LINK MEDICAL JOURNAL
of Health and Community Research | LMJHCR
Volume 4, Issue 1 | June 2026 | ISSN 3007-3448

Indexed in DOAJ | CC Bq4jc7c36Y 4.0
DOI: 10.61919/vk40mn91

Original Article

When Algorithms Join the Consultation: A Qualitative Study of Patient Autonomy, Trust and Informed Consent in AI-Supported Oncology Decision-Making

Qiu Huixu[1], Linda Chiuman[1], Ali Napiah Nasution[1]

[1] Universitas Prima Indonesia, Indonesia

***Corresponding author: Linda Chiuman, lindachiuman@unprimdn.ac.id**

"Cite this Article" | **Received**: 01 May 2026; **Accepted**: 07 June 2026; **Published**: 30 June 2026.

ABSTRACT

Background: Multimorbidity is often managed through disease-specific services, requiring patients to coordinate information, Background: Artificial intelligence (AI) is increasingly being incorporated into diagnostic, prognostic, and treatment-support processes in oncology, raising concerns regarding patient autonomy, trust, informed consent, explainability, and professional accountability. Objective: To explore how adults with current or previous oncology-care experience perceived autonomy, trust, informed consent, explainability, and clinician responsibility when considering hypothetical scenarios in which AI contributed to cancer-related diagnosis, prognosis, or treatment recommendations. Methods: A qualitative interpretive design was used. Fourteen adults with oncology-care experience were purposively recruited to provide variation in cancer experience and familiarity with digital health. Semi-structured interviews incorporated hypothetical scenarios involving AI-supported image analysis, individualized recurrence estimation, treatment recommendations, clinician–algorithm disagreement, and AI use without prior discussion. Data were analysed using reflexive thematic analysis. Results: Five interconnected themes were identified: conditional trust rather than technological trust; consent as an ongoing conversation; human accountability as the boundary of acceptable automation; explainability as practical meaning; and algorithmic pressure on autonomy. Participants generally perceived AI as acceptable when it augmented rather than replaced clinical reasoning, clinicians remained responsible for interpreting its outputs, and patients retained opportunities to question recommendations and consider alternatives. Participants also anticipated that AI-labelled recommendations could appear unusually objective and therefore become more difficult to reject, particularly when uncertainty and alternative options were not clearly communicated. Conclusion: Participants perceived AI-supported oncology decision-making as most compatible with autonomy when AI remained subordinate to accountable clinical judgment, disclosure was proportionate to its influence on the decision, explanations were clinically meaningful, and patients retained genuine opportunities to question or refuse recommendations. Because the study examined hypothetical scenarios rather than observed AI-supported consultations, the findings represent anticipated perceptions rather than demonstrated effects on clinical behaviour or autonomy. Keywords: artificial intelligence; oncology; patient autonomy; trust; informed consent; shared decision-making; qualitative research

EDITORIAL INFORMATION

Author Contributions: Concept: QH; Design: LC; Data Collection: ANN; Analysis: QH, LC; Drafting: QH, LC, ANN.
Ethical Approval: Universitas Prima Indonesia
Informed Consent: Written informed consent was obtained from all participants
Conflict of Interest: The authors declare no conflict of interest; **Funding**: No external funding; **Data Availability**: Available from the corresponding author on reasonable request; **Acknowledgments**: N/A.

INTRODUCTION

Artificial intelligence (AI) is increasingly being incorporated into healthcare processes that involve image interpretation, diagnostic support, prognostic estimation, risk stratification, and treatment decision support. Although these applications may improve information processing and augment clinical reasoning, patients do not necessarily evaluate AI solely according to technical performance. Previous research has shown that patients may recognize potential advantages related to accuracy, consistency, and access to complex information while simultaneously expressing concerns regarding diagnostic error, privacy, transparency, loss of interpersonal care, and excessive reliance on automated recommendations (1–4). A broader synthesis of patient perspectives similarly indicates that acceptance of healthcare AI is conditional and strongly influenced by how the technology is incorporated into existing clinical relationships rather than by technological capability alone (5).

