Informed consent and moral integrity

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Author's abstract

Informed consent is required for any medical procedure although the situations in which it is given are beset by uncertainties and indeterminacies. These make medico-legal scrutiny of such situations very difficult. Although some people find the decision in the Sidaway case incomprehensible because of its continuing regard for a 'professional practice standard' in informed consent, I will argue that an important fact in many cases is the moral integrity of the doctor concerned and the pattern of his practice. This may provide the only morally principled and legally accessible evidence enabling a correct decision to be made in a difficult case. Although the epistemological significance of a professional practice standard is thereby defended the 'prudent patient standard' for what counts as consent is left intact.

Introduction

As in any conceptual issue, the issue of informed consent can be addressed in two distinct ways: (i) what counts as informed consent (which we could call a metaphysical inquiry); and (ii) how do we tell that some event or series of events satisfies the requirements (an epistemological inquiry). Informed consent has been exhaustively reviewed in a recent publication in which it was noted that there was an ideal standard of autonomous authorisation by the patient for a proposed medical treatment (this could be thought of as a metaphysical specification). But it may be difficult to ascertain in any particular instance that this standard has been satisfied and therefore it cannot straightforwardly be used to frame policy for epistemological reasons (1).

In practice the issue is considered in terms of either the 'reasonable patient standard' or the 'professional practice standard'. Since Sidaway (2) it has become clear that doctors can no longer decide unilaterally what information a patient should be given and that the standard is set by what is of material concern to the patient involved. But Sidaway also enshrined the

principle of therapeutic privilege despite Lord Scarman's dissenting statement emphasising the material concerns of the patient. The overall effect, as far as many doctors were concerned, was to endorse a 'professional practice' standard for consent. I will concede, for the purpose of argument that Lord Scarman's position is, on balance, the more correct and that informed consent ought to be constrained by what is of material relevance to a prudent or reasonable patient. But even though this is what counts as informed consent and even if the doctor should also take account of the particular concerns of the individual patient he is advising (so that the metaphysics has an individual element), the epistemological issue, which is unavoidable when medical practice meets litigation proceedings, is less clearcut. Thus it is possible that the Sidaway decision to consider the known practice of the surgeon concerned was correct despite the confused metaphysics it has engendered.

In this paper I will offer a model of the consent process and then try to relate two things – the epistemology of 'informed consent' and a view of agent integrity which has been advanced by Peter Winch (3). I hope by so doing to endorse the prudent patient standard for what counts as consent but also to enter a plea for some sort of professional practice standard in post-hoc judgements about consent.

The informed consent transaction

It is clear that the patient should be informed about significant risks and side-effects of any proposed treatment and that this information should form part of a relationship of trust between the patient and his doctor. The model in Fig 1 captures what is important in consent and the process of obtaining it.

In this model we see the respective roles of doctor and patient at each level and how they affect the components of the consent process. Notice that it requires both patient and doctor to act reasonably and responsibly in order that a valid decision be made. But problems can occur at every level both in fact and in the retrospective scrutiny of what happened (4).

Key words

Informed consent; trust; moral integrity; doctor-patient relationship.

A: In fact

1: INFORMATION

The information given to the patient may not be accurate in terms of final outcome and diagnosis because the doctor is misinformed or because it is an indeterminate situation in which clearcut statements are difficult to make. Even if the doctor makes every effort the particular problems of a given patient may not fit neatly into a general summary of facts about the type of condition concerned.

1a: Communication can be effective or ineffective for a number of reasons.

(i) The doctor may not spend the time necessary and so fail in his role as responsible counsellor. He should try and do his best to allow the patient to understand or see the problem she is facing (1d).

(ii) The doctor may use incomprehensible terms and fail to allow the patient clearly to understand her predicament. Ten or more years of medical training induces a considerable 'knowledge-gap' between doctor and patient and this has to be taken into account in striving for communication (1d). We ask a lot of our patients when we ask them to absorb a sober and balanced medical assessment of their condition and the relevant therapeutic measures available for it. And they, in turn, ask a lot of us in expecting us to make the problem clear to them; indeed it may be less than clear to junior medical staff (as evidenced by their discomfiture at being grilled during ward rounds). Patients often achieve a clear understanding of their treatment and its rationale if helpful illustrations and analogies are used which are based on things that are familiar to them. Despite this, there are limitations which often lead to misunderstandings.

