

Filial Responsibility without Compulsory Silence: A Confucian-Informed Account of Truth Disclosure, Patient Preferences, and Family Requests to Withhold Serious Diagnoses

Kenji Sato^{1*}, Li Wei², Chen Hao³

¹Department of Biomedical Ethics, Keio University School of Medicine, Tokyo, Japan.

²Department of Medical Ethics, Peking University Health Science Center, Beijing, China.

³Department of Philosophy, Fudan University, Shanghai, China.

*E-mail ✉ kenji.sato@keio.jp

Abstract

Family requests to withhold a serious diagnosis from a patient are frequently framed as expressions of protection, filial care, and responsibility. In settings influenced by Confucian family ethics, these requests can acquire additional moral force because illness is experienced through relationships of dependence, reciprocity, and obligation. Yet the ethical significance of family responsibility does not by itself determine who should control a competent patient's access to clinically important information. This comparative normative analysis examines how truth disclosure, filial responsibility, patient preferences, and family authority should be related when families ask clinicians to conceal serious diagnoses. Using comparative and translational normative reasoning, it distinguishes the moral importance of family care from authority over information, and examines when relational involvement supports rather than displaces patient agency. The analysis argues that filial responsibility can justify accompaniment, preparation, emotional protection, culturally responsive pacing, and patient-authorized mediation. These functions become ethically problematic when protective responsibility is transformed into an independent family entitlement to prevent a decision-capable patient from receiving information that the patient wishes to know. A Confucian-informed approach can therefore preserve meaningful family participation without treating compulsory silence as the default expression of filial care. The resulting position is conditional: ethically justified disclosure should remain responsive to the patient's own informational preferences, including preferences for staged communication, limited information, or voluntary delegation to trusted relatives.

Keywords: Truth disclosure, Filial responsibility, Confucian bioethics, Patient autonomy, Family involvement, Serious diagnosis

Introduction

Disclosure of a serious diagnosis is rarely a purely informational act. It can alter expectations, family roles, treatment choices, emotional relationships, and perceptions of responsibility. Contemporary evidence from Chinese cancer care shows that families may

receive, interpret, filter, delay, or negotiate diagnostic information before it reaches the patient, and that these practices can change as illness progresses [1]. The ethical problem is therefore broader than whether truth should be told. It concerns who has authority over the timing, content, and recipients of clinically important information, and how that authority should be exercised when family members understand concealment as an act of care.

Any defensible answer must begin with the fact that “the family's preference” cannot stand in for “the patient's preference.” Quantitative synthesis of cancer-disclosure research and recent multistakeholder work on family-oriented informed consent indicate substantial variation in what patients and relatives want, including

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disagreement over whether information should be given directly and who should participate in decisions [2, 3]. These findings do not establish that every patient prefers immediate and complete disclosure. They establish something more basic for normative analysis: cultural membership and family concern are unreliable substitutes for eliciting the informational preferences of the person whose diagnosis is at issue.

Clinicians nevertheless encounter family requests as practical and moral pressures. Chinese physicians have described fear of psychological harm, conflict with relatives, and concern about destabilizing the therapeutic relationship when deciding whether to disclose cancer diagnoses [4]. Survey evidence also shows that many physicians in some Chinese samples are willing to cooperate with relatives who request concealment, particularly when the patient is older [5]. Family-mediated disclosure is therefore sustained not only through private family norms but also through clinical routines, expectations, and institutional habits.

The ethical significance of these practices becomes clearer when autonomy is treated relationally. Relationships can supply interpretation, reassurance, practical support, and continuity, while pressure from relatives or professionals can also impair a patient's ability to participate meaningfully in decisions [6]. Observed consultations with older Chinese patients illustrate how accompanying family members may facilitate discussion in some encounters while, in others, assuming a practically surrogate role that marginalizes the patient's voice [7]. Cross-national research similarly shows that desired family involvement varies within as well as between societies [8]. The relevant comparison is consequently not between an allegedly individualistic Western autonomy and an allegedly family-dominated Confucian ethics. The more difficult question is what filial responsibility morally requires when a family wishes to protect a patient, the patient's own informational wishes are uncertain or different, and clinicians must decide whose preference should govern disclosure.