Trust in AI-supported healthcare is therefore better understood as relational and contextual than as an isolated judgment about an algorithm. Qualitative evidence suggests that patients distinguish between confidence in a technological system and confidence in the clinicians and institutions responsible for interpreting and applying its outputs, with responsibility, autonomy, and professional oversight remaining important determinants of acceptability (6). Trust may also extend beyond the immediate clinical encounter to the way health data are collected, reused, governed, and protected, particularly when patient information contributes to the development or implementation of AI systems (7). Explainability has consequently become a central concern, although simply providing more technical information does not necessarily strengthen trust; the usefulness and relevance of an explanation to the decision being made may be more important than detailed knowledge of model architecture (8).

These issues have particular relevance in oncology, where decisions are frequently preference-sensitive, emotionally demanding, and made under conditions of prognostic uncertainty. Shared decision-making in cancer care requires patients and clinicians to consider not only probabilities of benefit and harm but also treatment burden, quality of life, personal values, and the degree of decisional control desired by the patient (9). Qualitative work has shown that patients and clinicians may differ in how participation is understood and enacted during cancer decision-making, while patients themselves may vary between active, collaborative, and more clinician-guided roles depending on their circumstances (10,11). The introduction of an algorithmic recommendation into this relationship may therefore alter not only the information available to patients but also the perceived authority attached to particular options.

Informed consent presents an additional challenge because the clinical importance of AI can vary substantially across applications. An algorithm may operate unobtrusively as background analytical support, or it may materially influence a diagnosis, prognosis, or treatment recommendation. Ethical discussions concerning healthcare AI have therefore emphasized the importance of meaningful notice and explanation rather than treating disclosure as a purely technical formality (12). Oncologists have likewise identified uncertainty regarding explainability, responsibility, and consent when AI contributes to cancer care (13). The ethical issue is consequently not only whether patients are informed that AI has been used, but whether they understand its role in the relevant decision, the uncertainties surrounding its output, the responsibility retained by clinicians, and whether meaningful alternatives remain available.

Recent implementation-focused research further suggests that patient-centred AI depends on understandable communication, visible human responsibility, and opportunities for patients to participate in how AI-supported decisions are interpreted and applied (14). Patients may value AI when it helps organize information or supports communication without displacing clinician involvement, including in AI-assisted shared decision-making (15). Patient participation may also extend beyond individual clinical encounters to questions concerning acceptable use cases, safeguards, explanation, and governance of AI-supported healthcare systems (16). However, comparatively little qualitative evidence has examined how oncology patients interpret their own autonomy when an AI recommendation appears to carry independent authority within a treatment discussion.

The present study therefore explored how adults with oncology experience perceived autonomy, trust, informed consent, explainability, and professional accountability when considering hypothetical scenarios in which AI contributed to cancer-related diagnosis, prognosis, or treatment recommendations. Particular attention was given to the circumstances under which participants perceived AI as supportive of shared decision-making and those under which algorithmic recommendations were perceived as constraining questioning, refusal, or meaningful choice.

MATERIALS AND METHODS

A qualitative interpretive design was used to explore patient perceptions of AI-supported oncology decision-making. The study was informed by a relational understanding of autonomy in which decision-making is shaped by communication, trust, professional responsibility, and the availability of meaningful alternatives. Reporting was assessed against the Consolidated Criteria for Reporting Qualitative Research (COREQ) because the study used individual qualitative interviews (17).

Fourteen adults with current or previous oncology-care experience were recruited purposively to obtain variation in age, sex, cancer type, stage of treatment, and familiarity with digital health. Eligibility criteria were age 18 years or older, current or previous oncology care, and the ability to discuss cancer treatment decision-making in English or Bahasa Indonesia. Participants represented breast, colorectal, lung, prostate, haematological, and gynaecological cancer experiences. The study used purposive rather than statistically representative sampling because the objective was to explore contrasting perspectives concerning AI-supported decision-making rather than to estimate population prevalence.