(iii) The patient is ill. This means that he is cognitively disadvantaged by more than just a disparity of knowledge. We implicitly recognise the difficulties involved in the sober assessment of one's own illnesses

or those which afflict loved ones when we recommend that a doctor should seek outside medical care for himself and his family. The difficulties induced by illness itself are compounded if there is a lack of trust between doctor and patient as the patient cannot achieve any understanding unless some things at least are believed (5). These problems can be helped by the clinician inviting question and comment on his explanation and by having other people, such as a relative, nurse or student available who can offer further information or discuss what has been said with the patient.

2: DECISION

(i) For the patient to make a reasoned decision she must be free to decide one way or the other for her own reasons and thus there must be a lack of coercion in the doctor-patient relationship (2a). Although the difference between coercion and persuasion is not at all clear-cut we can say that persuasion aims to enlist the patient's reason by providing information and coercion aims to manipulate the patient's decision by influences which undermine independent reasoning. This might include, for instance, an implicit threat of abandonment unless the doctor's wishes are followed. The decision can, of course, be influenced by the more indirect methods of slanting or selecting the information presented or by inducing panic and fear so that the patient retreats by 'leaving it all to you, doctor' (2d).

The patient can make things impossible by acting on fixed or superstitious opinions or by failing to participate responsibly in her management or its planning (2p).

These problems can largely be avoided if orthodox medical wisdom concerning the patient's

problem is set out simply and comprehensibly and any departure from it explained clearly by the doctor so the patient is aware of the respects in which her treatment might differ from that normally offered. Such controversial points ought to be 'flagged' in the written consent form (6).

3: THE CONSENT FORM

In some settings the consent form is recast as a request for treatment. This seems laughable; the true nature of the transaction is always that the doctor makes a recommendation for treatment and the patient or a suitable person consents to that recommendation being followed. A clearly worded, informative consent form which states exactly what is to be done and which has room for the patient to add any qualifications (such as 'No blood to be administered') would seem to be quite adequate for clinical purposes. The doctor in overall charge should, I believe, validate the consent before the procedure is embarked upon even if he is not the one who has obtained the signed consent (this is often done by a resident). Many forms are vague, uninformative and never seen by the operating surgeon prior to his procedure being performed. This multiplies the opportunities for errors and inconsistencies to creep into the process.

B: In retrospect

To these difficulties inherent in the consent transaction we must add certain problems with a retrospective decision about what was said and done when a given procedure was consented to.

1: THE INFORMATION COMMUNICATED

(i) The surgeon or physician involved usually discusses the procedure with the patient informally so as to allow free communication. In practice this is often done on a ward round or in a bedside conversation and no detailed record of the conversation enters the medical notes. The assessment of what information is given to a patient in such a transaction can clearly be facilitated if we keep some written record of what was said.

(ii) We have noted that the patient, in attempting to understand her disease and its treatment, has to struggle with concepts and terms which may seem perfectly clear to the medical staff but are often unfamiliar or even incomprehensible to her. Many senior medical staff do use helpful analogies and illustrations to make the problems clearer (and this is all to the good), but analogies may confuse as well as inform because they can be taken in various ways. It was clear in the Cartwright inquiry into the treatment of cancer of the cervix at National Women's Hospital in New Zealand that many women recalled the analogies they had been told about soldiers in a row and black sheep more clearly than they ever understood their significance in explaining the patho-physiology of carcinoma-in-situ (7). This can mean that it is difficult to ascertain (retrospectively) whether the information given was misleading or accurate.

(iii) The confounding effects of stress and illness raise doubts about whether what the patient recalls is a clear indication of what he was told. The message, be it as clear and accessible as one can make it, is beset around and about with fleeting hopes, fears, expectations and impressions, often themselves imperfectly formulated in a mind clouded by pain or the lethargy and helplessness induced by disease. It is also diluted by what others may have said in attempting to clarify the doctor's words.

(iv) These confounding factors tend to highlight the principal clinician, as a kind of refuge in the sea of uncertainty. Who he is and how he appears to the patient become salient features of the interaction and may colour his words with the wishes and fears that occupy the patient's mind. The doctor's demeanour and apparent level of concern may influence the patient's perception of how much she is being informed and consulted about her treatment.

