

When Family Participation Becomes Moral Substitution: A Relational Autonomy Framework for Protecting Patient Authority in Family-Involved Clinical Decisions in East Asian Healthcare Settings

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Abstract

Family involvement is integral to many clinical decisions in East Asian healthcare settings, yet its ethical status cannot be determined by the mere presence or intensity of family participation. Relational autonomy explains why patients may exercise agency through trusted relationships, shared deliberation, interpretive assistance, emotional support, and even voluntarily delegated roles. The same relational structures, however, can displace patient authority when access to information, opportunities to speak, or practical decisional control become governed by others without the patient's authorization. This normative framework examines the transition from relational participation to what is termed **moral substitution**: the exercise of practical control over a decision in place of a patient who retains relevant decisional authority and has not authorized that transfer. Drawing on contemporary relational-autonomy scholarship and empirical evidence concerning informed consent, disclosure, shared decision-making, and family-mediated clinical practice, the analysis distinguishes influence from control, chosen deference from imposed displacement, and support from surrogate decision-making. It argues that patient authority in relational settings depends on continuing access to relevant information, an effective opportunity to express preferences, authority to define the family's role, and the ability to revise or withdraw that authorization. Clinical responsibility therefore concerns not only coercion by relatives but also institutional routines that convert family involvement into de facto decisional authority. The resulting account protects family-inclusive care without treating either individual independence or family leadership as ethically presumptive.

Keywords: Relational autonomy, Family involvement, Patient authority, Informed consent, Shared decision-making, East Asian healthcare

Introduction

Autonomy in clinical ethics is sometimes described through the image of an independently reasoning patient who receives information, weighs options, and makes a choice that others then respect. That image captures an

important protection against coercion, but it does not adequately describe many decisions in which patients deliberately rely on relatives for interpretation, emotional stabilization, memory, practical knowledge, or deliberation. Contemporary relational-autonomy accounts instead emphasize that competence, authenticity, and interpersonal involvement may interact in determining whether agency is genuinely exercised [1]. Family participation therefore cannot be treated as ethically suspicious merely because another person influences how a decision is understood or reached. The difficulty arises when relational assistance and practical decision authority no longer coincide. Recent qualitative evidence from China illustrates this problem

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directly. Patients, family caregivers, and health professionals described family-oriented informed consent as familiar and sometimes protective, yet capable patients also expressed a strong interest in retaining authority over their own bodies and medical choices [2]. The ethical question is consequently narrower than whether family involvement is compatible with autonomy. It is whether, and under what conditions, involvement changes from a means through which a patient exercises agency into a practice through which someone else exercises authority in the patient's place.

Cultural explanation alone cannot answer that question. Appeals to an East Asian preference for collectivism can obscure substantial variation in how patients understand family roles and may incorrectly transform an empirical generalization into a normative permission. Critiques of the individualism–collectivism model have shown that culturally responsive practice need not require abandoning patient autonomy as a moral concern [3]. Interactional evidence further complicates any simple cultural account. In observed Chinese geriatric consultations, companions sometimes collaborated with patients, but they also sometimes assumed forms of surrogation that marginalized the older patient's participation in the encounter [4]. What matters ethically is therefore not whether a family is active, but what the patient is able and authorized to do within that activity.

The same tension appears in information disclosure and advance planning. Young Chinese physicians report substantial family involvement in informed-consent practices and frequent cooperation with requests to withhold information from patients [5]. A meta-analysis of cancer disclosure studies similarly identified a persistent divergence between what many patients wished to know and what relatives preferred them to be told [6]. Yet Asian advance-care-planning experts have also reached consensus around forms of planning that explicitly include family members or close persons while remaining centred on the patient's values, goals, and preferences [7]. These findings resist both a family-exclusion model and a family-sovereignty model. The unresolved task is to distinguish relational arrangements that sustain patient authorship from those that replace it. This article develops that distinction through relational autonomy and a normative account of responsibility for the conditions under which agency is exercised. Its central claim is conditional. Family participation becomes moral substitution when practical control over clinically relevant information, deliberation, or choice is

exercised in place of a patient who retains the relevant authority, without that patient's contemporaneous authorization or another ethically justified transfer of decisional authority. The analysis therefore does not classify chosen joint decision-making, supported decision-making, authorized deference, or legitimate surrogate decision-making as substitution merely because another person plays a substantial role. Instead, it asks where patient authority remains located, how that authority is exercised relationally, and who becomes responsible when clinical practices allow it to migrate elsewhere.

