr. Turkish failed to provide her with information sufficient to obtain her consent prior to performing an abortion centered around his statement that there was no human being present at the time of the procedure, but rather blood or tissue. She argued that in order to make an informed decision to consent to the procedure, she needed to know whether the embryo was an existing human being.[105] A key factor in her decision-making was whether she would be "prevent[ing] a human being from coming into exis-

97. *Id.* Ms. Acuna returned to the doctor's office three days later to have the TOP performed. *Id.*

98. *Id.*

99. *Id.* "A vacuum aspiration is a procedure in which the physician vacuums out the embryonic tissue." *Id.* at n.4.

100. *Id.* at 419. The termination of pregnancy was performed on approximately April 9, 1996 and the dilatation and curettage was performed on approximately May 4, 1996. *Id.*

101. *Id.*

102. *Id.* at n.5.

103. *Id.* at 420.

104. *Id.*

105. *Id.* at 423.

tence, [or] . . . terminat[ing] [the] life of an existing living human being."[106]

The New Jersey Supreme Court held that there is no duty for a physician to inform a pregnant patient that an embryo is an existing, living human being or that an abortion results in the killing of an existing human being.[107] In arriving at its decision, the court acknowledged that there was no 1) medical basis, 2) public policy rationale, or 3) legal basis to require a doctor to disclose such information.[108] New Jersey law is well settled. "A physician has a legal duty to disclose to the patient all medical information that a reasonably prudent patient would find material before deciding whether to undergo a medical procedure."[109] The key in this area of disclosure is "medical information." The court found that the disclosure Ms. Acuna sought—that an embryo is an existing, living, human being—was not within the category of medical information; rather, it was more akin to a theological, philosophical, or personal opinion. On this point, the court noted that both Ms. Acuna and Dr. Turkish would be able to have experts testify and both would reach different results as to when life begins.[110] In its decision, the court reaffirmed that this is not an area of medical certainty.[111]

Additionally, the court found no public policy reason that required doctors to make such a disclosure. The court specifically acknowledged the lack of public consensus surrounding the very disclosure Ms. Acuna was seeking to require a doctor to make:

> On the profound issue of when life begins, this Court cannot drive public policy in one particular direction by the engine of the common law when the opposing sides, which represent so many of our citizens, are arrayed along a deep societal and philosophical divide. We are not unmindful of the raging debate that has roiled the nation and of the sincerely and passion-

106. *Id.*
107. *Id.* at 428.
108. *Id.* at 424-28.
109. *Id.* at 426.
110. *Id.*
111. *Id.*

> ately held beliefs by those on opposite sides of the debate.[112]

The discord on this issue—among not only New Jersey citizens, but among citizens nationwide—was a significant factor in the court's decision not to impose a duty on doctors to disclose that "an abortion procedure will kill not just a potential life but an actual existing human being."[113] In addition, the defendants argued that compelling a doctor to disclose information that "is not a biological fact, but a moral, theological, and highly personal judgment" would violate the doctor's First Amendment right to free speech.[114] Although the court did not need to ultimately decide the constitutional argument raised by the defendants in this case,[115] it did acknowledge that a doctor's right to free speech may become an issue under other facts.[116] Moreover, the court stressed that "[u]nder the doctrine of informed consent, the knowledge that [Ms. Acuna] sought from [Dr. Turk-

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112. *Id.* at 427.

113. *Id.* at 424, 428.

114. *Id.* at 424.

115. *See id.* at 426-27. The court noted,

> [w]e need not reach the constitutional arguments raised by defendants and *amici* who claim that it is . . . a violation of a physician's First Amendment free speech right to compel a physician to advise a pregnant woman that an embryo is an existing human being and that an abortion is tantamount to killing a child. We do not resolve those arguments because we cannot find that New Jersey's common law imposes a legal duty on a physician to give [these] instructions.

Id. at 427.