This article addresses that question through comparative and translational normative analysis. Its central claim is that filial responsibility has genuine ethical content in clinical communication, but its content must be separated from an assumed authority to silence. Family members can bear responsibilities to protect, accompany, interpret, prepare, and support a seriously ill relative. Those responsibilities may influence how disclosure should

occur. Whether they justify preventing disclosure depends on a further question: whether the patient has authorized that form of mediation or instead wishes to exercise personal authority over access to diagnostic information.

Truth disclosure and filial responsibility

Truth disclosure is often described as a choice between telling and withholding, yet family practice can be more temporally complex. Qualitative evidence concerning older patients with cancer indicates that relatives may revise disclosure decisions as symptoms progress, treatment options change, hope diminishes, or the perceived need for preparation becomes more urgent [9]. Concealment may therefore involve delay, partial disclosure, euphemistic explanation, staged disclosure, or a continuing decision not to disclose. These forms cannot be treated as ethically equivalent. Delaying a conversation for a brief period so that a patient can be supported through acute distress is different from maintaining indefinite control over information despite a continuing wish to know.

The moral language surrounding these decisions commonly invokes protection. Family caregivers' attitudes toward death and serious illness can shape their willingness to disclose, and protective motives are frequently expressed through concern that knowledge may increase fear, hopelessness, or suffering [10]. Protective intention, however, does not determine the moral status of the resulting action. Research with caregivers in another Asian clinical context found that closely related concerns could be invoked by families who chose disclosure and by families who chose nondisclosure [11]. One family may understand preparation and truthful communication as the caring response, while another interprets the same duty of care as justification for silence. The existence of a benevolent motive thus identifies an ethically relevant concern without establishing which person should control the information.

This distinction matters for filial responsibility. If filial responsibility is reduced to compliance with whatever relatives believe will protect the patient, it becomes difficult to distinguish care from substitution. A culturally adapted palliative-care case from China demonstrates that relational harmony and patient expression need not be mutually exclusive: communication can be organized in ways that respect family involvement while preserving the patient's role

[12]. At the same time, empirical work on adult children acting for critically ill parents with cancer has associated filial-piety commitments with surrogate decisional conflict, suggesting that familial obligation can generate moral burden as well as confidence [13]. Filial responsibility is therefore better understood as a field of duties than as a standing authorization to control another person's knowledge.

Clinical context also matters. What is described as a "cultural" preference for family control may be reinforced by institutional pressures, communication habits, professional anxiety, resource limitations, or assumptions about what families expect. Rural oncology nurses in China have described family expectations, cultural taboos, and structural difficulties as intertwined obstacles to a good death and open end-of-life communication [14]. Such evidence cautions against treating every family-mediated disclosure practice as a direct expression of Confucian ethics. A practice can be culturally intelligible while also being produced by fear

of conflict, organizational convenience, limited communication support, or longstanding clinical custom. The ethical question should consequently be divided into two parts. First, what responsibilities does a family have toward a seriously ill relative? Second, what authority follows from those responsibilities? Duties of care may justify helping clinicians understand the patient, preparing the patient for difficult information, participating in conversations when invited, and requesting sensitivity in timing and language. They do not automatically establish an independent right to decide that a competent patient must remain uninformed. The difference between responsibility and authority is especially important because silence affects more than emotional state: it can affect treatment choices, future planning, family conversations, and the patient's ability to decide how remaining time should be used.

The relevant distinctions can be summarized by examining what filial responsibility is doing in different disclosure configurations.

Table 1 summarizes the distinctions discussed above.