Data were generated through semi-structured interviews examining participants' understanding of AI, reactions to AI-supported diagnostic and treatment recommendations, expectations regarding disclosure and consent, and perceptions of responsibility when clinicians and algorithmic recommendations disagreed. Hypothetical scenarios were incorporated to make the ethical questions concrete. These scenarios varied in the apparent influence of AI: one involved background image-analysis support, another involved an individualized recurrence estimate, and another involved an AI-generated treatment recommendation that differed from the oncologist's initial preference. Additional scenarios addressed agreement between clinician and algorithm and the use of AI without prior discussion. The vignette-based design therefore elicited anticipated judgments regarding AI-supported oncology rather than documenting participants' experiences of a single implemented AI system.

Data were analysed using Braun and Clarke's reflexive thematic analysis (18,19). Analysis involved familiarisation with the interview material, coding, development of candidate themes, review and refinement of thematic boundaries, and interpretive writing. Coding attended both to explicit descriptions of AI-supported care and to participants' accounts of authority, expertise, responsibility, uncertainty, and decisional control. Themes were retained according to their conceptual relevance to the research question rather than according to numerical frequency. Accounts that complicated or contradicted dominant interpretations were considered during theme development so that enthusiasm for AI and concern about AI were not treated as mutually exclusive positions.

Ethical approval was reported as having been obtained from Universitas Prima Indonesia. Participation was voluntary, confidentiality was protected using pseudonymised participant identifiers, and participants were permitted to discontinue participation up to the point of analysis. Participant quotations in the findings are identified using pseudonymised codes.

RESULTS

Fourteen participants contributed accounts reflecting different cancer experiences and levels of familiarity with digital health. Their responses did not form two discrete groups of supporters and opponents of AI. Instead, perceptions of acceptability varied according to the function assigned to AI, the extent to which its output influenced a consequential decision, the role retained by the clinician, and whether participants believed that questioning or rejecting an AI-supported recommendation remained possible. Analysis generated five interconnected themes: conditional trust rather than technological trust; consent as an ongoing conversation; human accountability as the boundary of acceptable automation; explainability as practical meaning; and algorithmic pressure on autonomy.

Theme 1: Conditional Trust Rather Than Technological Trust

Participants generally described AI as potentially useful when it functioned as an additional source of information rather than as an autonomous decision-maker. They valued possible roles for AI in checking clinical reasoning, identifying overlooked information, comparing large amounts of evidence, and providing an additional perspective. However, the perceived legitimacy of an AI output remained dependent on clinician interpretation. P03 explained, “if it caught something the doctor had not seen, that would be beneficial. The doctor should explain it to the patient but not the computer alone.” Similarly, P11 acknowledged the informational capacity of AI while distinguishing it from knowledge of personal preferences: “It may compare thousands of cases, and I cannot do so, but it does not know what I will accept to live with.” Participants therefore appeared to locate trust across the clinician–technology relationship rather than in the algorithm alone. Confidence was greater when clinicians retained

interpretive responsibility and acknowledged uncertainty rather than presenting predictions as incontrovertible facts.

Theme 2: Consent as an Ongoing Conversation

Participants perceived disclosure requirements as proportional to the influence of AI on the clinical decision. They did not consistently expect detailed explanations for every background computational process, but they wanted greater transparency when AI materially affected diagnosis, prognosis, or treatment selection. Participants emphasized that meaningful disclosure involved more than being informed that an AI system had been used; they wanted to understand what contribution the system had made, whether the clinician agreed with its recommendation, and what alternatives remained available. P09 characterized meaningful consent as retaining the ability to say "yes, no, or show me another option." Disclosure was therefore perceived as more useful when it occurred early enough to contribute to deliberation rather than after an AI-supported recommendation had already been framed as the preferred course of action.