LOOKING BACK

(v) Any course of treatment has its problems and it is in the light of these that the patient reflects on what has happened. After a medical procedure and as a result of what has been done the patient will usually find out more about his condition and what further treatments, if any, can be offered to him. He may find that he is cured or at least curable; he may find that his disease is incurable or even terminal. These disclosures and the way in which they are made will reflect upon what has gone before. They will colour his apprehension of the past. They may colour it favourably, even joyously, or they may colour it with a sombre dignity. They may colour it bitterly, highlighting all those inadequacies and shortcomings that are present within every course of human conduct. Again the clinician will be the focus of these thoughts. His words and expressions will be picked up, reflected upon and perhaps distorted or, by contrast, remembered with stark clarity. His warmth, courtesy, brusqueness, apparent callousness or whatever will be brought to centre-stage in the patient's reconstruction of the information which raised hopes that are now shattered or sparked uncertainties now being fed by pain and anxiety.

(vi) Memory is an often reliable but sometimes shifty servant of the mind. At times memory shuffles sideways to accommodate a present interest or emotional response into one's view of some past experience. We laugh at the confabulating alcoholic but the laughter is often slightly nervous, as we see there, in our most lucid moments, a caricature of our own constructive re-telling of the past. After months or even years, and under the influence of financial interest or long and bitter rumination over wrongs suffered, elusive memories of bedside conversations and medical communications may well shift. Here the clinician is at a disadvantage in that he may know the salient points of any one case among the many with which he deals but not the fine details that a medico-legal scrutiny seeks to unearth. The clinician must say what he did and said,

for instance, in one of the 200 liver biopsy patients that he treated or in one of the 50 lumbar disc patients that he assessed and operated upon in a given year. It is unreasonable to ask anybody to do this. By contrast the patient is likely to have had far fewer interactions with doctors over the same period, and to remember them better. Nonetheless even the patient's recall may be remarkably inadequate if we are to believe the results of a recent survey (8).

(vi) The patient may be distressed by certain complications of the procedure he has undergone, the true nature of which did not sink in at the time of his pre-operative care. He may say: 'But if I had known it would be like this I would never have agreed'. In such a case one can never be sure whether the patient has been told properly of the possible complication but has suffered a worse version than most patients get, or whether he is magnifying, intentionally or unintentionally, his discomfort beyond what a normal patient would, or whether the complication was indeed misleadingly played down in the pre-operative discussion. Again the truth is not something which can be pinned and held under the legal 'microscope' but is rather a 'vague thickening' in the mist of human feelings which dominate the situation.

Although all these problems are well rehearsed in the literature (and well known to those of us in surgical practice), in the face of these indeterminacies, even where no negligence, malpractice or malice is present in the case, it seems difficult, if not impossible to reconstruct exactly what happened on an occasion where consent has become an adversarial issue. The fact that we do not, despite the difficulties, lessen the doctor's duty to inform his patient about her management and that his actions in this regard may become the focus of an adversarial process emphasises that an ethical judgement is involved. We recognise that the norm or standard of informed consent should be obeyed by all practitioners. Some, of course, may be bad at the skills involved but, if it is part of an adequate clinical practice to enable a patient to give informed consent, a physician *ought* to make sure that communication is achieved. Thus the difficulties attending a legal scrutiny of consent may be elucidated by an analysis of retrospective judgements about the morality of an agent's actions. However, the indeterminacies I have sketched make it less than clear in a particular case whether the doctor has made a genuine attempt to satisfy the patient's right to know about her own treatment.

Some claim that this problem can be evaded and the indeterminacy eliminated by presenting the patient with a sheet of data about the operation or procedure planned, its indications, possible complications, and so forth. To this one may adduce four objections: (a) it can dehumanise the consent discussion; (b) it is probably indigestible to all but the most exceptional of patients; (c) it is impossible to list all the possible complications of a given treatment and the highly particular interaction between the patient, the disease

and the doctor(s) may always surprise one – sometimes in very significant ways, and (d) medicine is not wholly a science and unanimity in preferred treatment is not to be had: a given procedure may work well or badly in the hands of different doctors with different styles and skills. Notice that none of these objections trade on the idea that the patient must be shielded from the truth, an idea which typifies the objectionable and presumptive paternalism said to infect the 'professional practice' standard for consent.