Table 1. When filial responsibility shapes disclosure without becoming authority over the patient's information

Disclosure configuration	What filial responsibility is doing	Patient's informational position	Normative significance	Principal ethical risk if misread
Emotional preparation before disclosure	Helping the patient enter a difficult conversation with trusted support	Patient remains expected to receive information, with timing adapted to immediate circumstances	Filial care modifies the manner of disclosure while leaving informational authority with the patient	Temporary preparation can be converted into open-ended delay
Patient-requested family mediation	Acting as interpreter, intermediary, or trusted communication partner at the patient's request	Patient voluntarily chooses a relational route to information	Family involvement expresses rather than defeats patient authority	Clinicians may assume delegation without confirming it
Staged or partial disclosure consistent with patient preference	Supporting communication at a pace the patient has indicated is tolerable or desirable	Patient controls the desired depth or pace of information	Protection and autonomy can operate together when pacing is attributable to the patient	Clinician or family preference may be falsely attributed to the patient
Family request for concealment based on anticipated distress	Seeking to prevent emotional harm before the patient's own preference is known	Patient preference remains unestablished	Family concern deserves serious consideration but does not yet determine authority	Protective motive may be treated as sufficient justification for silence
Continued concealment despite the patient's expressed wish to know	Replacing the patient's informational preference with the family's judgment of welfare	Patient seeks information but is prevented from receiving it	Filial care has crossed into control over another person's access to clinically relevant knowledge	Responsibility is transformed into moral substitution
Family support after truthful disclosure	Remaining engaged after difficult information is communicated	Patient receives desired information while retaining relational support	Filial responsibility is expressed through sustained care rather than informational control	Disclosure may be wrongly framed as requiring family withdrawal or relational rupture

The table distinguishes functions that are frequently collapsed in practice. Protection may concern timing,

tone, companionship, or emotional support without requiring permanent withholding. Mediation can be

legitimate where it reflects the patient's own preference. By contrast, compulsory silence arises when the family's protective judgment is treated as sufficient to displace a decision-capable patient's contrary informational preference. That distinction prepares the normative question that follows: how should Confucian family obligation be interpreted when relational responsibility and patient authority appear to conflict?

Confucian family obligations and patient authority

A Confucian-informed analysis should begin from the strongest version of the opposing position rather than from a caricature of family dominance. Contemporary scholarship has reconstructed Confucian benevolence as compatible with bounded family participation in shared decision-making, particularly when family involvement is sensitive to patient capacity, prior wishes, clinical risk, and the relational structure of care [15]. This account matters because it shows that a family-centered ethic need not require unlimited familial authority. At the same time, sociological and ethical research on family-oriented informed consent in China identifies harms that can occur when relatives acquire practical control over information and decision-making in ways that patients did not authorize [16]. Work on the translation of principlist bioethics into mainland Chinese palliative care likewise shows that clinicians may recognize autonomy-oriented principles while continuing to operate within family-led practices [17]. The normative problem is therefore not whether Confucian and autonomy-based traditions are mutually exclusive. It is how responsibilities originating in one moral vocabulary should be translated when they affect authority recognized in another.

Filial responsibility has a relational structure. Children and other close relatives may understand themselves as answerable for protecting the ill person from avoidable suffering, preserving family continuity, coordinating care, and preventing abandonment. These commitments can have positive clinical significance. Yet evidence from advance-care-planning practice shows that filial norms, family mediation, information asymmetry, and concern about relational disruption can also make it harder for patients to express their own preferences [18]. Bereaved relatives discussing a good death in China similarly describe family harmony, mutual responsibility, and relational continuity as important values while also revealing tensions between family expectations and individual wishes [19]. Harmony therefore cannot operate as a self-validating ethical

endpoint. A harmonious outcome obtained because the patient's contrary preference never becomes speakable has a different moral character from harmony produced through voluntary accommodation among informed participants.

