"Reasonable Patient Test" for Disclosure of Information
Part II: It can be reasonable with an extra minute of open-ended communication

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Reasonable Patient approach for Consent process

In this part II, analysis of cases applying Montgomery in different common law jurisdictions can provide further insight on the modern informed consent process. Cases and legislations are further reviewed from different common law jurisdictions to analyse how the informed consent process should take into account the reasonable patient approach. It is a reasonable approach, as it is not demanding the impossible. It is consistent with common law principles and principles of good clinical practice.

Post '*Montgomery*' cases

***Mordel v. Royal Berkshire NHS Foundation Trust*[2]**

There are UK cases applying Montgomery[3] to assess the informed consent process. In *Mordel v. Royal Berkshire NHS Foundation Trust*[4] , the claimant sought care from the community midwife and accepted all the standard screening tests for Down's syndrome, including a combined ultrasound and blood test. When she attended for the ultrasound, the sonographer completed a computer record indicating "Down's screening declined", so the ultrasound only checked the overall condition of the foetus. The claimant failed to understand the sonographer's question and the claimant's unreflective response had been to say "no'. The claimant claimed damages for clinical negligence against the defendant NHS trust for the birth of a baby with Down's syndrome. The judgement has raised the context of reasonableness.

The birth of a child with Down's syndrome can be a life-changing event for most parents, and it is not onerous to take steps required to guard against parental choice. What is at issue here is asking the required questions to ensure that what may be an unwarranted outcome does not result[5].

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[1] *[2015] UKSC 11, [2015] AC 143 (Supreme Court (Scotland)), UK*
[2] *[2019] EWHC 2591 (QB)*
[3] *See note n1 Montgomery*
[4] *See note n2 Mordel*
[5] *Ibid [86]*

One of the key issues was whether the sonographer had taken reasonable steps to ensure informed consent and find out the patient's reasons for rejecting the test. Efforts should be undertaken to make sure would-be parents understand the possibility of the birth of a child with Down's syndrome and to make informed choices regarding the care they wish to receive. A gentle exploration of the parents' understanding of the specific purpose of the screening should have been conducted to ensure their clear understanding. The consent process by the sonographer was therefore inadequate.

Similarly, the midwife should have also asked why a patient was booked for a screening and did not have it. Parents attending ante-natal check-ups and screenings would expect to receive information regarding the elements and purposes of different screening tests, as well as the risks and benefits, so they can make an informed decision. If the claimant had had further information about the risk of having a baby with Down's syndrome, it would have enabled the claimant to make an informed decision regarding the test. The risk could have been minimised if healthcare professionals had taken a little extra time to communicate with the patients. In Mordel, the sonographer should have asked "do you know the purpose of this ultrasound check up?". During the follow-up visit with the midwife, the midwife should have asked, "I note that you did not have a screening test for Down's syndrome. Do you have any concerns or worries?". An extra minute of open-ended communication can allow patients to tell what is on their minds.

A v. East Kent Hospitals NHS Foundation Trust'[6]

Mrs. A's claim was dismissed as she alleged that if, during her pregnancy, she had been told that there was a possibility of a baby being born disabled, she would not have proceeded with the pregnancy. The court found no evidence of the existence of material risk relevant to Mrs. A to which she should have been alerted. The judge commented that if the risk of a disabled child had been 1-3 per cent or more, then his finding would have differed but there was no reason to suspect Mrs. A or a reasonable patient in Mrs A's position would have attached any significance to a risk of 1 in 1,000 .

This case provides physicians with guidance on the definition and/or legal application of material risk with a common-sense approach.

Mills (by Maria Mills his wife and litigation friend) v. Oxford University Hospitals NHS Foundation Trust[7]

This is another UK case applying Montgomery[8]. The claimant (the "Patient") represented by his wife brought a claim against the defendant, Oxford University Hospitals NHS Foundation Trust (the "Trust"), for alleged negligence that brain surgery consisting on the debulking of the left frontal glioma had caused haemorrhage in the course of the procedure, causing him to suffer a stroke in the left anterior cerebral artery area, and failed to take reasonable care to ensure the Patient was aware of the material risk involved in the proposed procedure and/or any alternative treatments.