Even if we move toward an objective norm governing medical communications, it may still be that, after the event, we are left almost bereft of adequate evidence on which to judge an individual case. In some cases it may be perfectly clear that counselling was deceptive, offhand, coercive, inadequate or objectionably paternalistic but in many cases such clear evidence is not to be had. How then can one arrive at an ethically sound judgement about the rightness of what was done? Here, I think, Peter Winch can help us out.

Agent integrity and moral evaluation

To review, moral integrity and the retrospective spectator assessment of a moral action are relevant to informed consent because:

- a) we judge that the doctor has done wrongly if we decide against him;
- b) even if he is unfortunate enough to be a bad communicator we regard consent as an intrinsic part of good practice and hold him responsible for seeing that his clinical practice is competent in this area;
- c) we believe that the patient has a right to know and to be able to make a reasonable decision about his own treatment and we are attempting to determine whether the doctor has infringed that right.

Therefore, we *are* passing a moral judgement on an agent – the doctor – with respect to what he did on a particular occasion when he should have elicited informed consent to a procedure from the patient on whom he performed it.

Peter Winch has analysed retrospective moral evaluation in such a way as to focus on the agent as participant. His points are made forcefully in his discussion of the actions of Captain Vere with respect to the seaman Billy Budd.

Billy Budd, a foretopman of angelic character, is impressed into service on the *Indomitable* from the merchantman *Rights of Man* on the high seas. He is persecuted by a satanic master-at-arms of the *Indomitable*, Claggart, in a campaign which culminates in Claggart's falsely accusing Billy, before Vere, of inciting the crew to mutiny. In the stress of this situation, Budd is afflicted with a speech-impediment which prevents him from answering the charge. Frustrated, he strikes Claggart, who falls, strikes his head and dies (9).

Captain Vere was an upright and humane naval officer who realised that he held a tenuous line of defence between England and the invasion fleets of Napoleon. There had been recent fleet mutinies at Spithead and the Nore and he felt that a great weight of events rested on the naval discipline which made his service the fighting force that it was. Naval law dictated that Billy Budd should hang for striking a superior officer and yet conscience cried out that Billy Budd was innocent. Vere summoned and presided at a drumhead court-martial called to deal with the emergency and directed his co-adjutors to accept that 'private conscience should yield to that imperial one formulated in the code under which alone we officially proceed' (10). He requested the death penalty, although he was genuinely moved by Billy Budd's plight and shared the compassion that all those present felt for the unfortunate seaman.

Winch argues that one can feel that there was a genuinely right decision for Vere to make, that he made a principled judgement and yet, while respecting the rightness of his actions in making the decision, not concur with it (11). Winch claims that the reactions of an upright person in a moral dilemma constitute *facts* to be taken into account in assessing or evaluating what was done where we are unable to appreciate all the nuances of the situation. Vere was an upright man; he was torn by conflicting moral demands and made a decision with which we may feel that we cannot agree. But, for all that, one can contend that what Vere did, as the principal agent in the situation, deserves special weight in deciding whether he acted rightly. It does so because the realities of the situation are not clear to a spectator and certain conditions are satisfied:

- (1) he appreciated the moral conflict;
- (2) he acted with recognisable and endorsable moral sensitivities;
- (3) he acted sincerely.

Winch does not claim that whatever anybody does in a moral dilemma is right but rather that the agent is sometimes uniquely placed to appreciate the ethical dimensions of his action. Notice that in this case we know exactly what happened and yet still Winch's conclusion commends itself.

Winch argues, in a further paper, that moral integrity, a quality of the agent's character, is also of concern in moral evaluation (12). He contends that we cannot evaluate actions 'split-off', as it were, from the agent who acts, in any but the most simple of cases. A moral judgement is an evaluation of the person's thought and life, as manifest in a particular situation. He implies that we must look at the life and activity of a man as a 'gestalt' which is thrown into a particular kind of focus in a moral dilemma. That 'gestalt' must be an important guide in our judgements about the action under consideration. This was clearly a factor in the Sidaway case as the surgeon concerned was known to be a person who was, if anything, over-fastidious

about counselling his patients and warning them of the hazards of operations.