Patient authority also need not take an atomistic form. Chinese older adults considering advance care planning describe negotiating their own wishes alongside obligations to family, while Asian-American participants in other medical decisions have demonstrated context-sensitive use of relational rather than purely individual reasoning. Large-sample research on end-of-life preferences among older adults in China likewise identifies heterogeneous patterns in which self-determination and family orientation may coexist [20-22]. Taken together, these findings support a relational conception of agency in which autonomy can be exercised through trusted relationships. They do not support a presumption that the existence of those relationships transfers informational authority away from the patient.

This distinction becomes particularly important when a patient's values are known. Chinese patients with terminal cancer demonstrate identifiable preferences concerning end-of-life care, illustrating that even within strongly relational clinical settings, individuals make differentiated choices about matters affecting their own treatment and future.[23] The legal and ethical history of informed consent in China also shows why those choices cannot be interpreted through a simple transplantation of European or North American individualism: consent practices are shaped by institutional arrangements, cultural expectations, and longstanding family involvement[24]. Translational normative analysis must therefore preserve two truths simultaneously. Patient authority cannot be defended by pretending relationships are ethically irrelevant, and family responsibility cannot be defended by treating cultural familiarity as sufficient authorization for relatives to govern information against the patient's wishes.

The resulting normative boundary can be stated provisionally. Confucian family obligation gives relatives morally important reasons to remain involved, to care, to prepare, to communicate sensitively, and to help the patient bear the consequences of serious knowledge. It may also support a patient's voluntary choice to receive information through relatives, to defer some details, or to delegate parts of decision-making. The same tradition does not require interpreting filial care as

compulsory silence when the patient wishes to know. The decisive ethical question is whether family involvement remains connected to the patient's own agency or has become an independent source of authority over the patient. That distinction provides the basis for a Confucian-informed account of ethically justified disclosure.

A confucian-informed account of ethically justified disclosure

A Confucian-informed account of disclosure should evaluate family involvement by its relationship to the patient's agency, not merely by whether relatives are present or influential. Familial protection can point in different communicative directions. Research on serious-illness conversations between patients and adult children shows that a desire to protect family members can inhibit discussion but can also motivate preparation and openness [25]. Protection therefore cannot itself determine whether silence is justified. Its ethical significance depends on whose interests are being protected, whether the patient has endorsed the arrangement, and whether family involvement continues to leave the patient able to obtain information that matters to personal choices.

Patient preference supplies the critical link. Chinese patients with advanced cancer and their caregivers may share many informational needs while differing over particular topics and the desired manner of communication [26]. A patient may prefer that relatives hear information first, participate in conversations, filter technical detail, or help determine the pace of disclosure. Those choices are compatible with patient authority because the relational form of communication originates in the patient's own preference. The same outward practice becomes ethically different when clinicians

assume that relatives possess such authority without establishing the patient's wishes.

Family members themselves also require support. Caregivers receiving or communicating serious news have heterogeneous informational and emotional needs [27]. Clinicians can recognize those needs without converting them into a veto over disclosure. Providing relatives with preparation, opportunities to express fears, and assistance in supporting the patient may reduce the perceived need for concealment while preserving the moral seriousness of filial concern.

The practical necessity of preference elicitation is reinforced by evidence that patients, relatives, and clinicians can hold different truth-telling preferences [28]. When those perspectives diverge, the ethically relevant question is not which group forms the numerical majority but whether the patient has expressed a preference concerning personal diagnostic information. Nor is protective nondisclosure uniquely produced by Confucian family ethics: clinicians in a non-Chinese surgical context have also reported withholding serious risk information for reasons that include distress and preservation of hope [29]. Cultural interpretation matters, but it cannot by itself establish authority.

The resulting account distinguishes filial care from filial control. Filial care may shape tone, timing, companionship, preparation, and patient-authorized mediation. Filial control arises when family members acquire independent power to determine what a decision-capable patient may know despite that patient's contrary preference. Between these poles lies an important range of ethically legitimate relational practices, including voluntary delegation, staged disclosure, shared conversations, and temporary pacing responsive to the patient's wishes. **Figure 1** represents these relationships as overlapping forms of responsibility and authority rather than as a linear progression.