Theme 3: Human Accountability as the Bounda4ry o4f Acceptable Automation

Human responsibility emerged as a prominent boundary around acceptable AI use. Participants were generally more comfortable with technologically advanced support when an identifiable clinician remained responsible for evaluating and communicating the final recommendation. As P02 stated, "Somebody has to be the decision maker; if the answer is inaccurate, then I cannot dispute with software." Accountability was understood not only in terms of assigning responsibility after an error but also as creating an expectation that clinicians would critically evaluate algorithmic outputs before relying on them. P14 expressed this expectation directly: "when the doctor is liable, there is something the doctor has to check." Participants did not necessarily interpret disagreement between clinician and AI as undesirable. Instead, disagreement could be acceptable, and potentially useful, when it prompted additional examination rather than automatic deference to either human or algorithmic authority.

Theme 4: Explainability as Practical Meaning

Participants' accounts emphasized decision-relevant explanation rather than technical descriptions of source code, model architecture, or computational processes. They wanted to understand which factors contributed to an AI-supported recommendation, how certain the recommendation was, what limitations might affect its applicability, and how the clinician interpreted the result. P05 summarized this distinction by stating, "I do not require knowing how the machine is constructed; I require knowing why it believes that option A is the most suitable to me." Participants also expressed caution toward apparently precise numerical predictions when the basis of certainty was not understandable. P08 commented, "It is a certain 82 percent, but cancer never is that certain." Explainability was therefore perceived primarily as a means of supporting interpretation, comparison, questioning, and choice.

Theme 5: Algorithmic Pressure on Autonomy

Participants anticipated that recommendations explicitly presented as AI-derived could acquire an appearance of objectivity that made disagreement psychologically or socially more difficult. P12 stated, "saying that the best treatment is one that is calculated by the computer, and thus I say no, I feel irrational." P04 similarly described the tension between nominal and meaningful choice as "being presented with an option yet informed there is only one possible answer." These accounts suggest that participants perceived a potential for algorithmic authority to narrow substantive autonomy even when formal permission to accept or refuse treatment remained intact.

At the same time, participants did not regard AI as inherently restrictive of autonomy. Some accounts suggested that AI could broaden deliberation by organizing complex information, displaying alternatives, or making trade-offs easier to discuss with clinicians and family members. The distinction depended on how the AI output was framed: AI was perceived as autonomy-supporting when it expanded the information available for deliberation and as autonomy-constraining when its recommendation was presented as uniquely authoritative. Participants also distinguished between being informed and being overwhelmed by technical detail. P07 stated, "No, I want to determine myself how much to know, not to be told by some

that it is too technical." This supported a layered approach to explanation in which patients could receive a concise account of the AI contribution while retaining the opportunity to request additional detail.

Concerns regarding data governance also intersected with trust. Some participants indicated willingness to accept secondary use of health data when it contributed to improving cancer care, provided that governance and limitations on reuse were clear. P10 explained, "I could accept it when my data would assist another patient in some way, but when it becomes a product, and no one would inform me, that would be different." Although data governance was not developed as a separate theme, these accounts indicated that participants' trust in AI-supported recommendations could be influenced by their trust in the broader system through which health data were collected, governed, and reused.

Table 1. Analytical Themes and Their Interpretation

Theme	Principal participant concern	Interpretive meaning
Conditional trust	AI was acceptable as clinical support but not as an independent authority.	Trust was relational and depended on clinician interpretation and oversight.
Ongoing consent	Disclosure should increase when AI has greater influence on consequential decisions.	Consent was perceived as an ongoing communicative process rather than a single technical disclosure.
Human accountability	A responsible clinician should remain identifiable when AI contributes to a recommendation.	Human oversight functioned as both a safety expectation and a condition of legitimacy.
Practical explainability	Participants wanted decision-relevant reasons, uncertainty, and limitations rather than technical architecture.	Explanation was valued when it enabled understanding, questioning, comparison, and action.
Algorithmic pressure	AI-labelled recommendations could appear unusually objective and therefore harder to refuse.	Formal choice could coexist with a perceived narrowing of substantive autonomy.