This is not claimed to be a simpler or easier method of arriving at moral judgements but is rather, Winch claims, the only adequate perspective which can be taken. Again, we are not saying that whatever a good agent (or doctor) does is right, no matter what the facts suggest. Winch is claiming that when the facts are unclear it may be that the best guide we have to the rightness of what was done is what a morally endorsable agent actually did as a participant in the situation. This takes us closest to the test we do apply which is to imagine what it would have been like to be the principal actor acting out of a sense of moral rectitude in the face of a difficult challenge. His suggestion engages our full sensitivity as agents and moral thinkers and urges us to exercise a great deal of empathy for the actors in the moral conflict.

'When I think about the moral decisions and moral dilemmas of others, it seems to me that I am very often asking: "What would I think it right to do in such a situation?" that is, I am making a hypothetical agent's judgement of my own. Thus only a man who is himself a moral agent, capable of making moral decisions of his own, is capable of making and understanding a spectator's moral judgements about the actions of other people' (13).

Not only do I think that this view greatly commends itself in general debate about moral judgements but also it seems particularly relevant to questions of medical conduct. It is, for several reasons, well suited to cut the Gordian knot of indeterminacies surrounding an issue of informed consent.

First, we find it hard to get at the facts which allow a principled judgement in a particular case. Second, we cannot formulate a watertight and objective set of criteria to resolve the problem. We are faced with one-off situation in which we are evaluating the agent by some sort of test like Winch's 'What would I think it right to do in such a situation?'. Third, we have to weigh the evidence we have in the light of the character of the people giving it and the way that they are being influenced by various factors. Thus we are placed in much the same situation as spectators considering Captain Vere's actions who know a great deal but are not participants in the situation. We, as judges, have to decide how we shall overcome the epistemic difficulties which a retrospective evaluation presents.

Disentangling the questions

In some cases of informed consent the issue is clearcut. It is clear that the patient has (or has not) been adequately informed prior to the procedure and throughout her course of treatment. But in many cases which come under medico-legal scrutiny it is far less clearcut. I have detailed the reasons which tend to undermine the reliability of evidence in such cases but let me list them again:

- (i) the desirable informality of the discussion and the lack of detailed written records;
- (ii) the opacity of medical language and the ever-present possibility of misinterpretation;
- (iii) the emotional 'noise' that often obscures the information in the 'signal';
- (iv) the retroactive effect of reflection upon the recall of events;
- (v) the fallibility and suggestibility of human memory;
- (vi) the individual response of the patient to his symptoms.

Our concern in scrutinising informed consent is that the doctor should respect his patient's autonomy and allow the patient to understand the procedure envisaged within the context of a relationship with him in which the patient can both exercise trust and yet be a responsible participant in his own medical care. The unquantifiable nature of these desiderata are evident.

Justice Kirby notes:

'The most, as it seems to me, that ethical rules and the law can do is to emphasise, lest it ever be forgotten, the integrity and autonomy of the patient. Most medical professionals do not forget. Most are faithful to the trust put in them by patients dependent because of need' (14).

We are all aware that it is not only impossible but also not always in the patient's best interests to talk about all the possible complications of a given procedure for reasons of information overload and emotional clouding of a major decision (these undesirabilities show up in the proposed model at 2p). We also acknowledge, as actors involved in this moral dilemma, that there will be situations in which failures of communication occur and that these, though regrettable, are inevitable in view of the pace of modern medical practice and the difficulties I have enumerated. It seems that we do a lot less in this area than we should and that we ought to make efforts to improve. We are concerned, however, both that patient's rights may not be respected and that there are certain members of our profession who are particularly prone to a succession of problems in this area. A complaint indicates a distinct fault in the doctor-patient relationship. We are lastly concerned at the distortion of this relationship that would occur if the bedside chat was totally replaced by a medico-legally motivated form the signing of which constituted effective consent. It is clear to all that not only is an exhaustive and exhausting document listing medical facts obnoxious as a substitute for a rather more informal discussion but that also it is ineffective and does not allow informed discussion and explanation (15). It remains true that most of the genuine satisfaction that a doctor gains is from the exercise of what is for him a caring profession in which his medical skills are used to help his patients. He feels a special

responsibility for those patients and usually establishes a close relationship with them. We are therefore faced with a dilemma in attempting to abstract guidelines by which that informality can be preserved in the face of a medico-legal challenge. Shall we surround the practice of medicine with a battery of formal requirements which will protect the doctor from litigation but leave the patient somewhat deprived of an important aspect of his care or shall we attempt to define an approach which will safeguard the caring relationship but attempt to provide workable guidelines where it breaks down?