Family participation and relational autonomy

Relational autonomy begins from the premise that agency is exercised by socially situated persons. This does not imply that relationships are inherently autonomy-enhancing. A meta-synthesis of medical decision-making studies identified supportive relationships and access to information as conditions that can facilitate relational autonomy, while undue pressure and dominant professional voices can impair it [8]. The ethics literature likewise shows that “relational autonomy” is not a single settled doctrine: different accounts emphasize social constitution of the self, interpersonal support, power, recognition, authenticity, or the circumstances under which preferences are formed and exercised.[9] Any clinically useful application must therefore specify which relational feature matters and why.

A contextual account is especially important in family-involved care. End-of-life ethics scholarship has argued that individualistic accounts may fail to capture decisions whose meaning is inseparable from illness relationships, dependency, care histories, and shared responsibilities [10]. Yet relationality should not itself become an identity assigned to patients on cultural grounds. Asian American participants considering organ-donation decisions, for example, shifted between more individualistic and more relational forms of reasoning according to the decision context.[11] Although that population is not equivalent to patients receiving care in East Asia, the finding illustrates a broader point: relational orientation is not necessarily a fixed personal or ethnic trait.

Family influence can also coexist with clear patient authority. In interviews concerning ovarian-cancer clinical-trial decisions, patients frequently used family members as informational, emotional, and deliberative

resources while continuing to describe themselves as holding final decisional authority [12]. Chinese cancer patients likewise vary in the degree of family participation they want during information exchange, deliberation, and final choice; discordance between expected and experienced family roles can matter to the decision process [13]. These observations make influence a poor proxy for loss of autonomy. Advice may be forceful, relationships emotionally consequential, and deliberation genuinely shared without converting the relative into the holder of the decision right.

The opposite configuration is also possible. Observational and interview evidence from colorectal-cancer surgery in China has described family-centred decision processes in which relatives controlled information and assumed major practical responsibility for treatment choices [14]. Research among patients with advanced cancer similarly indicates that desired and actual modes of participation do not always align and that decision involvement can change during care.[15] These findings suggest that family participation should be understood as a variable relational arrangement rather than a single category. The ethically important question is whether the arrangement continues to express the patient's own preferred way of deciding.

Time adds another dimension. Family caregivers describing decisions about inpatient hospice care portray decision-making as a changing process shaped by hope, suffering, perceived patient wishes, practical constraints,

and the evolving meaning of illness [16]. Cross-national evidence also warns against treating East Asian practice as culturally uniform: communication with patients nearing death differed markedly across palliative-care settings in Japan, Korea, and Taiwan, even though families were commonly informed [17]. A patient's desired family role must therefore be capable of revision as illness, decisional burden, family dynamics, and understanding change. Relational autonomy is not protected by establishing a preferred role once and assuming that it remains ethically valid thereafter.

The practical distinction is consequently between relationships that extend the patient's capacity to understand and act and relationships that begin to reallocate the authority to determine what the patient may know, say, or choose. That distinction remains porous because a single family arrangement can change character over time. A trusted relative may initially translate information, later speak on behalf of an exhausted patient at the patient's request, and later still continue controlling communication after the patient wishes to re-enter the decision. Patient authority is preserved only if the relational arrangement remains connected to the patient's authorization and remains open to revision.

The transition is summarized in **Table 1** by treating the family role as a configuration of authorization, information access, voice, and practical control rather than simply as "high" or "low" involvement.