116. *Id.* at 426. In its opinion, the court cites to *Planned Parenthood of Southeastern, Pennsylvania v. Casey*, 505 U.S. 833, 875-76 (1992), and *Wooley v. Maynard*, 430 U.S. 705, 714 (1977), for the proposition that doctors may have a right to be free from government-compelled speech. *Acuna*, 930 A.2d at 426. The court also commented on the current litigation over a South Dakota informed consent statute in the case of *Planned Parenthood Minnesota v. Rounds*, 467 F.3d 716, 719 (8th Cir. 2006), which required a physician "before performing an abortion and as a precondition to informed consent, [to] advise the patient that 'the abortion will terminate the life of a whole, separate, unique, living human being' and that 'by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated.'" *Acuna*, 930 A.2d at 427 (citing S.D. CODIFIED LAWS §§ 34-23A-10.1(1)(b), (d) (2005)). The court in *Acuna* remarked that "[c]learly, the compelled disclosure required by the South Dakota Legislature is pushing the doctrine of informed consent to the edge of a new constitutional fault line." *Id.* (citing Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 956-60 (2007)).

ish] cannot be compelled from a doctor who may have a different scientific, moral, or philosophical viewpoint on the issue of when life begins."[117] Ultimately, the court was unwilling to impose a duty on a doctor to disclose such views that society itself has been unable to reconcile.[118]

Finally, the court reasoned that there is no legal duty for a doctor to disclose to a pregnant woman that an embryo is an existing, living, human being.[119] First of all, it is not the practice of other medical practitioners in New Jersey or elsewhere to disclose such information.[120] In addition, there is presently no applicable state or federal law that imposes such a duty on a doctor.[121] Moreover, Ms. Acuna failed to identify any jurisdiction or court that has imposed such a common law duty upon a doctor.[122] As a result, the court held that under the common law doctrine of informed consent, doctors are required to "provide their pregnant patients seeking an abortion *only* with material medical information, including gestational stage and medical risks involved in the procedure."[123]

III. Analysis: Finding the Middle Ground

The courts decision in *Acuna* provides guidance as to the level of disclosure a doctor in the digital age must provide to satisfy the requirements under the doctrine of informed consent. The approach in *Acuna*—requiring a doctor to disclose only material medical information—provides a middle ground between the minimal disclosures doctors have used for some medical treatments and the excessive disclosures being sought by some states.[124] This approach is effective because it advances the principles behind the doctrine of informed consent,

117. *Acuna*, 930 A.2d at 428.
118. *See id.* at 427.
119. *Id.* at 428.
120. *Id.* at 426.
121. *Id.*
122. *Id.*
123. *Id.* at 428.
124. See National Abortion and Reproductive Rights Action League: Pro-Choice America, http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/ (last visited Sept. 11, 2009), for a searchable database of abortion laws by state.

while at the same time taking into consideration the evolution of the reasonable patient into that of the informed consumer.

There are primarily three public policy reasons for requiring a doctor to obtain a patient's informed consent:

> First, physicians have knowledge and experience beyond that of the average patient, putting them in a position to provide information about disease processes, risks, and benefits of potential treatments, and prognoses. Second, the personal and intimate nature of the doctor-patient relationship invites the patient to rely on the advice and expertise of the physician. Third, the idea that physicians owe a duty of care is already established in tort law, such that failure to obtain a patient's informed consent breaches that duty and gives rise to a claim of negligence. The underlying public policy is to ensure that patients have sufficient facts for making health care decisions.[125]

The decision of the New Jersey Supreme Court in *Acuna* advances all three of these policy reasons by striking the proper balance between requiring doctors to provide their patients with information necessary to make their own decisions regarding medical treatment, while at the same time recognizing that the "reasonable patient" has evolved into an "informed consumer."

