

Whose Voice Counts in Family-Mediated Consent? A Scoping Review of Patient Participation, Decisional Authority, and Cultural Variation across East, South, and Southeast Asian Clinical Settings

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Abstract

Clinical decisions involving family members are often described through broad contrasts between individual autonomy and family-oriented decision making. Such contrasts obscure important differences between family presence, assistance, influence, information control, surrogate action, and final decisional authority. They can also encourage unwarranted generalization across heterogeneous Asian healthcare settings. To map how patient participation and decisional authority are defined, operationalized, and represented in literature concerning family-mediated clinical decisions across East, South, and Southeast Asia, and to identify the clinical, relational, institutional, and cultural conditions associated with variation. A scoping-review approach informed by JBI methodology and PRISMA-ScR reporting principles was used. Evidence was charted according to country or region, clinical setting, actors, decision context, form of patient participation, family role, location of practical or formal decisional authority, methodological design, and contextual conditions. Studies and contextual sources were interpreted separately so that family involvement was not assumed to constitute either patient exclusion or shared decision making. Figure 1 reports identification and selection stages through 63 included studies. The mapped literature showed substantial variation within as well as between countries. Patient participation ranged from receipt of information and expression of preferences to deliberation and final decision control. Family involvement likewise ranged from supportive interpretation, navigation, emotional assistance, and dyadic planning to control over disclosure, communication with clinicians, or treatment decisions. Cancer care, serious illness, advance care planning, and end-of-life decisions were prominent contexts. Evidence from routine, non-cancer, and South Asian settings was comparatively limited. Country labels alone explained little of the observed variation; decision type, patient preference, illness stage, institutional routines, communication practices, and legal or professional arrangements frequently altered the practical distribution of authority. Family-mediated consent in Asian clinical settings cannot be adequately characterized by the presence or absence of family participation. The more informative question is how patient voice, information access, deliberative influence, and final authority are distributed in a particular decision and whether that distribution corresponds to the patient's own preferences. Cultural interpretation is strongest when linked to specific relational and institutional arrangements rather than treated as a national attribute.

Keywords: Family-mediated consent, Patient participation, Decisional authority, Shared decision making, Family involvement, Clinical autonomy

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Introduction

Family participation is common in many clinical decisions, yet its ethical significance depends on what family members actually do and what the patient wants them to do. Interviews with patients, caregivers, and health professionals in northern China illustrate this distinction: endorsement of family care can coexist with

a preference for retaining personal authority over consent [1]. Cancer disclosure creates a related but analytically different problem because family members may influence whether diagnostic information reaches the patient and how that information is framed [2]. In geriatric consultations, family participation may become especially consequential when relatives answer for an older person, redirect interaction, or otherwise reduce the patient's opportunity to speak, even when their involvement is presented as protective or practical [3]. These situations involve different clinical acts, but each demonstrates why the simple observation that "the family was involved" reveals little about whose voice carried decisional weight.

The ambiguity persists when family participation is examined from multiple actor perspectives. Among patients with advanced cancer and their caregivers in Singapore, caregiver involvement could support illness understanding and decision making in some dyads while creating discordance in others [4]. Qualitative evidence from South Korea identifies time pressure, informational asymmetry, deference to clinicians, and patient self-restraint as additional constraints on participation [5]. A national Korean survey similarly indicates that preferred roles in medical decision making are differentiated rather than reducible to a single passive or autonomous model [6]. Family caregivers in chronic illness may translate information, coordinate care, and facilitate communication while also acquiring substantial practical influence over decisions [7]. In deceased organ donation, family consent assumes a distinct institutional role because the relevant authority structure differs fundamentally from ordinary treatment decisions involving a competent patient [8]. Chinese physicians' accounts of informed consent likewise describe family involvement as embedded in clinical practice, although clinician perceptions cannot establish that patients themselves authorize the resulting distribution of decision-making power [9].