Table 1. Family-involvement configurations distinguished by patient authorization and practical control

Family-involvement configuration	Patient's relation to the family role	Access to clinically relevant information	Patient voice in deliberation	Practical locus of choice	Capacity for revision	Relational-autonomy interpretation
Invited interpretive support	Patient actively requests assistance in understanding or contextualizing information	Patient retains direct access; family may clarify or translate	Patient remains an active speaker	Patient	Patient may expand, narrow, or end support	Relationally supportive
Shared deliberative partnership	Patient wants family members to reason through options jointly	Information available to patient and chosen family participants	Patient participates directly within joint discussion	Patient or explicitly shared process	Family role remains revisable	Compatible with relational agency when authorization persists
Authorized family-led communication	Patient prefers information to be mediated or initially received through a trusted relative	Access is structured according to the patient's stated preference	Patient determines desired degree of direct participation	Patient retains authority over the arrangement	Patient can request direct disclosure or change the intermediary	Potentially autonomy-supporting despite asymmetric communication
Chosen decisional deference	Patient knowingly prefers a relative to take a leading role in	Sufficient information is available for the patient to	Patient may participate minimally by choice	Family leads under patient authorization	Ethical status depends on the patient remaining	Relationally permissible but requires attention to

	choosing among options	authorize deference			able to reconsider where feasible	authenticity and revisability
Unrequested information filtering	Family controls what the patient is told without clear patient authorization	Patient access is restricted by another actor	Voice is constrained by incomplete information	Control begins to move away from patient	Revision is difficult because the patient may not know what has been withheld	High risk of displacement of patient authority
Presumptive family spokesperson control	Family is treated as the default decision-maker despite retained patient authority	Information may be routed primarily through family	Patient voice becomes secondary, indirect, or absent	Family exercises practical control	Patient must actively overcome an established family role to regain authority	Strong indication that participation is approaching or has become moral substitution

From participation to moral substitution

One pathway from participation to substitution is control over information. Families of older Chinese cancer patients have described concealment and disclosure as dynamic strategies that change across the illness trajectory, often in response to hope, anticipated distress, or treatment possibilities [18]. These motives may be protective, but motive alone cannot determine whether information control is ethically justified. Patients, relatives, and healthcare professionals also differ in what they believe patients want to know, and relatives or clinicians may underestimate a patient's preference for truthful disclosure [19]. A person who does not receive information cannot meaningfully authorize the way that information is being managed unless the preference for mediated or limited disclosure has itself been elicited.

Clinical routines can magnify this problem. Chinese physicians interviewed about cancer disclosure have described telling relatives first and making subsequent disclosure to patients contingent on family wishes [20]. Once that practice becomes routine, family participation is no longer merely a relationship surrounding the patient; it can become an institutional route through which another person gains control over the conditions of patient choice. The fact that a relative cares deeply about the patient does not by itself create an unlimited right to exercise such control. Analysis of family refusal of emergency treatment in China similarly demonstrates that family status does not settle the ethical or legal authority question, particularly where delay or refusal threatens a patient who cannot currently decide [21]. That incapacity context is different from the capable-patient problem examined here, but the distinction is instructive: familial relationship and legitimate decisional authority are not synonymous.

The ethical concern is not reducible to measurable downstream harm. Japanese bereavement research has

examined associations between diagnosis nondisclosure and quality of dying or care, underscoring that information practices may affect a patient's experience near the end of life [22]. Yet displacement of authority can remain ethically significant even when no adverse outcome is proven. Chinese oncology nurses have described family-mediated decisions, information asymmetries, and power imbalances as barriers that may suppress patient participation in advance-care planning [23]. The normative problem is therefore partly procedural: who is allowed to know, speak, revise, and ultimately authorize the course of care?

Recorded preferences do not automatically solve this problem. Stakeholders involved in living-will implementation in China have described tensions around who participates, where decisions occur, and how professional or family roles can dominate the process [24]. A formally patient-centred instrument can lose practical force if later implementation is controlled by others. Conversely, joint decision-making should not be condemned simply because authority is shared in an unconventional way. Ethical analysis of couples' healthcare decisions shows that people can autonomously choose to make decisions jointly or to allocate substantial decision-making responsibility to a trusted other [25]. The challenge is therefore to identify unauthorized substitution without invalidating chosen relational forms of agency.