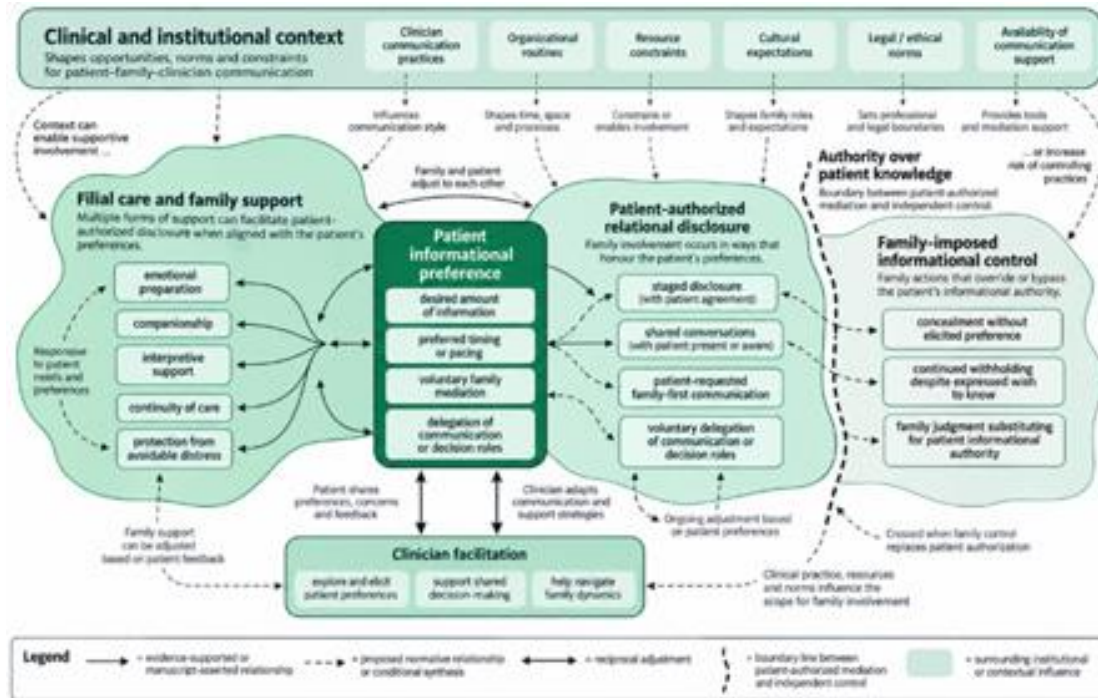


Figure 1. Where filial care supports disclosure—and where protective mediation becomes control over patient knowledge

Clinical implications

The clinical response to a family request for nondisclosure should begin by clarifying the patient's own informational preference rather than immediately accepting or rejecting the family's request. This is especially important where family-oriented practice is customary, because patients may genuinely prefer relatives to mediate communication while others may want direct access to information.[3] Clinicians should therefore establish, as far as circumstances permit, whether the patient wants detailed information, wishes relatives to participate, prefers staged communication, or voluntarily delegates some communicative authority.

Family concerns should then be explored as clinically and ethically relevant information. Physicians report fears about distress and relational conflict [4], while relational-autonomy research shows that family relationships can either support or constrain agency [6]. A request for temporary pacing may therefore warrant a different response from a request for indefinite concealment. Dynamic disclosure practices also make reassessment necessary because family and patient preferences may change during illness [9].

The practical distinction is summarized in **Table 2**.