Existing syntheses make clear that these distinctions extend beyond individual studies. Reviews of advance care planning describe substantial family involvement across Asian settings, but also marked variation in willingness, timing, communication, and actual participation [10–12]. A recent scoping review of shared decision making in South Korea likewise found heterogeneity in conceptual frameworks, measurement approaches, populations, and implementation contexts [13]. This diversity matters because evidence from

advance care planning, cancer treatment, disclosure, organ donation, chronic illness, and routine consultations addresses different decisions. Combining those settings under a single cultural account risks mistaking a recurring family presence for a stable form of authority. Institutional arrangements further complicate cultural explanations. Policy analysis in China has argued that medical familism interacts with formal rules governing patient autonomy and consent [14]. Work on patient-centred care in Chinese community health similarly emphasizes that organizational hierarchy and professional power can shape how much practical agency a patient can exercise even when patient-centred language is formally endorsed [15]. The relevant unit of analysis is therefore neither "culture" in the abstract nor family participation alone. It is the configuration connecting patient preference, access to information, opportunities to speak and deliberate, family action, professional practice, and the authority attached to the eventual decision.

This scoping review maps that configuration across East, South, and Southeast Asian clinical settings. It asks how the literature defines and operationalizes patient participation and decisional authority; where family members enter the decision process; which clinical, relational, institutional, or cultural conditions are associated with different authority arrangements; and where the evidence remains concentrated or sparse. The review treats countries and regions as contexts in which particular practices occur, rather than as homogeneous cultural categories. Its aim is descriptive and interpretive: to distinguish forms of involvement that are often compressed into the same vocabulary and to identify where apparently similar family participation corresponds to substantially different distributions of patient voice and control.

Materials and Methods

The review was designed as a scoping review because the central objective was to map concepts, evidence types, clinical contexts, and forms of decisional participation rather than estimate a pooled intervention effect. Reporting was organized with reference to PRISMA-ScR [16], while the conduct and evidence-charting logic followed contemporary JBI methodological guidance for scoping reviews [17]. Search documentation was structured according to the transparency principles of PRISMA-S, including explicit recording of concepts,

sources, date limits, and supplementary search routes where these could be verified [18]. Published medical-ethics scoping work provided an additional methodological precedent for combining structured evidence mapping with thematic analysis while keeping selection procedures distinct from substantive interpretation [19].

The review question was operationalized through three linked concepts: patient participation, family mediation, and decisional authority. Patient participation encompassed receipt and understanding of information, expression of preferences, questioning, deliberation, participation in clinician communication, and involvement in the final decision. Family mediation encompassed supportive communication, interpretation, navigation, emotional or practical assistance, preference expression, information filtering, clinician-family negotiation, surrogate action, and control over access to information or decisions. Decisional authority referred to the practical or formal ability to determine what information was disclosed, which options remained available, whose preference governed, or who authorized the final course of action. This separation was important because decision-support research shows that informed participation includes several processes that should not be collapsed into the single observation that a decision occurred [20].

Search concepts combined terms for family or caregiver involvement with informed consent, decision making, shared decision making, disclosure, advance care planning, treatment choice, patient autonomy, and participation, together with geographic terms covering East, South, and Southeast Asia. The mapped literature was limited to the contemporary period relevant to the review. Searches and verification routes included PubMed-indexed literature, publisher records, reference chaining, and targeted retrieval of relevant reviews and

empirical reports. Journal quartile was not used as an eligibility criterion for substantive evidence.

Eligible substantive evidence addressed clinical or healthcare decisions in which patients and family members, caregivers, clinicians, or other relevant actors could influence information exchange, deliberation, consent, treatment choice, advance care planning, disclosure, or related decisional processes. Empirical qualitative, quantitative, mixed-method, longitudinal, and intervention designs were charted. Reviews, consensus studies, policy analyses, and conceptual articles were retained when they clarified terminology, regional context, law, institutional arrangements, or the interpretation of primary evidence; they were distinguished from primary empirical evidence rather than treated as additional independent patient samples.