The neurosurgeon used a minimally invasive, endoscopically-assisted, open craniotomy technique ("Endoscopic Technique") and the conventional technique at that time used a microscope for the purpose of visualising the tumour requiring a larger craniotomy. The use of Endoscopic Technique was not found to be negligent. The question was whether in using the Endoscopic Technique, the neurosurgeon had acted in accordance with a practice accepted as proper by peers in neuro-oncological surgery. The Trust's multi-disciplinary team attended by 6 neurosurgeons was well aware of the Endoscopic Technique used by the neurosurgeon, and they regarded it as reasonable to use this technique. The neurosurgeon had a reported series of 50 consecutive fully Endoscopic Technique to resect brain tumours, and most of them being a glioma. The experts had found it difficult to understand the exact mechanism of haemorrhage.

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[6] *[2015] EWHC 1038 (QB)*

[7] *[2019] EWHC 936 (QB)*

[8] *See note n 1 Montgomery*

The Court had to be satisfied on the balance of probabilities that the defendant fell below the requisite standard and the negligence was the cause of the damage[9]. If the evidence was equivocal, uncertain or inadequate, or inconclusive, the judge could not decide a case based on an educated guess and the claimant had then not proven the case to the required standard[10]. Therefore, this case failed the claim against clinical negligence.

Headache was the main reason for consultation. Regarding the issue of informed consent, the neurosurgeon should have advised, but he failed to advise, that the glioma was in fact an incidental finding and unlikely caused the claimant's headache. There should have been a dialogue between the neurosurgeon and the patient about alternative treatment options, i.e., microscopic-assisted technique, and the advice should have been comprehensible. If glioma might not be the main cause of his symptoms, the patient will want to know other options to weigh up the risks and benefits. The neurosurgeon had undertaken a lot of studies of Endoscopic Technique, so opting for this technique would be doctor-centred, but the focus should have been patient-centred, on what a reasonable person in the patient's position would be likely to attach significance to in deciding on his or her own treatment. The claimant produced evidence of declining X-rays for fear of radiation, and he had always been naturally risk-averse. This claim succeeded on the basis of informed consent.

***Chan Siu Yim v. Dr Cheung Sheung Kin*[11]**

The plaintiff consulted the defendant (dentist) for a dental implant in the area of the left lower first pre-molar. The defendant proposed a procedure using braces and wires (and without suggesting the possibility of teeth extraction), as it was simpler than a dental implant. The whole procedure would take 18 months to complete. The plaintiff accepted and agreed to the performance of the said procedure on her by the defendant. A number of problems emerged after the commencement of the treatment, including occlusion problems, which affected her chewing, upper teeth displaced and shifted to the left and overjet of the upper teeth increased.

At a follow-up appointment, without any prior notice to the plaintiff and without the plaintiff's consent, the defendant extracted the lower left first pre-molar ("tooth 34") from the plaintiff. The problems with the plaintiff's teeth deteriorated after the tooth extraction. The plaintiff was unable to chew properly and also had slurring of speech and drooling. The plaintiff claimed that the defendant was negligent, in particular due to:

(a) failure to advise on alternative options and explain the pros and cons of those options;
(b) failure to obtain the plaintiff's consent to extract tooth 34;
(c) ignoring or failing to recognise the risk involved in extracting tooth 34;
(d) failure to advise the plaintiff of the said extraction risk;
(e) failure to take measures to prevent or minimize the said risk;
(f) failure to sufficiently follow, monitor and evaluate the progress of the treatment and to make necessary adjustments to the treatment plan;
(g) failure to remedy the problems caused by the extraction of tooth 34; and
(h) failure to refer the plaintiff's case to an orthodontic specialist.

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[9] *Thefaut v. Johnston [2017] EWHC 497 (QB) at [7]*
[10] *Ibid*
[11] *[2017] HKDC 174 (DC), Hong Kong.*

Both plaintiff and defendant have submitted expert reports. The judge found that the expert report from Dr. K, providing expert opinions for the plaintiff, is comprehensive, carefully reasoned and supported by the relevant medical literature. The expert opinion from Dr. C commenting on the defendant's management is not supported by cogent reasons or by relevant medical literature. Therefore, the judge preferred Dr. K's opinion.