The first policy reason takes into consideration that a doctor has "knowledge and experience beyond that of the average patient," which is necessary to assist patients in making an informed decision about their medical treatment.[126] Today, with the advent of the Internet and direct-to-consumer advertising, the reasonable patient has evolved into an informed consumer.[127] Yet, despite the success in breaking down the barriers that once prevented consumers from accessing medical information, "[k]nowledge and information are not synony-

125. McKenzie, *supra* note 7, at 272 (citations omitted).

126. *Id.*

127. Janet L. Dolgin, *The Evolution of the Patient: Shifts in Attitudes About Consent, Genetic Information, and Commercialization in Health Care*, 34 HOFSTRA L. REV. 137, 175 (2005) ("[T]he notion of the 'informed patient' merges with the notion of the 'informed consumer.'") The author specifically notes that "[p]atients have begun to see themselves as consumers." *Id.*

mous."[128] It remains necessary for the doctor to serve as a sounding board to reaffirm the medical risks and benefits associated with a particular treatment. Approximately 80% of American Internet users, or some 113 million adults, have used the Internet to find health information; however, only 15% of those individuals bother to check the source and date of the health related information they access online.[129] Statistics such as these illustrate that despite a patient's ability to access medical information, they are not necessarily obtaining information that is reliable, accurate, or even current. Rather, this suggests that just as during the early twentieth century, the doctor is still the expert—the ability to access information might have evolved, but the doctor's role remains the same. With the advent of websites such as *Web*MD,[130] consumers can search for information on a myriad of health topics, as well as research the side effects, precautions, and interactions of various pharmaceutical drugs.[131] There are also interactive features available on *Web*MD's website, such as the "symptom checker," which enables consumers to diagnose their symptoms, and the "questions for your doctor" link, which provides consumers with a list of prepared questions for them to use as a guide when discussing various medical conditions with their doctors.[132] These websites provide consumers with access to medical information that was previously inaccessible to the general public.[133]

Additionally, the advent of direct-to-consumer advertising has been very influential in converting "patients" into "consumers." As a result of the Food and Drug Administration's decision in 1998 to allow drug companies to run ads on television and in magazines, pharmaceutical companies have increasingly used advertising to target patients through multiple mediums—such

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128. Lars Noah, *Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 376 (2002).

129. Susannah Fox, Online Health Search 2006, http://www.pewinternet.org/Reports/2006/Online-Health-Search-2006.aspx (last visited Sept. 10, 2009). *See also* Michael A. McCann, *Message Deleted? Resolving Physician-Patient E-Mail Through Contract Law*, 5 YALE J.L. & TECH. 104, 115 (2003) (noting that in 2001, 98 million Americans searched the Internet for health information).

130. *Web*MD Homepage, http://www.webmd.com (last visited Mar. 29, 2009).

131. *See generally id.*

132. *Id.*

133. Noah, *supra* note 128, at 433.

as in print, on television, and through the Internet.[134] A recent study shows that the United States pharmaceutical industry spent almost twice as much on advertising than it did on research and development in 2004.[135] In addition, in 2006, the total spending for drug advertising rose to $4.7 billion, an increase of 14.1%.[136] Today, practically every major pharmaceutical manufacturer has either a general company website or a specific product website for consumers to obtain information about products and even diagnose their symptoms.[137]

The availability of this information is a great resource for consumers, but it does not serve as a substitute for the doctor-patient relationship. First of all, the information available to patients is frequently incomplete or inaccurate,[138] especially given the fact that advertisements by pharmaceutical companies, "by virtue of [their] nature as . . . marketing tool[s], pitch[ ] one treatment to the exclusion of others."[139] A key component of informed consent is the disclosure of alternative treatments. Direct-to-consumer marketing does not provide consumers with the same information, such as treatment options, that would be disclosed by a physician. Moreover, many consumers lack the expertise to understand much of the medical information they are downloading or reading about in a magazine.[140] As such, it is necessary for them to discuss their findings with their doctors to ensure that the information they

134. *Id.*

135. Sciencedaily.com, Big Pharma Spends More on Advertising than Research and Development, Study Finds (Jan. 7, 2008), http://www.sciencedaily.com/releases/2008/01/080105140107.htm.

136. Jim Edwards, *Special Report: Prescription Drugs*, ADWEEK, April 30, 2007, *available at* http://www.adweek.com/aw/esearch/article_display.jsp?vnu_content_id=1003577966.

137. *See, e.g.*, Bayer Homepage, http://www.bayer.com (last visited Mar. 29, 2009); Claritin Homepage, http://www.claritin.com (last visited Mar. 29, 2009); Johnson & Johnson Homepage, http://www.jnj.com (last visited Mar. 29, 2009); Merck Homepage, http://www.merck.com (last visited Mar. 29, 2009); Prevacid Homepage, http://www.prevacid.com (last visited Mar. 29, 2009); Wyeth Homepage, http://www.wyeth.com (last visited Mar. 29, 2009).