Reports arising from the same underlying participant group were linked at the evidence-unit level. This precaution was necessary because separate publications can examine different ethical or sociological questions using the same interviews or cohort. Such reports could both inform synthesis, but they were not treated as independent replications. The same rule was applied conceptually to overlapping reviews and secondary analyses wherever linkage could be established.

Data charting captured study design; country or region; clinical setting; population and actors; decision context; focal construct; definition or operationalization; data source; analytical method; patient-participation form; family role; mechanism or process; mediator, moderator, or contextual condition; practical or formal locus of authority; contradictory or null findings; authors' stated limitations; and applicability boundaries. The central methodological requirement was therefore to chart where family involvement occurred in a decision and what form of authority accompanied it, rather than recording family presence as a sufficient descriptor (**Table 1**).

Table 1. Operational charting frame for distinguishing patient participation from family-mediated decisional authority

Charted dimension	Coding question	Evidence treated as affirmative	Evidence not inferred
Information access	Did the patient directly receive clinically relevant information?	Direct disclosure, explanation, documented access	Knowledge merely assumed because relatives were informed
Patient voice	Could the patient express questions, goals, values, or preferences?	Reported speech, preference elicitation, consultation participation	Presence in the room
Deliberative participation	Did the patient take part in weighing options or reasons?	Discussion of alternatives, trade-offs, preferences	Formal signature alone

Family support	Did relatives enable patient participation?	Interpretation, navigation, emotional support, recall, logistical assistance	Any family attendance
Family influence	Did family preferences materially shape discussion or options?	Reported persuasion, negotiation, option framing	Familial relationship by itself
Information control	Did another actor determine what the patient was told?	Withholding, filtering, staged disclosure, gatekeeping	Ordinary clinician summarization
Practical decisional control	Who effectively determined the chosen course?	Reported dominance, substitution, unilateral choice, decisive veto	Advice that the patient freely accepted
Formal authority	Who was legally or institutionally authorized to decide?	Recognized patient consent, surrogate authority, mandated family consent	Practical influence without formal status
Patient authorization of family role	Did the patient want or delegate the family's involvement?	Expressed preference for family participation or delegation	Cultural assumption about what the patient would prefer
Contextual conditions	What altered the distribution of voice or authority?	Illness stage, setting, law, workflow, communication, family relationship	National culture used as an unexplained residual category

The synthesis proceeded in two layers. First, descriptive mapping identified the clinical and regional distribution of evidence and separated information, participation, influence, and final authority. Second, interpretive synthesis examined recurring configurations and divergences across settings. Apparent contradictions were retained where studies differed by decision type, actor perspective, illness stage, institutional arrangement, or patient preference. Quantitative pooling was not undertaken because the review question and mapped constructs were too heterogeneous to support a common effect estimate.

The selection flow depicted in **Figure 1** reports 1,482 records from databases and 58 from other sources. It also reports 287 duplicates removed, 1,253 records screened, 1,018 screening exclusions, 235 full texts assessed, 172 full-text exclusions, and 63 included studies. These displayed stage totals reconcile arithmetically.

Evidence configuration and selection transparency

The mapped literature was methodologically heterogeneous and included cross-sectional surveys, qualitative interview studies, consultation-focused analyses, dyadic and longitudinal designs, randomized intervention evidence, reviews, consensus work, and policy or legal analyses. Cancer treatment, serious illness, advance care planning, disclosure, and end-of-life decisions were especially prominent. The evidence base therefore offered considerable depth on high-stakes and preference-sensitive decisions, while providing a less even picture of routine care, non-cancer conditions, younger populations, and some South and Southeast Asian clinical settings.

The identification, screening, eligibility, and inclusion counts reported in the selection diagram are shown in **Figure 1**.