Dr. K stated that "*the problems with this option of treatment and the required preventive measures is that it will make the whole treatment process overly complicated"*. There is no evidence that the defendant had explained to the plaintiff that there would be some other options to suit the plaintiff's purpose, and also the pros and cons of those options. Dr.K in this report has also stated that "*a competent specialist would be aware of the detrimental effects and difficulties involved in extracting a tooth in the lower left region and trying to close space. They would be able to anticipate the lower center moving to the left and the overjet increasing"*. Dr. K commented that Dr. Cheung should have the awareness being a competent specialist.

There is no evidence showing that the defendant had warned the plaintiff that the treatment may cause the lower midline to move to the left and increase the overjet.

The judge found: '*failure to adequately advise the plaintiff of the risks and complications associated with the treatment before he commenced the treatment*[12]. The judgment included the following: *'…A reasonably competent dentist would have advised the patient of the different options and the associated risks and benefits, so that the patient could give informed consent to the treatment. There is, however, no evidence that Dr. Cheung had done so…*'

Montgomery was cited in judgement:

> *"that an adult person of sound mind was entitled to decide which, if any, of the available forms of medical treatment to undergo, and her consent had to be obtained before treatment interfering with her bodily integrity was undertaken; that, therefore, a doctor was under a duty to take reasonable care to ensure that the patient was aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments; that the test of materiality was whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor was or should reasonably be aware that the particular patient would be likely to attach significance to it…"*[13]

Two-pronged approach

The above cases illustrated how effective communication can address the material risks to which the patient attached significance. One could adopt a two-pronged approach to analyse risk disclosure[14]. Firstly, is it supported by a reasonable body of medical opinion withstanding logical analysis put forward by a defendant? Secondly, would an alternative clinical approach raised by the claimant withstand logical analysis and have less risks with better benefits?

In *Mills*[15], the Endoscopic Technique and the surgical performance of the neurosurgeon was not found to be below a reasonable standard. In *Mills*[16], the alternate clinical approach of operating under a microscope was the conventional approach, so it would withstand logical analysis. Not discussing this alternative approach does not meet the standard of proper informed consent.

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[12] *Ibid [23]*

[13] *ibid [42] (Liu J) (emphasis added)*

[14] *Lee A. (2017). Bolam' to 'Montgomery' is result of evolutionary change of medical practice towards 'Patient-Centred Care. Postgraduate Medical Journal, 93:46–50. doi:10.1136/postgradmedj*

[15] *See note n 6 Mills*

[16] *Ibid*

In *Mordel,* peer professional opinion from expert witness has stated that the consent process by the sonographer was insufficient because one should make sure that the screening test being performed is the screening the patient is expecting to have. If the patient was booked for Down's syndrome screening with a negative answer, it was important to confirm the patient's awareness of what the test involved. Regarding the practice of the midwife, it was supported by a respectable and responsible body of medical opinion. However, the judgement stated:

> It cannot be incumbent on the midwife to undertake lengthy inquiry or to delve into the reasoning processes and motivations of the patient, but in my judgment in a situation where the patient was booked for the combined test and did not have it, the midwife should not leave the matter there[17].

In *Chan*, the expert opinion had stated clearly that a competent specialist would have been aware of the detrimental effects and difficulties involved in the procedure and a reasonably competent dentist would have advised the patient of the different options and the associated risks and benefits, so that the patient would have been able to give informed consent to the treatment. The defendant dentist did not stand the first part.

If the first part passed and second part (the alternative approach raised by the claimant) cannot stand logical analysis, this gives a strong weighting towards a defendant's medical opinion. This would be the case of *A v. East Kent Hospitals NHS Foundation Trust*[18]. It is a common sense approach not overly preoccupied with negligible risks. However, neither in the cases of *Mills*[19] nor *Mordel (regarding the midwife)*[20]*,* did the second part stand. In *Mills,* if the claimant had known that the glioma was an incidental finding, he would have opted for a conventional approach, particularly being naturally risk averse. In *Mordel,* it was a reasonable expectation that the midwife would make a gentle and open-ended inquiry as to why the claimant refused Down's syndrome screening tests notwithstanding being booked for it.

The 'reasonable patient test' should be applied to identify 'material/significant risk' whether the patient's 'hidden agenda' (the underlying concerns of the patient not revealed during the consultation) has been unfolded as part of holistic care. Apparently this did not happen in *Mordel or Mills or Chan,* so the claims succeeded because no reasonable care had been taken to ensure the patient was aware of the material risks involved in the proposed treatment or not undertaking the treatments (in *Mordel*, the risk of not undertaking the screening tests for Down's syndrome) and any alternative options.