This distinction requires attention to practical authority rather than family involvement alone. Practical authority concerns who, in the actual decision process, can obtain and control information, introduce or exclude options, speak with clinical authority, determine whether the patient participates, and settle what happens when preferences conflict. Family influence becomes morally problematic when these functions are exercised in place of a patient who still retains the relevant authority and has

neither authorized the transfer nor lost authority through a legitimate capacity-based or legal process.

Three features distinguish this account from a simple coercion test. First, substitution can occur without threats. A patient may be respectfully excluded through established routines in which clinicians speak almost entirely to relatives. Second, beneficent intent does not settle the issue. A family may sincerely seek to protect a patient while nevertheless exercising control the patient has not authorized. Third, substitution can be partial. A patient may retain formal consent authority yet lack direct access to diagnosis, may be allowed to speak but not to revise a family-negotiated plan, or may receive information only after relatives determine what can safely be disclosed. Moral status therefore depends on the distribution of authority across the decision process, not solely on who eventually signs a form.

A relational autonomy framework for protecting patient authority

Protecting patient authority does not require stripping decision-making of relational support. Informed consent is epistemically demanding: patients rely on clinicians, interpreters, relatives, and other trusted persons to understand information and relate it to their values. The concept of epistemic scaffolding captures how assistance from others can strengthen rather than diminish autonomous decision-making when it improves a patient's ability to comprehend, deliberate, and act [26]. The relevant question is thus whether relational involvement expands the patient's effective agency or acquires independent control over it.

Supported decision-making provides a related distinction. Work on people at the margins of autonomy argues that targeted support can preserve a person's decision-making agency rather than prematurely replacing it with guardianship or surrogate authority [27]. A1 applies this conceptual separation cautiously because its central case is different: the patient may possess ordinary decisional capacity while family members nevertheless acquire practical control. Support should therefore be understood as assistance that leaves the person's authority intact. Once another actor begins to determine the content or outcome of the decision independently of the patient's authorization, the arrangement requires a different ethical justification.

Authorization itself cannot be treated mechanically. A patient may state that "my family decides" for many reasons: trust, affection, fatigue, culturally meaningful

role expectations, fear of conflict, economic dependency, or longstanding deference. Scholarship on adaptive preferences shows why social conditions can shape preferences in ways that complicate a purely face-value account of autonomous choice [28]. This does not authorize clinicians to invalidate relational or family-centred preferences because they appear culturally unfamiliar. It does require attention to whether the patient has a meaningful opportunity to endorse, modify, or reject the arrangement without retaliation or loss of care. Recent Chinese normative scholarship has likewise sought a middle position between atomistic autonomy and unbounded family authority through a Confucian account of benevolence in shared decision-making [29]. The present framework addresses a different analytical problem. Its focus is not whether family involvement can be reconciled with culturally grounded beneficence, but how to identify a change in the holder of practical decision authority and allocate responsibility when that change occurs. The central issue is therefore not the amount of family participation but the relationship among patient authorization, access to information, voice, revisability, and practical control.

Four linked requirements follow.

First, patient authority requires informational standing. A patient need not demand every detail or insist on receiving information before relatives do. A patient may authorize selective, staged, or family-mediated communication. The relevant protection is the authority to determine that communicative arrangement. When relatives or clinicians decide unilaterally that the patient should not know, informational management ceases to be an expression of the patient's relational preferences.

Second, patient authority requires effective voice. Voice is more than physical presence during consultation. A patient must have a meaningful opportunity to express concerns, alter the direction of deliberation, ask questions, and disagree with a relative without the clinical process automatically treating the relative's position as controlling. The need for voice is compatible with quiet, deferential, or family-led styles of communication; what matters is whether silence is chosen or structurally imposed.