A complaint requires, as I have noted, that a 'spectator' moral judgement be made, in the face of uncertainty about what actually happened, on the action of the clinician involved. Winch has directed our attention to the character of the agent and suggested that we ask whether he acted sincerely and with an endorsable set of ethical principles. No one could deny that these are essential to the communication between a doctor and a patient prior to any procedure, particularly if that procedure carries a high risk. But these critical features of the moral situation are not codifiable. Thus a consent transaction, surrounded by the indeterminacies which I have stressed and with a vital informal ingredient, cannot be assessed purely in terms of hard facts and the exact nature of the consent which was elicited may elude us. Therefore, as moral spectators, we must turn, as Winch does, to the character of the agent under scrutiny. We must ask: i) whether he appreciated the moral demand; ii) whether he acted with an endorsable set of values; and iii) whether he acted sincerely.

The track record

In the absence of clear evidence concerning the particular occasion in dispute, we are forced to turn to the known practice of the doctor concerned, as materially relevant to the present decision. We must therefore assess the nature of the doctor-patient relationships that he forms and his procedures in dealing with the problem of consent. We may have to find out from patients with similar problems to the complainant what their experience of pre- and post-operative care and information were like. It is here that we will detect those who draw on the authoritarian tradition in medicine: 'In its more extreme forms this tradition denies any significant patient participation and leaves the ultimate choice of treatment solely with the physician' (16). The picture we need is one which tells us whether the patients of a particular physician do generally give substantially autonomous authorisations for treatment. Does this physician respect the patients' right to decide, value and welcome their participation and refrain from duplicity in his patient counselling? Once such a picture has been established to the satisfaction of those deliberating then the grounds of spectator evaluation become a little more clear (this was the case with Sidaway).

Winch concludes, in regard to Captain Vere, that he could not have acted as Vere did and yet that Vere, in the situation in which he found himself, probably acted with moral rectitude. This is because great weight must be given to what a person of the right moral character, who was aware of the moral factors to be taken into account, actually did in the situation under scrutiny. Similarly, in a consent dispute we often do not know what was done and yet we may be able to judge that it was morally correct because it was the action of a person of the requisite character who acted with an informed grasp of the situation. This is not a licence for unbridled moral relativism nor for immunity from medico-legal censure but rather an admission of the highly particular nature of each consent discussion and the need for a sensitive participant to weigh what should and should not be said at any given juncture in treatment. Once we have satisfied ourselves that the agent concerned is a competent moral judge and that he acted in accordance with adequate principles, then we should accept that his actions are likely to have been *the* right thing to do or perhaps *a* right thing to do in the situation. That is because his actions express the judgement of a participant with moral integrity which is what we are striving to use as a standard in our own verdict.

Thus, where other evidence gives us no clearcut guide as to whether a patient's rights have been infringed, we must assess the physician's 'track record' in such situations because it is our only evidence of his integrity and sensitivity (or lack thereof) in the area of informed consent. By so doing we get at what he probably did by asking what he usually did. This can guide us where 'picking over' the details of a poorly recorded and dubiously recalled incident in a busy hospital practice might be unsatisfactory, inconclusive and highly unreliable. On the present recommendation the character of the patient is also of material relevance to the judgement and certain patients, whose track record is a miscellany of disaffected medical entanglements, will have their claims regarded in that light.

Conclusion

Informed consent is a process involving the communication of information and the making of a reasoned and co-operative decision by doctor and patient. The duty is quite clear and its dereliction also clear in certain cases. But disputes in this area cannot

always satisfactorily be settled by reference to an individual transaction because of the indeterminacy of the events surrounding particular instances and the informal nature of desiderata for eliciting informed consent. I have briefly sketched Peter Winch's views on 'spectator moral judgements' and related these to the problem of informed consent. I have suggested that the history and character of both doctor and patient are materially relevant to disputes over informed consent. These two aspects of a given situation are often far more accessible than the details of a particular encounter in which information was or was not adequately conveyed to and understood by a patient.

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