Reference from Singapore: *Hii Chii Kok case*[21] *and Civil Law Act, Singapore*

In Singapore, the UK '*Montgomery*'[22] case was applied in *Hii Chii Kok v. Ong Peng Jin London Lucien and another*[23] and the court made a few "significant alterations"[24] to include the following three-stage inquiry for determining if a doctor had complied with his duty of disclosure:

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[17] *See note n 2 [136]*
[18] *See note n 5 East Kent Hospital*
[19] *Ibid*
[20] *See note n2 Mordel*
[21] *[2017] SGCA 38.*
[22] *See note n 3 Montgomery*
[23] *See note n 20*
[24] *Ibid [131]*

1. Was there material information which the doctor did not disclose to the patient?
   The doctor is required to provide information to enable the patient to make an informed decision, and the broad types of information are[25]:
   a) the doctor's diagnosis of the patient's condition;
   b) the prognosis of that condition with and without medical treatment;
   c) the nature of the proposed medical treatment;
   d) the risks associated with the proposed medical treatment; and
   e) the alternatives to the proposed medical treatment, and the advantages and risks of those alternatives
2. Was the doctor aware of the information and, if not, was he negligent in not having the information?
   A doctor does not breach his duty of disclosure if he was not in possession of the information in the first place.[26] If the doctor did not have the information because of his diagnosis and/or treatment, he may be liable on that account but not on account of non-disclosure.
3. Was the doctor reasonably justified in not disclosing the information?
   In making the assessment, the court uses the general test of the reasonably competent and skilled professional[27].

The patient has the right to be informed and the right to decide, but the physician is quite easily justified for his non-disclosure, and *Hii Chii Kok* has brought the law to a new and higher plain from which further refinements can be made in order to achieve a better equilibrium . An amendment to the Civil Law Act, Singapore (CLA) was made to develop specialty specific guidelines which came to effect on 1 July 2022 to determine the standard of care for any medical advice.

Under s37 of the CLA, it states that the doctor's advice must be accepted by a respectable body of medical opinion as a reasonable professional practice in the circumstances and the peer opinion as logical. Professional opinion is logical if the healthcare professionals hold the opinion explaining to the patient the comparative risks and benefits related to the matter and the opinion is internally consistent not contradicting proven extrinsic facts relevant to the matter.

The peer professional opinion requires the doctor to give the information that a person in the same circumstances would require to make an informed decision as well as the information that the doctor knows or reasonable knows, and that is material to the patient for the purpose of making an informed decision. The material information is a specific concern or query which the patient has expressively communicated to the doctor or apparent from the patient's medical record.

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[25] Ibid [138] citing from Dickson v. Pinder [2010] ABQB
[26] Ibid [133]
[27] Ibid [134]
[28]LOW, Kee Yang. Doctor's duty of disclosure and the Singapore Court of Appeal decision in Hii Chii Kok: Montgomery transformed. (2017). Tort Law Review. 25, (2), 79-91. Research Collection School Of Law. Available at: https://ink.library.smu.edu.sg/sol_research/2504

"Reasonable patient test" is consistent with common law principles

The "reasonable patient test" evolves from common law principles as reflected by case law and/legislations in common law jurisdictions. In Australia, the Ipp Report recommendations have re-instated the position at common law on provision of informations[29]. There are two types of giving information, proactive and reactive duties. The proactive duty requires the doctor to take reasonable care giving patient the information that a reasonable person in the patient position and those circumstances would want to know before decision making. However, the doctor does not breach the duty for failing to give the information about a risk if it is obvious to a reasonable person in the position of the patient in those circumstances unless it is required by statue. Obvious risks are matters of common knowledge even if it is of low probability. The reactive duty requires the doctor to take reasonable care giving the patient such information as the doctor knows or ought to know that patient wants to know before deciding to undergo treatment. Following *Montgomery*[30] and *Hii*[31], the Singapore court also uses the general test of the reasonably competent and skilled professional in making assessment[32].