Third, authorization must remain revisable. A patient who initially asks a daughter, spouse, or other relative to lead may later want direct information or a different treatment. Relational autonomy therefore cannot be secured by a single early statement if the clinical environment makes later revision practically impossible.

Authority remains with the patient only when the relational role can, where feasible, be renegotiated. Fourth, responsibility follows practical control. Family members are not the only actors capable of producing substitution. Clinicians may create it by automatically routing information through relatives, refusing to speak privately with a capable patient, or treating family agreement as a prerequisite for disclosure or treatment. Institutions may reinforce it through consent routines, visiting structures, documentation practices, or conflict procedures that assume family primacy. Responsibility is therefore distributed according to who shapes the conditions under which patient authority can actually be exercised.

These requirements yield a conditional moral test. Family involvement remains autonomy-supportive when it operates through a role the patient has authorized and

continues to enlarge or faithfully enact the patient's agency. It becomes moral substitution when practical control over information, deliberation, or choice moves to another actor while the patient retains the relevant authority, and that transfer is neither authorized by the patient nor justified by a legitimate change in decisional status. This test is deliberately distinct from judging whether family influence is culturally common, emotionally intense, clinically convenient, or benevolently intended.

The relationship among these conditions is represented in **Figure 1**. Its central distinction is not between "individual" and "family" decision-making, but between relational arrangements that remain anchored in patient authority and arrangements in which practical control migrates beyond that authority.

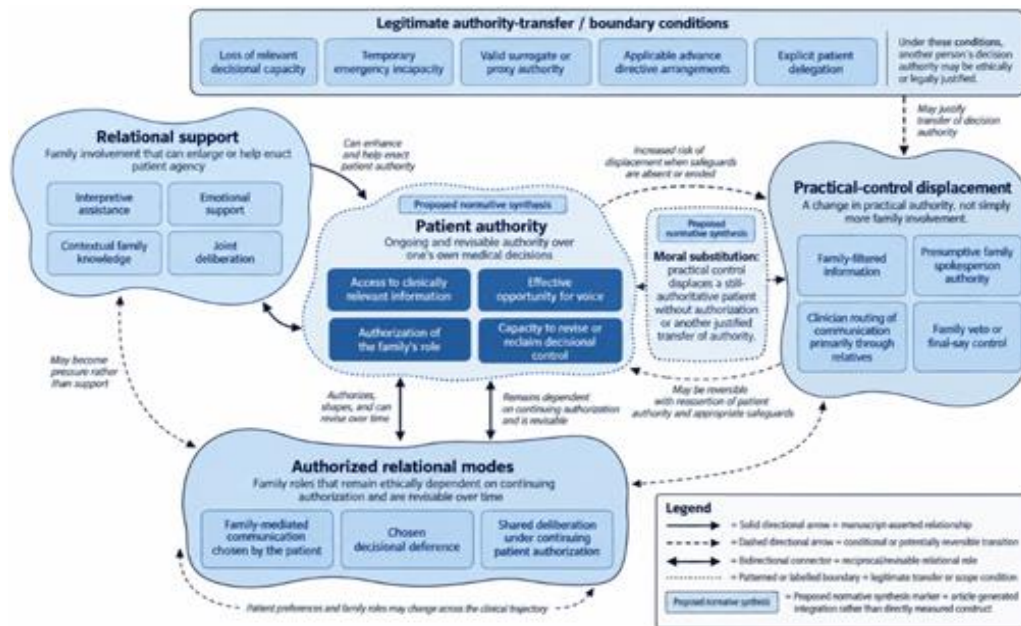


Figure 1. Patient authority under family involvement: relational support, authorized deference, and the migration of practical control

Clinical and institutional implications

A relational-autonomy account changes the practical question clinicians should ask. The relevant issue is not simply whether relatives are present, active, or influential, but whether their involvement remains connected to the patient's chosen way of exercising authority. Family-inclusive planning can support this aim. A systematic review and meta-analysis of dyadic advance care planning found benefits for selected advance-care-planning outcomes, demonstrating that

involving a family caregiver need not weaken patient-centred decision-making [30]. The implication is not that dyadic processes are inherently superior. Their ethical value depends on whether the dyad helps articulate and preserve the patient's values instead of converting the relative into an unofficial decision-maker.