138. Noah, *supra* note 128, at 433.

139. *See* W. John Thomas, *Direct-To-Consumer Pharmaceutical Advertising: Catalyst for a Change in the Therapeutic Model in Psychotherapy?*, 32 CONN. L. REV. 209, 235 (1999).

140. Noah, *supra* note 128, at 433-34.

have obtained is truthful and not misleading.[141] Ultimately, "[p]hysicians are thought to be in a better position to convey information to patients and to quantify the risks involved with certain medication."[142] Although information on certain websites can arguably guide consumers in asking their doctors the "right questions" when deciding on a course of treatment, they should not be the sole resource relied on by a patient.[143]

It is this expansion of the general populace's access to information that necessitates that the information provided by a doctor be limited to only *material medical information*. A patient can easily be misled by the plethora of information readily available at their fingertips—such as news articles, pharmaceutical studies, and Internet postings—while trying to make a decision regarding any medical treatment, not just an abortion. In fact, in *Acuna,* it was only after Ms. Acuna conducted her own research that she reached the conclusion that her abortion caused the termination of an existing, living, human being.[144] Ms. Acuna had every right to consult with her family, community, or spiritual advisors in order to make a decision regarding her abortion in light of the medical information, her religious beliefs, and her moral and ethical values. The role of her doctor in the decision-making process, however, should be limited to the disclosure of material medical information.

The disclosures proposed in *Acuna* also advance the second policy reason: the "intimate nature of the doctor-patient relationship."[145] The underlying principle behind the doctrine of informed consent is that a patient has a right to self-determination.[146] "The doctrine has evolved to reflect strong judicial deference for individual autonomy—that is, the belief that an individual has the right to be free from non-consensual

141. *See* Jack B. Harrison & Mina J. Jerrerson, *Some Accurate Information is Better than No Information at All: Arguments Against an Exception to the Learned Intermediary Doctrine Based on Direct-To-Consumer Advertising*, 78 OR. L. REV. 605, 615 (1999) ("Both judges and scholars alike are quick to point out that given the abundance of consumer advertising, patients are the ones who initiate the prescription of certain well-advertised drugs.").

142. *Id.* at 620.

143. Thomas, *supra* note 139, at 234.

144. Acuna v. Turkish, 930 A.2d 416, 419-20 (N.J. 2007).

145. McKenzie, *supra* note 7, at 272.

146. Paula Walter, *The Doctrine of Informed Consent: To Inform or Not to Inform?*, 71 ST. JOHN'S L. REV. 543, 545 (1997).

interference with his or her person."[147] "In the medical context, the concept of autonomy translates into an understanding that the individual has an unfettered right to choose the course of medical treatment, including the right not to pursue treatment and to desist from any treatment where such medical protocol has already been initiated."[148] An important component of patient autonomy is for the patient to reach a decision that is free from coercion.[149] In considering the influence that a doctor can exert over a patient, it is very important for a doctor's disclosures to be free from his or her own personal views and to reflect an objective medical standard. The court's decision in *Acuna* advances a patient's right to autonomy by limiting a doctor's disclosures to only material *medical* information.[150] This requirement is a double-edge sword—it not only limits what a doctor is required to disclose, but it also prevents a doctor from disclosing his own "moral, theological, or philosophical" views.[151] A patient's decision to undergo any medical treatment should be based on the information she deems important in rendering a decision. This decision should not be influenced by what a particular doctor personally believes. Conversely, a doctor should not be required to disclose information that is not in accordance with his or her own moral or religious beliefs just because the belief is held by that particular patient.[152] To avoid such dangers, it is necessary for a doctor's disclosures to be limited to only material medical information; the disclosures should not encompass information that is based on moral or religious beliefs. This will ensure that a patient is not coerced into a decision that reflects the moral and religious views of the doctor, rather than the patient. The third policy reason acknowledges the tort remedies available to a patient in the event a doctor breaches his or her duty to obtain informed consent.[153]

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147. *Id.* at 545.