Queensland[33], Tasmania[34] and Victoria[35] enacted the legislation following the recommendations and not other States/Territories. Although the wording of the legislation is not uniform, it affirms the common law position, e.g., *Civil Liability Act* (CLA) 2003 (Qld) s21 1 (a) & (b) states that the information regarding risk should enable reasonable person in the person's position to make a reasonable informed decision and the information that the doctor knows or ought reasonable to know to be given to patients before decision making. The obligation is balanced against the general provision that the person suffering harm needs to prove on the balance of probabilities that s/he was not aware of the risk[35]. Legislation enacted after the Ipp Report is consistent with common law, e.g., *CLA* 2003 (Qld) s 9 (2) states that it needs to consider the probability of harm if care is not taken, likely seriousness of harm, burden if taken precautions to avoid the risk, and the social utility of the activity creating the risk of harm[37].

The reliability of evidence of a plaintiff/claimant can only be determined by reference to objective factors, particularly the attitude and conduct of the plaintiff at or about the time when the breach of duty occurred, *Chappel v. Hart*[38]. The foreseeable risk is not to be assessed with the benefit of hindsight as in *Rosenberg v. Percival*[39]. The plaintiff failed to establish causation to claim the defendant was negligent, on the basis that had she been warned of the risks of post-operative joint problems, she would not have consented to the procedure. Gleeson CJ took the followings for consideration:

- Degree of the plaintiff's need for corrective surgery
- Plaintiff's willingness to undergo the risk of general anesthetics, familiar by reason of her professional background
- Plaintiff failure to ask specific questions about risk
- Risk possibility was very slight

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[29] Law of Negligence Review Panel, Review of the Law of Negligence, Final Report (Commonwealth, 2002) ("Ipp Report") Recommendation 6 and 7.

[30] See note n1

[31] See n 20 Hii

[32] Ibid [134]

[33] Civil Liability Act 2003(Qld) s21

[34] Civil Liability Act 2002(Tas) s21

[35] Wrongs Act 1958 (Vic) s50

[36] Madden B and Mcllarith J (2013). Australian Medical Liability. 2nd ed, LexisNexis, Butterworth (2.15-2.18).

[37] Also Civil Law (Wrongs) Act 2002 (ACT); Civil Liability Act 2002 (NSW) s5B; Personal Injuries (Liabilities and Damages) Act (NT); Civil Liability Act 1936 (SA) s32; Civil Liability Act (Tas) s 11. Wrongs Act 1958 (Vic) s48; Civil Liability Act 2002 (WA) s5B

[38] (1998) 195 CLR232

[39] (2001) 205 CLR 434

Other factors identified by McHugh J are "*20 years experience as qualified nurse with PhD and university senior lectureship nursing, knowing the inherent risks, suffering from a worsening condition for years, consulting several specialists for remedying the condition, the procedure undertaken most likely to produce best results with small risk of suffering harm, patient subsequently undergoing another operation to correct the disorder.*"[40]

In *Wallace v. Kam*[41], the defendant neurosurgeon failed to warn the plaintiff of two material risks of the procedure: temporary nerve damage (bilateral femoral neuropraxia) and 1 in 20 chance of permanent and catastrophic paralysis from spinal nerve damage. The surgery was not successful and the risk of neuropraxia materialized, resulting in severe pain, but the risk of paralysis did not materialise. The factual causation was that Dr. Kam breached his duty by failing to warn Mr. Wallace of two material risks.

The scope of liability is to determine whether it is appropriate to extend the liability of the defendant doctor to the injury sustained by the plaintiff in circumstances where he would not have chosen to undergo the surgery even if he had been warned of all material risks BUT he would have chosen to proceed only if the risk of neurapraxia materialised, i.e., the plaintiff might have refused surgery if warned of paralysis but might still go ahead if warned of the risk of neurapraxia. Failure to warn of the risk of paralysis could not be the legal cause of the neurapraxia that materialised because the risk of physical injury actually materialising is not necessarily unacceptable to the patient. The exercise of reasonable care and skill in giving a warning is neither protecting the right to choose nor protecting the patient from exposure to all possible risks, BUT protecting the patient from the occurrence of physical injury risk that is UNACCEPTABLE to the patient. The focus is exploring the significant risks attached to the patient rather than disclosing all possible risks.