Clinical practice therefore requires explicit role elicitation. Patients should be asked how they want relatives involved: who should receive information, who should participate in discussion, whether anyone should

help interpret choices, and whether the patient wants another person to take a leading role. Such preferences should be documented as relational preferences rather than treated as an irrevocable transfer of authority. The same patient may want a daughter present for diagnosis disclosure, prefer private discussion about prognosis, and later ask the family to lead practical treatment deliberation. A single label such as “family-centred” cannot represent these distinctions.

Capacity remains a critical boundary. Comparative work on conflict between advance directives and family consent in China and Korea has proposed capacity-first approaches in which current patient decision-making authority is assessed before proxy or family hierarchy is considered [31]. The broader ethical principle is valuable even where particular legal rules differ: family authority should not be presumed merely because serious illness makes relatives more involved. When the patient retains the relevant decision-making capacity, the clinical task is to support that patient’s chosen relational arrangement. When capacity is lost, the problem changes from protecting current patient authority to identifying the legitimate basis on which another person may decide.

The evidentiary role of family members also needs separation from their decisional role. Japanese judicial decisions concerning impaired decision-making capacity illustrate that relatives may provide evidence about a patient’s likely wishes without thereby possessing an unrestricted right to determine treatment [32]. This distinction is important even outside litigation. A spouse may know the patient’s values better than the clinical team; an adult child may explain longstanding preferences; a family caregiver may recognize how treatment burdens fit the patient’s life. Such knowledge can strengthen patient-centred decisions. It does not automatically create authority over a patient who can still speak and decide.

Clinicians consequently need procedures that make patient authorization visible. Where family involvement is substantial, direct opportunities to hear from the patient should remain available whenever clinically feasible. This does not require removing relatives from every encounter. Private conversation can be used selectively

when the patient appears unable to contradict a family member, when information appears to have been filtered, when relatives answer every question directed to the patient, or when a previously expressed preference suddenly changes in circumstances suggesting pressure. The purpose is not to discover a supposedly “pure” individual preference outside relationships. It is to determine whether the relational arrangement still reflects the patient’s own authorization.

Institutional responsibility begins where recurring routines shape who can exercise authority. Practices in which clinicians automatically inform relatives first, defer disclosure to family permission, or treat family agreement as necessary before following a capable patient’s preference can produce moral substitution without any single actor intending coercion. Evidence concerning family-mediated decisions, information asymmetry, and patient silencing in oncology settings shows why responsibility cannot be confined to individual bedside communication [23]. Consent forms, documentation fields, communication protocols, interpreter practices, visiting rules, escalation mechanisms, and ethics-consultation pathways can all affect whether patients retain effective access to information and decision-making.

A patient-authority safeguard should therefore contain several linked functions: explicit elicitation of the desired family role; documentation of that role in terms sufficiently specific to guide clinicians; opportunities for direct patient communication; reassessment when illness or relationships change; capacity-sensitive transition to legitimate surrogate processes when necessary; and escalation when disagreement persists over who may decide. These are not proposed as a universal checklist whose completion proves that autonomy has been achieved. They are institutional conditions intended to make unauthorized displacement easier to detect and correct.

The distinction among these functions is shown in **Table 2**. The rows are organized around moments when patient authority can be preserved, obscured, or transferred in family-involved care.