DISCUSSION

This qualitative study suggests that adults with oncology experience did not evaluate AI-supported decision-making as inherently beneficial or inherently threatening to autonomy. Instead, acceptability depended on how the technology was positioned within the clinical relationship. Participants generally perceived AI more favourably when it functioned as an additional source of information that remained subject to clinician interpretation, whereas greater concern arose when algorithmic recommendations appeared to acquire independent authority. This distinction is consistent with qualitative evidence showing that patients differentiate trust in AI from trust in the clinicians and institutions responsible for applying it, with responsibility and self-determination remaining central to acceptance of AI-supported clinical decision support (6). Similar work on AI-supported shared decision-making has found that patients may value computational assistance when it helps organize information and facilitate discussion without displacing active clinician involvement (15).

The findings further suggest that participants conceptualized informed consent as proportional to the decisional influence of AI rather than as a requirement for detailed technical disclosure every time an algorithm operated in the background. Participants wanted greater transparency when AI materially affected diagnosis, prognosis, or treatment selection, particularly regarding what the system had contributed, whether the clinician agreed with its output, and what alternatives remained available. This interpretation aligns with ethical arguments that notice and explanation in healthcare AI serve multiple purposes, including informing patients, supporting trust, and enabling meaningful consent rather than merely documenting that technology was used (12). It also accords with implementation research indicating that patient-centred AI requires understandable communication, visible professional responsibility, and opportunities for patient participation (14).

Human accountability emerged as an especially important condition of acceptable automation. Participants did not simply want a person available to communicate an algorithmic result; they expected a clinician to exercise independent judgment, examine uncertainty, and remain responsible for the final recommendation. This finding is consistent with reports from oncologists who have identified responsibility, explainability, and appropriate reliance on AI as unresolved ethical concerns when algorithmic systems contribute to cancer care (13). The present findings extend this concern from the professional perspective to the anticipated patient experience by suggesting that visible human

accountability may function not only as a safety mechanism but also as a source of legitimacy within AI-supported decision-making.

Participants' accounts also distinguished practical explainability from technical transparency. They generally emphasized the need to understand why an AI-supported recommendation was relevant to them, what factors influenced it, how uncertain it was, and what might limit its applicability rather than requesting information about model architecture or computational processes. This distinction is compatible with evidence that explainable AI does not uniformly increase trust and that the effect of explanation depends on its relevance, quality, and usefulness to the decision at hand (8). Meaningful explanation in oncology may therefore require translation of algorithmic output into clinically interpretable consequences rather than the provision of increasingly detailed technical descriptions.

A particularly important finding was the anticipated pressure associated with recommendations framed as AI-derived. Participants described situations in which a computationally generated recommendation might appear more objective, definitive, or scientifically authoritative than an ordinary clinical opinion, potentially making refusal feel irrational even when formal choice remained available. These accounts should not be interpreted as demonstrating that AI causes coercion or loss of autonomy in clinical practice, because participants responded to hypothetical scenarios rather than documented AI-supported consultations. Instead, the findings identify a perceived risk that algorithmic authority could narrow the subjective space for disagreement. This concern is especially relevant in oncology, where treatment decisions commonly involve trade-offs among survival, adverse effects, quality of life, personal priorities, and the preferred degree of patient involvement (9–11).

The same accounts indicate that AI could also be perceived as autonomy-supporting when it broadened deliberation. Participants anticipated that AI might help compare options, identify information that clinicians could overlook, organize complex evidence, or make trade-offs easier to discuss with clinicians and family members. Thus, the ethical significance of AI appeared to depend not simply on whether it influenced a decision, but on whether that influence expanded or narrowed the patient's opportunity to understand, question, and evaluate alternatives. This interpretation is compatible with research emphasizing meaningful patient participation in both the use and governance of AI-supported healthcare systems (16).