Results and Discussion

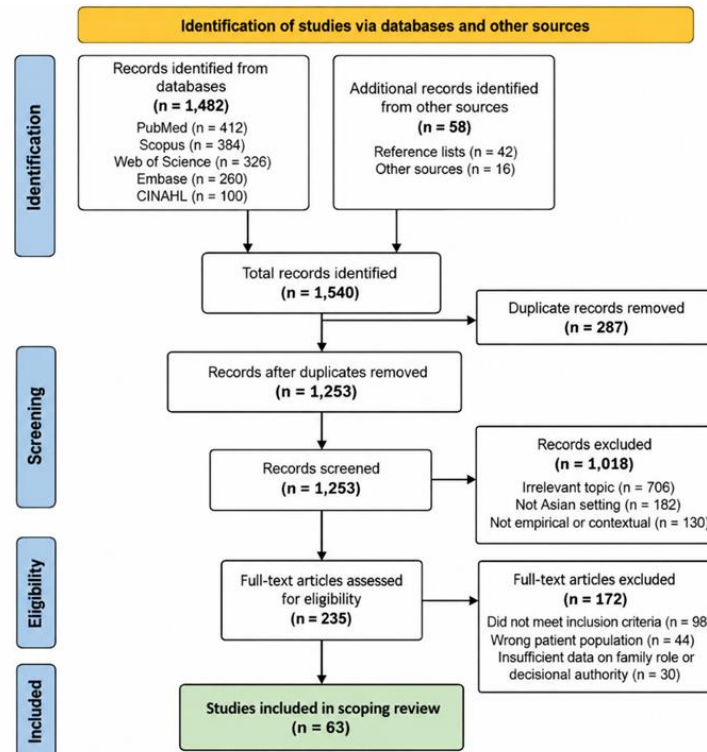


Figure 1. PRISMA-ScR flow diagram

Participation varies across stages of decision making

The strongest recurring finding was that participation could not be represented as a single binary variable. A multicenter Chinese cancer study separated preferences concerning information, deliberation, decisional control, and family involvement, showing that these components could vary within the same patient and across stages of decision making [21–23]. Evidence from outpatient settings further demonstrated that reported shared decision making and satisfaction depend on how participation is experienced within the consultation, while breast-cancer literature identified both individual and system-level conditions shaping whether involvement becomes practically possible.

Family participation became particularly consequential when relatives influenced transitions into hospice or other high-stakes care. Qualitative work on inpatient hospice decision making showed that caregivers can acquire substantial practical control over whether and when such transitions occur [24]. Dyadic advance-care-planning research, by contrast, illustrates a more deliberately structured form of family involvement in which patients and relatives are engaged together [25]. These forms should not be placed on the same ethical axis without considering patient authorization, because

structured dyadic participation and caregiver control over a decision are different relational arrangements. Longitudinal evidence from advanced cancer further suggests that decision roles and planning experiences may have consequences for caregivers themselves, although observational associations do not establish a single causal pathway [26].

Context also changed the meaning of participation. Japanese mixed-method evidence indicates that religious motivations may influence whether advance-care-planning discussions are initiated or pursued [27]. Across the wider Asia-Pacific literature, favorable attitudes toward planning do not necessarily translate into knowledge, completed discussions, or formalized decisions [28]. Legal analysis from China and South Korea identifies another source of variation: a previously expressed patient directive may conflict with subsequent family preferences or consent practices [29]. These findings shift attention from whether families participate to how relational expectations interact with institutional rules.

Caregiver roles also evolve over time. In advanced cancer, caregivers reported different degrees of involvement in treatment decisions, with those roles relating to burden and psychological experience [30].

Hospital research across Bangladesh, Indonesia, and South Korea demonstrates that family involvement is additionally structured by institutional expectations concerning care provision [31]. Such findings are particularly important for this review because helping with bedside care, navigating services, or communicating with staff may increase practical influence without conferring formal decisional authority. Indonesian advance-care-planning research likewise depicts planning as a relational process in which patient and family expectations are negotiated within local clinical practice [32].