Table 2. Authority-preserving conditions across recurrent family-involved clinical situations

Clinical situation	Patient-authority question	Family role compatible with relational autonomy	Clinician or institutional responsibility	Signal that practical control may be shifting	Required reconsideration
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Initial information disclosure	Who does the patient want informed, and in what sequence?	Receive, interpret, or discuss information according to patient preference	Elicit and document disclosure preference before assuming family-first communication	Information is withheld because relatives object despite no patient authorization	Offer direct communication and re-establish the patient's preferred disclosure arrangement
Shared deliberation	Does the patient want advice, joint reasoning, or family leadership?	Provide values, history, practical knowledge, and recommendations	Direct questions to the patient as well as relatives and monitor whether participation remains voluntary	Family answers become the only clinically operative account	Reopen the patient's opportunity to speak or modify the family role
Chosen deference	Has the patient knowingly authorized another person to lead the decision?	Lead deliberation or choice within the scope authorized by the patient	Record the scope of deference and preserve opportunity for revision	Deference is assumed from culture, age, dependence, or silence	Confirm continuing authorization without treating independent choice as mandatory
Change in illness or treatment	Does the previous family arrangement still reflect the patient's preference?	Continue the prior role if still endorsed	Reassess relational preference when circumstances materially change	Earlier authorization is treated as permanently binding	Revisit information, participation, and decision-role preferences
Emerging disagreement	Does the patient retain authority, and whose preference is controlling in practice?	Advocate, question, or disagree without displacing the patient's decision right	Clarify capacity, patient preference, family role, and escalation pathway	Treatment is delayed or altered because family approval is treated as necessary	Restore patient authority or identify a legitimate alternative decision-maker
Loss of relevant decision-making capacity	What ethically and legally justifies transfer of decision authority?	Serve as proxy, surrogate, supporter, or evidence source according to applicable rules and known wishes	Distinguish current incapacity from prior family involvement; identify lawful and ethically justified surrogate authority	Informal family influence is simply converted into formal authority	Apply capacity, advance-directive, proxy, and substituted-judgment or best-interest standards as appropriate

Together, these conditions relocate the clinical focus from the quantity of family involvement to the integrity of patient authority across changing relationships and institutional processes. **Figure 2** represents that

responsibility across the patient, family, clinician, and institutional levels without depicting autonomy as an individual-versus-family contest.

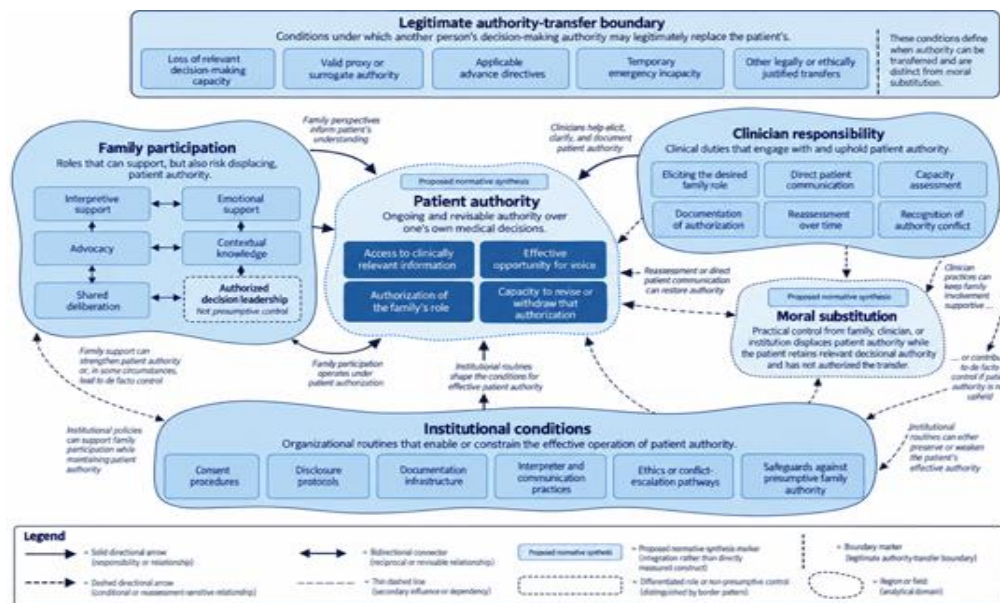


Figure 2. Keeping patient authority operative across family, clinician, and institutional layers of care

Results and Discussion

The framework developed here rejects two opposing simplifications. The first assumes that autonomy is strongest when family influence is minimized. The second assumes that culturally familiar family leadership carries sufficient moral authority by itself. Both obscure the more precise question of whether the patient remains the source of authorization for the relational arrangement through which the decision is being made.