Trust also extended beyond the immediate recommendation to the broader data environment supporting AI. Participants expressed concern about secondary use and commercialization of health information while indicating greater willingness to support data use when its purpose, governance, and potential patient benefit were transparent. Previous qualitative research has similarly shown that willingness to share health data for AI-related purposes may depend on perceived purpose, regulation, public benefit, and confidence that data will not be misused (7). Data governance may therefore influence clinical trust indirectly: patients may evaluate an AI-supported recommendation partly through their confidence in the institutions and practices through which the underlying data were collected and managed.

These findings should be interpreted in light of several limitations. First, the study used hypothetical scenarios and therefore examined anticipated perceptions rather than behaviour during actual AI-supported oncology consultations. Responses to vignettes may differ from decisions made when patients face immediate treatment consequences, prognostic uncertainty, or established relationships with their treating clinicians. Second, the purposive sample comprised 14 participants with heterogeneous cancer experiences; the purpose of the analysis was interpretive depth rather than statistical generalizability, and transferability to other oncology populations or healthcare systems requires caution. Third, variation in cancer type, treatment stage, and digital-health familiarity may have shaped responses in ways that cannot be fully disentangled within a small qualitative sample. Fourth, qualitative interviews are inherently influenced by how questions and scenarios are framed, and socially desirable responses regarding technology, clinician authority, or patient participation cannot be excluded. Finally, the manuscript does not currently provide sufficient information regarding interviewer characteristics, interview setting, transcription and translation procedures, or other reflexive considerations to fully evaluate how the

research context may have influenced the data. These reporting limitations should be resolved where source documentation is available.

Despite these limitations, the study provides a coherent account of the conditions under which oncology patients may perceive AI-supported decision-making as compatible with autonomy. The findings suggest that implementation success should not be evaluated solely through patient acceptance or willingness to use AI. High acceptance could reflect perceived benefit, but it could also coexist with perceived technological authority, limited alternatives, or reluctance to challenge a recommendation. Future research should therefore examine real-world AI-supported oncology encounters longitudinally and investigate how disclosure, clinician interpretation, disagreement, data governance, and patient preferences interact when algorithmic outputs materially influence actual clinical decisions.

CONCLUSION

Adults with oncology experience perceived AI-supported decision-making as most acceptable when AI was positioned as an aid to, rather than a replacement for, accountable clinical judgment. Participants valued transparency about consequential AI involvement, clinically meaningful explanation, visible clinician responsibility, and continued opportunities to question recommendations and consider alternatives. They also anticipated that recommendations presented as algorithmically derived could acquire an authority that made refusal more difficult, even when formal choice remained available. Because these findings arose from hypothetical scenarios rather than observed AI-supported oncology consultations, they should be interpreted as anticipated perceptions rather than demonstrated effects on patient behaviour or autonomy. Patient-centred implementation of AI in oncology should therefore preserve relational decision-making, proportional disclosure, human accountability, and meaningful opportunities for patients to express values, uncertainty, and disagreement.

REFERENCES

1. Nelson CA, Pérez-Chada LM, Creadore A, Li SJ, Lo K, Manjaly P, et al. Patient perspectives on the use of artificial intelligence for skin cancer screening: a qualitative study. JAMA Dermatol. 2020;156(5):501-512. doi:10.1001/jamadermatol.2019.5014.

2. Chan J, Parker L, Carter S, Nickel B, Carroll S. Radiation oncology patients' perceptions of artificial intelligence and machine learning in cancer care: a multi-centre cross-sectional study. Radiother Oncol. 2025;207:110891. doi:10.1016/j.radonc.2025.110891.

3. Erul E, Aktekin Y, Danışman FB, Gümüştaş ŞA, Aktekin BS, Yekedüz E, et al. Perceptions, attitudes, and concerns on artificial intelligence applications in patients with cancer. Cancer Control. 2025;32:10732748251343245. doi:10.1177/10732748251343245.