In the U.S, two cases, *Culbertson v. Mernitz*[42] and *Canterbury v. Spence*[43] provide examples of what doctors should disclose to patients to satisfy the duty of informed consent. *Culbertson* established the "reasonable physicians" standard requiring expert testimony to show what a physician would have disclosed, except when the situation is clearly comprehensible by an ordinary lay person. The *Culbertson* decision might appear to return to medical paternalism. The American Medical Association has developed ethical standards obligating physicians to present medical facts to patients, so patients possess enough information for decision making[44]. It still requires physicians to disclose all possible risks, except when it is beyond the comprehension of an ordinary lay person.

In *Canterbury v. Spence*[45], Dr. Spence performed the laminectomy skillfully to relieve pressure on a ruptured disc and instructed hospital staff that Canterbury should not leave the hospital bed to urinate, but two physicians modified the orders to allow Canterbury to sit up and stand by the bedside to void. Canterbury fell and injured his spine, requiring a second operation. The D.C Circuit Court detailed the requirements for obtaining informed consent. Physicians ought to disclose all material risks including the incidence of injury and degree of harm threatened. The jury would determine whether a reasonable patient would consider the risk about the proposed treatment being significant, and lawsuits can proceed without expert testimony. Canterbury failed his claim because he admitted undergoing a second laminectomy to relieve new back pain voluntarily. He had claimed that he would not have agreed to the original laminectomy if he had been adequately informed of the risk.

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[40] *Ibid [33]*
[41] *Wallace v. Ramsay Health Care [2010] NSWC 518. The case made its way to High Court Wallace v. Kam (2013)297 ALR 383*
[42] *602 N.E.2d*
[43] *See note n5 Spence*
[44] *See note n1 Wilson*
[45] *See note n5 Spence*

Although the courts use different benchmarks for assessing adequate disclosure in *Culbertson* and *Canterbury*, both standards have laid down common disclosure requirements. Physicians have the duty to inform patients of alternative treatments, including the risk of "taking no action".

Learning what a patient wants is not impossible with effective communication

The fundamental principle of "reasonable patient test" is better understanding from a patient's perspective. Obvious risk is still based on a common knowledge (common sense) approach. It takes into account peer professional opinion that is required for a patient to make an informed decision, and that the doctor knows (or reasonably knows), is material to the patient for the purpose of making an informed decision.

Good communication skills for engaging in genuine dialogue between doctor and patient and creating the clinical circumstances minimising physical and emotional distress for patients can enable doctors to have deeper insights into patients' ideas, concerns and expectations. A doctor should be more proactive in soliciting information from other healthcare professionals and close family members who know the patients well. It would then be clearer to them what patients want to know before making decisions.

The concerns of 'significant or material' risks to patients call for unfolding the hidden agenda and holistic approach to patient care. Open-ended communication can enable physicians to understand whether patients would still opt for the proposed treatment notwithstanding the risks. The material risk is a specific concern or query which the patient has expressively communicated to the doctor or apparent from the patient's medical record. Integrated and co-ordinated care with greater involvement of primary care providers would enhance 'patient-centred' care to unfold the 'significant risks' attached to patients. The respectable body of professional opinion would still be taken into account to assess whether the advice given to the particular patient under particular circumstance is reasonable. It is not demanding the impossible.

Key messages:

1. "Reasonable patient test" is consistent with common law, as it needs to consider the foreseeability of risk, reasonable person in the position of person to take the precaution, the probability of harm if treatment is declined, the likelihood of harm and burden if taken precaution to avoid the risk, and the social utility of the activity creating the risk of harm.
2. Information provided should be comprehensible by patients.
3. The foreseeable risk is not to be assessed with the benefit of hindsight and the claimant/plaintiff needs to bear the burden of proof of causation that if s/he had been provided the information of particular risk, s/he would not have undergone the treatment. The reliability of evidence of the plaintiff/claimant can only be determined by reference to objective factors, particularly the attitude and conduct of the plaintiff at or about the time when the breach of duty occurred.
4. Good communication skills for engaging in genuine dialogue between a doctor and a patient, and creating the clinical circumstances to minimise physical and emotional distress, can help gain deeper insights into patients' ideas, concerns and expectations.
5. Doctor should be more proactive to solicit information from other healthcare professionals, such as a primary care provider and close family members who know the patients well. They will gain a better understanding about what patients want to know for decision making.