Institutional rules are necessary but insufficient to answer that question. Evidence from Flemish general practice provides a useful external comparison: physicians sometimes endorsed family-involvement strategies that were legally impermissible, and greater legal knowledge reduced but did not eliminate such responses [33]. The jurisdiction differs from East Asian settings, so the finding should not be transferred as evidence about Chinese, Japanese, Korean, or Taiwanese practice. It nevertheless demonstrates a general implementation problem. Formal rules cannot protect patient authority if every day clinical routines continue to grant practical control to others.

The converse risk is overdiagnosing coercion. Families may be emotionally forceful, distressed, protective, or insistent without actually usurping a patient's decision. Clinical ethics analysis of apparent family override emphasizes that influence within close relationships can remain compatible with autonomy and that threats, abuse, or suppression of a patient who wishes to speak provide stronger evidence of compromised agency [34]. This is why moral substitution cannot be inferred from intensity of influence alone. The decisive issue is whether another actor has acquired practical control that the patient has neither authorized nor become unable to exercise.

Several boundary conditions follow. A patient may authentically want relatives to receive difficult information first, may prefer joint decision-making, or may delegate substantial choice to a trusted family member. Preventing these arrangements merely because they are relational would substitute a professional ideal of independence for the patient's own preferred form of agency. Equally, an early preference for family leadership cannot be treated as permanent when the patient later seeks direct information or participation. Relational autonomy requires enough flexibility for the patient to change the terms of the relationship.

Relevant loss of decision-making capacity changes the ethical structure more fundamentally. When a patient can no longer exercise the decision authority at issue, appropriate surrogate, proxy, advance-directive, substituted-judgment, or best-interest processes may become necessary. Those arrangements may be deeply family-centred without constituting the phenomenon identified here. Moral substitution concerns displacement while patient authority remains operative; legitimate surrogate decision-making concerns the justified exercise of authority when that condition no longer holds.

The evidence base also limits the scope of the argument. Much of the recent East Asian literature used here comes from oncology, palliative care, advance care planning, older-patient consultations, or end-of-life decision-making. China is particularly prominent, while evidence from Japan, Korea, and Taiwan is less extensive and sometimes addresses different clinical questions. Qualitative, cross-sectional, observational, philosophical, and legal sources answer different questions and should not be collapsed into a single empirical estimate of how often substitution occurs. The framework is therefore normative and diagnostic, not epidemiological.

Its principal contribution is to specify the moral object that clinical practice should protect. Patient-centred care does not require that every decision be individually performed or family-free. It requires that the patient remain able, when possessing the relevant authority, to determine how relational assistance is organized and whether that arrangement continues. Family members can be indispensable participants in that process. They become substitute decision-makers in the problematic sense developed here only when their practical control ceases to derive from the patient's authorization while clinicians or institutions nevertheless allow that control to govern care.

Conclusion

Family participation and patient autonomy are not opposing principles. In family-involved clinical care, autonomy may be exercised through dependence, advice, shared deliberation, emotional support, and chosen deference. The ethical problem begins when these relational practices alter who actually controls information, participation, or treatment choice.

Moral substitution therefore describes a conditional change in authority: another actor becomes practically determinative while the patient retains the relevant decisional authority and has neither authorized that displacement nor undergone a justified transfer of decision-making authority. Protecting patients in such settings requires more than encouraging individual independence. It requires preserving their ability to determine the family's role, receive or regulate access to information, participate in ways they value, and revise relational arrangements as circumstances change.

A relational-autonomy approach is strongest when it protects both sides of this distinction. It must resist unauthorized displacement of patient authority without converting culturally meaningful family participation into an ethical defect. The appropriate clinical goal is therefore neither maximal individual control nor maximal family involvement, but a relational arrangement whose authority remains traceable to the patient for as long as the patient retains the right and ability to decide.

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