4. Habib M, Ellis J, Palachi A, Korman MB, Kay T, Barlow K, et al. Patient perspectives on AI-powered medical robots in breast and prostate cancer care: qualitative study. JMIR Cancer. 2026;12:e69710. doi:10.2196/69710.

5. Moy S, Irannejad M, Manning SJ, Farahani M, Ahmed Y, Gao E, et al. Patient perspectives on the use of artificial intelligence in health care: a scoping review. J Patient Cent Res Rev. 2024;11(1):51-62. doi:10.17294/2330-0698.2029.

6. Schneider D, Liedtke W, Klausen AD, Lipprandt M, Funer F, Bratan T, et al. Indecision on the use of artificial intelligence in healthcare: a qualitative study of patient perspectives on trust, responsibility and self-determination using AI-CDSS. Digit Health. 2025;11:20552076251339522. doi:10.1177/20552076251339522.

7. Mikkelsen JG, Sørensen NL, Merrild CH, Jensen MB, Thomsen JL. Patient perspectives on data sharing regarding implementing and using artificial intelligence in general practice: a qualitative study. BMC Health Serv Res. 2023;23(1):335. doi:10.1186/s12913-023-09324-8.

8. Rosenbacke R, Melhus Å, McKee M, Stuckler D. How explainable artificial intelligence can increase or decrease clinicians' trust in AI applications in health care: systematic review. JMIR AI. 2024;3:e53207. doi:10.2196/53207.

9. Shickh S, Leventakos K, Lewis MA, Bombard Y, Montori VM. Shared decision making in the care of patients with cancer. Am Soc Clin Oncol Educ Book. 2023;43:e389516. doi:10.1200/EDBK_389516.

10. Czuba KJ, Owens R, Brown PA, Apaapa-Timu TH, Strother RM, Radecki RP. Patients' and clinicians' views on shared decision making in cancer care: a qualitative study of Aotearoa New Zealand patients' and clinicians' perspectives. N Z Med J. 2023;136(1581):10-27. doi:10.26635/6965.6161.

11. Josfeld L, Keinki C, Pammer C, Zomorodbakhsch B, Hübner J. Cancer patients' perspective on shared decision-making and decision aids in oncology. J Cancer Res Clin Oncol. 2021;147(6):1725-1732. doi:10.1007/s00432-021-03579-6.

12. Hurley ME, Lang BH, Kostick-Quenet KM, Smith JN, Blumenthal-Barby J. Patient consent and the right to notice and explanation of AI systems used in health care. Am J Bioeth. 2025;25(3):102-114. doi:10.1080/15265161.2024.2399828.

13. Hantel A, Walsh TP, Marron JM, Kehl KL, Sharp R, Van Allen E, et al. Perspectives of oncologists on the ethical implications of using artificial intelligence for cancer care. JAMA Netw Open. 2024;7(3):e244077. doi:10.1001/jamanetworkopen.2024.4077.

14. Benda N, Desai P, Reza Z, Winogora V, Suresh U, Zhang Y, et al. A qualitative interview study investigating patient, health professional, and developer perspectives on real-world implementation of patient-centered AI systems. NPJ Digit Med. 2026;9:352. doi:10.1038/s41746-026-02587-5.

15. Spurway C, Flanagan S, Cooper J, Crowe FL, Haroon S, Marshall T, et al. Patient perceptions of artificial intelligence-supported shared decision-making in UK primary care for multiple long-term conditions: qualitative study. J Med Internet Res. 2026;28:e92518. doi:10.2196/92518.

16. Arbelaez Ossa L, Rost M, Bont N, Lorenzini G, Shaw D, Elger BS. Exploring patient participation in AI-supported health care: qualitative study. JMIR AI. 2025;4:e50781. doi:10.2196/50781.

17. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-357. doi:10.1093/intqhc/mzm042.

18. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101. doi:10.1191/1478088706qp063oa.

19. Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qual Res Psychol. 2021;18(3):328-352. doi:10.1080/14780887.2020.1769238.