Disclosure, understanding, and practical authority

Truth telling provides one of the clearest examples of why information access must be separated from final consent. Chinese cancer research has documented differences between patients, relatives, and professionals concerning disclosure practices and preferences [33]. In serious illness in Hong Kong, advance-care-planning participation was constrained by interacting patient, family, emotional, and service-level barriers [34]. South Korean evidence further links illness understanding with advance-care-planning engagement and end-of-life preferences, although the observed association cannot establish that information alone produces greater decisional control [35]. Together, these studies indicate that a patient may be nominally included in care while having unequal access to the knowledge needed for meaningful participation.

Qualitative evidence from Taiwan similarly depicts palliative-care decisions as negotiated among patients,

families, and professionals, with the balance of influence shifting according to illness progression and the clinical situation [36]. In South Korea, national stakeholder surveys conducted before implementation of later life-sustaining-treatment legislation found substantial differences among patients, family caregivers, physicians, and the general public in attitudes toward advance care planning [37]. These historical data remain useful for understanding the policy context, but they cannot be assumed to describe contemporary practice unchanged. Chinese nursing research on truth telling likewise demonstrates actor-level disagreement over disclosure and decision processes [38].

Intervention evidence offers a different perspective. A nurse-led post-discharge advance-care-planning programme in Hong Kong treated patients and family members as an explicit dyad and evaluated structured planning rather than ordinary family involvement [39]. This distinction matters because evidence that facilitated dyadic communication can support planning does not show that unstructured family influence is inherently beneficial. Across the mapped literature, family involvement therefore ranged from patient-authorized assistance through collaborative deliberation to information filtering and practical substitution.

The comparative pattern is summarized in **Table 2**. The rows represent decision contexts rather than countries alone because the same national setting may contain markedly different authority arrangements depending on whether the decision concerns disclosure, cancer treatment, advance care planning, routine chronic-illness management, hospice transfer, or another clinical act.

Table 2. Context-specific configurations of patient participation and family decisional influence in the mapped literature

Decision context	Typical form of patient participation mapped	Family role observed in the literature	Where practical authority may shift	Contextual modifiers requiring separate interpretation
Cancer diagnosis disclosure	Receiving information; expressing disclosure preference	Mediating or filtering information; communicating with clinicians	Control over timing or completeness of disclosure	Prognosis, family preference, patient request, clinician practice
Cancer treatment choice	Information seeking; deliberation; treatment preference	Supporting deliberation, advocating options, participating in clinician discussion	Option framing or final choice in some cases	Disease stage, decisional burden, patient-family concordance
Geriatric outpatient care	Speaking during consultation; answering questions; expressing goals	Speaking for patient, coordinating care, translating practical concerns	Consultation voice may move toward relatives	Functional status, communication pattern, time pressure
Chronic-illness management	Ongoing preference expression and self-management decisions	Navigation, coordination, communication, practical support	Influence can accumulate through dependence on caregiver support	Disease duration, household structure, health-system complexity

Advance care planning	Values clarification; future-care discussion; documentation	Dyadic discussion, emotional support, surrogate preparation	Family interpretation may shape future implementation	Readiness, illness understanding, policy, professional facilitation
Hospice/palliative transition	Expressing care goals and place-of-care preference	Organizing care, negotiating transfer, bearing logistical burden	Caregiver may become operational decision maker	Prognosis, caregiving capacity, service availability
Life-sustaining-treatment decisions	Current or prior preference; advance directive	Family consultation, surrogate action, consent or objection	Conflict may arise between prior patient choice and family position	Legal rules, documentation, capacity, institutional policy
Organ donation after death	Prior expressed wishes where available	Formal or practical family authorization	Family may hold institutionally decisive consent power	Donation law, trust, bereavement, institutional procedure

Evidence concentration and unresolved coverage

The evidence base was not regionally or methodologically balanced. Mainland China, South Korea, Hong Kong, Singapore, Taiwan, and selected Indonesian settings were comparatively visible in the mapped sources, whereas many South Asian and Southeast Asian health systems appeared less frequently in literature directly examining patient voice and final authority. Even where several studies came from one jurisdiction, clinical concentration created another limitation: cancer, serious illness, advance care planning, and end-of-life care generated much of the detailed relational evidence.