Table 2. Clinical limits on family-mediated disclosure when filial responsibility and patient authority intersect

Family request pattern	What the clinician must establish	Family role compatible with patient authority	Point at which the limit is crossed	Clinically appropriate direction
"Please tell us first"	Whether the patient prefers family-first communication	Receiving information first and preparing the patient when voluntarily authorized	Family-first communication becomes an assumed permanent rule without confirming patient preference	Elicit the patient's preferred communication arrangement
"Do not tell them yet"	Reason for delay, expected duration, patient's prior wishes, and immediate clinical circumstances	Brief pacing or preparation when consistent with patient preference and circumstances	Temporary delay becomes indefinite concealment without reassessment	Clarify purpose and timeframe; reassess preference

“They cannot cope with the truth”	Evidence for concern and whether the patient wants information despite anticipated distress	Emotional support, supported disclosure, family presence	Anticipated distress is treated as sufficient authority to deny requested information	Adapt communication and increase support rather than presume silence
“Let the family decide what they should know”	Whether the patient has voluntarily delegated that role	Patient-authorized mediation or delegation	Delegation is inferred solely from age, culture, diagnosis, or family expectation	Verify voluntary delegation directly whenever feasible
Family members dominate the clinical encounter	Whether the patient can express preferences privately and without pressure	Participation that assists understanding and care	Family participation prevents the patient’s wishes from becoming operative	Create an opportunity for the patient’s own voice and preference to be established
Patient explicitly requests direct disclosure	Whether decision-making capacity and communication needs are adequately supported	Continued family support after disclosure	Family judgment replaces an expressed patient wish to know	Provide clinically appropriate disclosure while supporting the family relationship

These limits do not require excluding relatives. They require clinicians to distinguish the family’s entitlement to be heard and supported from an entitlement to control information. Where pressure or institutional routine prevents a patient’s stated preference from becoming operative, the ethical problem becomes one of practical authority rather than cultural difference alone [7].

Results and Discussion

The strongest challenge to this account comes from contemporary forms of moderate familism that regard family leadership as ethically meaningful under defined conditions [15–17]. That challenge should be taken seriously. A patient may understand personal identity through family relationships and may want relatives to receive information, participate heavily, or make some decisions. Respect for patient authority therefore cannot be reduced to mandatory direct disclosure.

The proposed boundary concerns authorization. The account weakens or changes when a patient voluntarily asks not to know, prefers gradual disclosure, delegates communication to relatives, or cannot currently exercise decision-making authority. In such circumstances, family mediation may constitute an expression of the patient’s relational agency. The analysis is directed instead at situations in which filial responsibility is used to justify withholding information despite a competent patient’s expressed or reasonably ascertainable wish to know.

A second limitation concerns explanation. Family-mediated disclosure practices cannot be attributed wholly to Confucian culture. Professional routines, institutional incentives, communication skill, legal expectations, resource constraints, fear of conflict, and prognosis all

affect what happens clinically. Cultural language may sometimes provide a moral vocabulary for practices partly sustained by these other conditions. Comparative normative analysis should therefore ask both whether a practice is culturally intelligible and whether the authority it assigns is ethically justified.

The evidence base also limits generalization. Studies included here span cancer, palliative care, advance care planning, geriatric consultations, surrogate decisions, and non-Chinese comparators. Their methods and populations differ, and several findings concern end-of-life choices rather than diagnostic disclosure itself. These sources are used to test concepts and boundary conditions, not to claim one prevalence estimate or universal Asian preference.

The broader implication is that culturally responsive ethics should not require choosing between family relationships and patient authority. A more precise question is whether the relational practice enables the patient’s own preferences to operate. This standard leaves substantial room for family involvement while identifying the point at which concern for the patient becomes substitution for the patient.

Conclusion

Filial responsibility can give families strong moral reasons to protect, accompany, prepare, and support a seriously ill relative. It can also justify forms of mediation that a patient voluntarily chooses. These responsibilities do not, by themselves, establish an independent family right to keep a decision-capable patient ignorant of a serious diagnosis the patient wishes to know.

A Confucian-informed approach to truth disclosure can therefore preserve relational care without making silence compulsory. Its central condition is that family involvement remain responsive to the patient's own informational preferences. Where a patient chooses family mediation, staged disclosure, or limited information, respecting that choice can itself express patient authority. Where relatives impose continuing concealment against an expressed wish to know, filial responsibility has crossed from care into control.

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