148. *Id.* at 546.

149. *Id.* at 545-46.

150. Acuna v. Turkish, 930 A.2d 416, 427-28 (N.J. 2007).

151. *See id.*

152. *See* Paula Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U. L. REV. 201, 256 (1994); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 956-57 (2007).

153. McKenzie, *supra* note 7, at 272.

Because doctors are ultimately liable for their failure to obtain informed consent, it is important to set forth guidelines that delineate what the law does, and does not, require a doctor to disclose. The New Jersey Supreme Court succeeded in providing basic guidelines for doctors by employing both an objective "reasonably prudent patient" standard and by limiting the nature of disclosures to only material medical information.[154]

Although New Jersey employs a reasonable patient standard for evaluating the required level of informed consent, the court reaffirmed in *Acuna* that this is an objective standard, which focuses on what a "reasonable patient needs to know."[155] It does not require a doctor to make disclosures based on what a *particular patient* may "need to know."[156] In her complaint, Ms. Acuna was arguably asking the court to employ a subjective standard. Ms. Acuna repeatedly stated that "to make an informed decision whether to terminate her pregnancy, she needed to know that her embryo was even at that point an existing human being."[157] For a court to impose liability on a doctor based on what *any particular patient* may "need to know" to make a decision to have an abortion would require a doctor to go well beyond disclosure of medical information and delve into areas of moral, philosophical, and religious concern. As in the present case, where Ms. Acuna failed to clearly voice her concerns to her doctor as to whether an embryo is a life, most doctors will not be privy to what non-medical information each of their patients deem important in rendering a decision regarding medical treatment. To impose liability on a doctor based on what each individual patient would find significant to make an informed decision would expose doctors to tremendous liability. Furthermore, in light of the liability a doctor is exposed to for failing to obtain informed consent, it is necessary to limit the level of disclosure to only material medical information. Just as is the case with patients, doctors also suffer from information overload.[158] Doctors struggle to keep up with the volume of

154. *Acuna*, 930 A.2d at 425, 428.

155. *Id.* at 425.

156. *See id.* at 427-28 ("[T]he knowledge that plaintiff sought from defendant cannot be compelled from a doctor who may have a different scientific, moral, or philosophical viewpoint on the issue of when life begins.").

157. *Id.* at 423.

158. Noah, *supra* note 128, at 402-03.

medical information produced, even with the assistance of electronic databases that offer search engines and summaries of articles.[159] In 2002, there were "more than 25,000 biomedical journals worldwide [that] publish[ed] more than two million articles annually."[160] Although many doctors view the Internet as an effective method of finding information that can significantly reduce their research time,[161] "the pace of knowledge production and acquisition presents significant challenges for the medical profession."[162] Doctors have both "ethical and legal obligations to stay abreast of the latest research in their fields."[163] This requires doctors to do more than just access information; they must actually take the time to comprehend it. In light of the burden doctors already carry in staying apprised of recent medical developments it would be impractical to extend this burden to non-medical information.

IV. Conclusion

In the twenty-first century, the traditional "reasonable patient" has evolved into a techno-savvy, web-surfing consumer who seeks out and is bombarded by medical information from all available sources. But despite this change in the reasonable patient, there still exists a great need for doctors to play a prominent role in educating patients about their treatments prior to obtaining consent. The New Jersey Supreme Court's decision in *Acuna v. Turkish* not only balances a patient's need for information in order to make an educated decision regarding treatment, but also reflects the limited role a doctor should play in that process—to provide only material medical information. The *Acuna* court recognized the changing face of today's patients and the need to limit a doctor's disclosures in order to ensure that patients are not misled by the wealth of information available to the average person. Although the court's decision was made in the context of an abortion case, the reasoning behind

159. *Id.*
160. *Id.* at 402.
161. McCann, *supra* note 129, at 115.
162. Noah, *supra* note 128, at 404.
163. *Id.*

its decision and its recognition that the role of the patient has evolved can be applied to the doctrine of informed consent for all medical treatments.