Methodological concentration was also apparent. Qualitative studies offered rich accounts of communication and practical control, while cross-sectional surveys measured preferences, attitudes, perceived participation, or concordance. Far fewer studies directly observed how authority moved during clinical encounters over time. Longitudinal caregiver

evidence and structured advance-care-planning interventions broadened the picture, but they addressed specific populations and should not be generalized to ordinary treatment consent.

A second gap concerned construct precision. Studies frequently measured family involvement, patient satisfaction, shared decision making, disclosure preference, or caregiver role without simultaneously establishing who had final authority, whether the patient had authorized the family's role, and whether the patient possessed the information needed to exercise choice. This makes apparently similar findings difficult to compare. A high level of family participation can indicate supportive collaboration in one study and practical substitution in another.

Table 3 therefore identifies where the mapped evidence is comparatively developed and where interpretation remains restricted. The entries describe concentrations and gaps qualitatively; no unsupported study counts or regional proportions are introduced.

Table 3. Evidence concentrations and interpretive gaps in research on family-mediated clinical decisions

Evidence dimension	Comparatively developed area	Underrepresented or unresolved area	Consequence for interpretation
Clinical context	Cancer, serious illness, end-of-life care, advance care planning	Routine ambulatory care, preventive decisions, many non-cancer chronic conditions	High-stakes findings should not automatically be transferred to ordinary consent
Geographic coverage	China, South Korea, Hong Kong, Singapore, Taiwan; selected Indonesian evidence	Many South Asian and Southeast Asian jurisdictions	"Asian" regional claims require strong qualification
Actor perspective	Patients, caregivers, clinicians are all represented in parts of the literature	Simultaneous multi-actor observation within the same decision remains limited	Discordance may be missed when only one actor reports the encounter
Patient participation	Information preference, deliberation, SDM experience, ACP discussion	Direct measurement of patient influence on the eventual decision	Participation measures may overstate actual authority
Family involvement	Caregiving, communication, support, preference expression, surrogate activity	Clear distinction between invited delegation and unwanted substitution	Ethical meaning cannot be inferred from involvement alone

Information control	Cancer disclosure and truth-telling research	Information gatekeeping outside oncology and serious illness	Disclosure evidence may be disproportionately shaped by cancer settings
Formal authority	Advance directives, life-sustaining treatment, organ donation	Relationship between formal rules and ordinary bedside practice	Legal authority and practical control may diverge
Temporal evidence	Some longitudinal caregiver and ACP studies	Repeated observation of changing patient-family authority over illness trajectories	Static surveys may miss progressive shifts in dependence or control
Intervention evidence	Structured dyadic advance care planning	Interventions designed specifically to protect patient voice during family participation	Supportive family involvement and authority protection remain incompletely tested together
Conceptual measurement	SDM, ACP, autonomy, disclosure, caregiver-role instruments	Cross-study measures that separate voice, influence, delegation, and final control	Construct heterogeneity limits direct comparison

Across these patterns, the central empirical result is heterogeneity in the location and meaning of participation. Family involvement is widespread in several mapped contexts, but its form varies sufficiently that presence alone cannot identify whether a patient's agency is being supported, shared by preference, informally constrained, or practically displaced. The next section therefore examines the relationship among patient participation, decisional authority, and cultural variation directly, while preserving the clinical and institutional distinctions established in the descriptive results.

Patient participation, decisional authority, and cultural variation

The mapped evidence indicates that patient participation and decisional authority should be treated as related but separate dimensions. A patient may receive information, express preferences, and participate actively in discussion while still lacking control over the final choice. Conversely, a patient may deliberately authorize substantial family involvement without relinquishing ultimate authority. Family-mediated consent therefore cannot be classified ethically from the amount of family participation alone.

A useful distinction emerging from the synthesis is between supportive participation, shared deliberative influence, delegated authority, and substitutive control. Supportive participation occurs when relatives help patients understand information, communicate preferences, navigate services, or manage practical burdens while leaving the patient's preferred role intact. Shared deliberative influence occurs when patient and family preferences jointly shape the decision through a

process accepted by the patient. Delegated authority involves a patient intentionally assigning substantial decision responsibility to relatives. Substitutive control is different: information, options, or decisions are controlled by others without adequate evidence that the patient requested such displacement.

These configurations cannot be mapped directly onto countries. Evidence from China includes both patients who value family involvement and circumstances in which family control over information or decisions can produce clinically and ethically important harms [40]. Korean evidence similarly includes preferences for involvement, clinician-centred communication, family caregiving, and legally structured end-of-life decisions rather than one uniform decision model. Singaporean studies show variation even within patient-caregiver dyads, while Indonesian and Taiwanese research emphasizes relational negotiation within specific clinical and institutional environments. Cultural interpretation is therefore more defensible when it identifies the norms, expectations, family relationships, professional practices, and institutional arrangements through which influence is exercised.

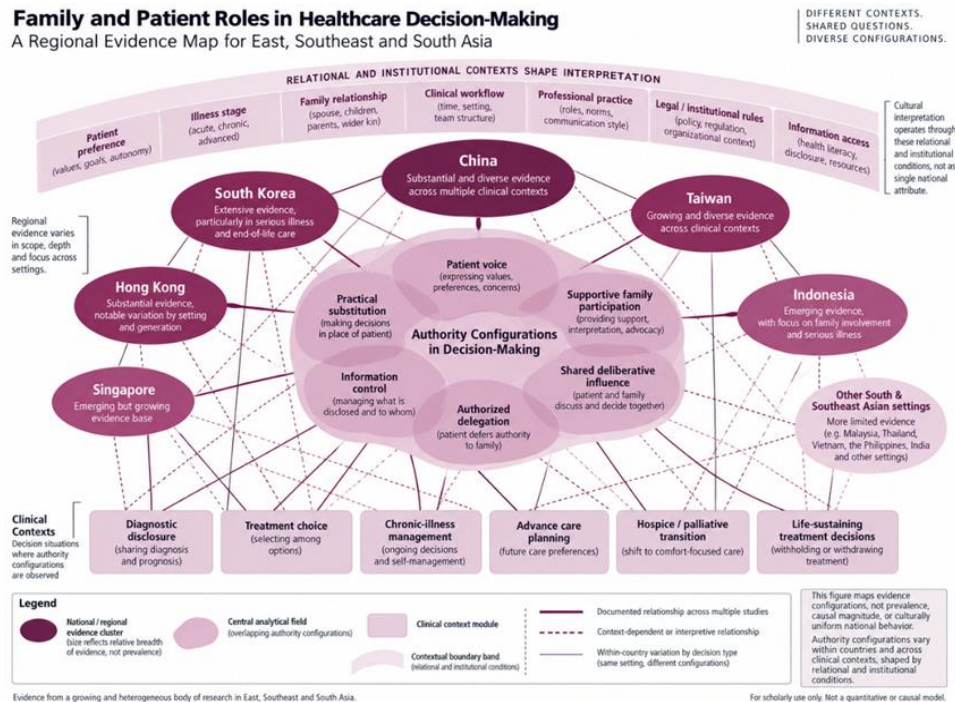
The synthesis further suggests that information authority and decision authority may be located differently. A family may control diagnostic disclosure while the patient formally signs consent; a patient may express treatment preferences while relatives exercise practical veto power; or a patient may invite family members to make decisions while remaining the origin of that delegation. Formal documentation alone therefore cannot reveal the relational distribution of authority.

The resulting configurations are summarized in **Table 4**.

Table 4. Relational configurations of family-mediated consent distinguished by patient voice and location of authority

Configuration	Patient voice	Family function	Location of practical authority	Ethical interpretation
Supportive participation	Preserved and actively elicited	Communication, navigation, emotional or practical support	Patient remains principal decision maker	Family involvement supports patient agency
Collaborative deliberation	Preserved within joint discussion	Reciprocal preference exchange and reasoning	Shared influence with patient authorization	Relational decision making consistent with patient preference
Authorized delegation	Patient chooses reduced direct decisional role	Family assumes substantial responsibility	Family exercises delegated authority	Compatible with autonomy when delegation is informed and voluntary
Information-mediated dependence	Patient participation constrained by incomplete or filtered information	Family controls access, timing, or framing of information	Authority becomes partly indirect	Ethical status depends on patient preference and consequences for meaningful choice
Practical substitution	Patient voice is present but has limited effect	Family dominates options or implementation	Family holds effective control	Participation may be nominal rather than authoritative
Unrequested displacement	Patient voice is marginalized or bypassed	Family determines information or decision without demonstrated authorization	Patient authority is displaced	Strongest concern for loss of patient-directed decision making

The regional evidence is therefore better represented as overlapping authority configurations than as country-specific cultural types. **Figure 2** maps these relationships while keeping clinical context and institutional conditions visible.

**Figure 2.** Regional evidence map

Results and Discussion

This review shows that the ethically important distinction in family-mediated consent is not between “individual”

and “family” decision making. The more informative distinction concerns how participation is organized and where authority ultimately lies. Family involvement can

strengthen patient participation when it improves comprehension, communication, emotional support, or navigation. It can also become restrictive when family members control information or effectively determine a course of treatment without clear patient authorization. The evidence also cautions against using national culture as a sufficient explanation. Studies conducted within the same country report different participation patterns across cancer care, geriatric consultation, advance care planning, disclosure, chronic illness, and end-of-life decisions. Institutional workflow, professional hierarchy, legal requirements, prognosis, family dependence, and patient preference can therefore be as important as broader cultural norms in explaining whose voice becomes influential.

For clinical practice, this implies that clinicians should establish not merely whether a family is involved but what role the patient wants the family to perform. Patient-centred practice may accommodate strong family participation, including intentional delegation, while still requiring direct attention to the patient's informational preferences and preferred locus of authority. Where patient and family wishes differ, documenting the patient's preferred decision role may help distinguish relational participation from unintended substitution.

For research, future studies should measure information access, opportunity to speak, deliberative influence, authorized delegation, and final control separately. Greater observational and longitudinal evidence is particularly needed outside cancer and end-of-life care and across underrepresented South and Southeast Asian healthcare systems.

Strengths and limitations

A major strength of the review is its separation of family presence from family authority and its preservation of within-region, within-country, and within-setting variation. The scoping design also allowed qualitative, quantitative, dyadic, policy, legal, and review evidence to be considered without imposing an inappropriate common effect measure.

The evidence base was concentrated in cancer, serious illness, advance care planning, and relatively well-represented East Asian settings. Heterogeneous constructs and measures limited direct comparison, and some sources described preferences or perceptions rather than observed decisional behavior.

Conclusion

Whose voice counts in family-mediated consent depends on more than whether relatives participate. The decisive questions are whether the patient receives the information needed to participate, whether the patient's preferences are heard, what role the patient wants the family to perform, and who ultimately controls the decision. Across the mapped Asian clinical literature, family involvement ranges from supportive collaboration and chosen delegation to information control and practical substitution. Cultural interpretation is therefore most defensible when it remains tied to specific relationships, clinical decisions, institutional arrangements, and patient preferences rather than treating countries or regions as homogeneous models of authority.

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