

## When Cultural Accommodation Transfers Harm to the Patient: A Normative Framework for Negotiating Religious Commitments, Gendered Family Authority, and Treatment Refusal in Plural Asian Societies

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### Abstract

Cultural accommodation is an important component of ethically responsive clinical care because patients understand illness, obligation, family membership, religious commitment, and decision making through social relationships rather than in isolation. Yet accommodation becomes ethically difficult when practices intended to respect family or religious values alter who receives information, who participates in deliberation, who exercises practical authority, or who bears the consequences of treatment decisions. This article develops an original ethical boundary analysis using a Boundary-Condition / Normative Responsibility approach. It asks when culturally responsive practice ceases to support a patient's relational agency and instead transfers decisional, informational, temporal, psychological, or clinical burdens to that patient while authority moves to relatives, surrogates, clinicians, or institutions. The analysis distinguishes culturally legitimate participation, patient-authorized delegation, relational support, and shared deliberation from authority displacement, coercive influence, protective nondisclosure, and third-party refusal that the patient has not authorized. It argues that neither individualistic independence nor family-centred practice provides an adequate default. Ethical permissibility instead depends on whether the patient retains meaningful authority over how relational involvement is structured, whether the arrangement remains sufficiently contestable, and whether avoidable burdens are imposed without corresponding patient authorization. The framework preserves legitimate pluralism while identifying responsibilities that arise when clinical institutions enable family or religious accommodation to become a vehicle for patient-facing harm.

**Keywords:** Cultural accommodation, Relational autonomy, Family authority, Treatment refusal, Informed consent, Religious ethics, Patient agency

### Introduction

Respect for patient autonomy is often discussed as though its principal ethical challenge were deciding how strongly individual choice should be protected against

cultural or familial influence. That framing is too narrow for plural clinical environments. East Asian bioethical scholarship has shown that the familiar contrast between “individualistic” and “collectivist” cultures can obscure rather than clarify how patients actually understand agency, obligation, dependence, and family membership [1]. Relational accounts of autonomy likewise show that decision making need not become less autonomous merely because significant others contribute to reflection, interpretation, emotional support, or practical deliberation [2]. The ethical problem therefore cannot be solved by treating social influence as a deviation from an otherwise isolated decision maker. Health-related

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choices are routinely interdependent, and the social relationships surrounding patients can shape the options they consider, the reasons they find intelligible, and the forms of support through which preferences become actionable [3].

The harder question arises when relational participation changes the distribution of practical authority. Recent Chinese evidence illustrates the distinction. Family-oriented informed-consent practices can provide support and protection, yet they can also restrict what patients are told, narrow their opportunities to decide, or place relatives in a position to direct treatment for patients who retain decisional capacity [4, 5]. Similar concerns arise when older patients become peripheral participants in consultations conducted primarily between clinicians and relatives. These findings do not establish that family participation is intrinsically harmful. They show that the moral status of participation depends partly on whether the patient remains an author of the arrangement or becomes its object. A relative may speak because the patient wants assistance, because the clinical encounter makes participation difficult, because the family has assumed that role without explicit authorization, or because clinicians themselves find family-mediated decision making easier. These situations may look similar at the bedside while carrying different ethical meanings.

Gender and religion further complicate the distribution of authority. In Chinese end-of-life care, family decision processes can reproduce gendered hierarchies in which some relatives acquire greater legitimacy to speak, interpret obligations, or determine what counts as an appropriate death [6]. Religious commitments can also become central to refusals of treatment, but their ethical function cannot be inferred from the mere presence of religion. In an Islamic ethical analysis of third-party refusal in an emergency context, religious reasoning was used to limit rather than reinforce a guardian's attempt to refuse life-preserving intervention [7]. Religion may therefore support a patient's own refusal, shape family obligations, constrain surrogate authority, or provide reasons for preventing serious harm. The relevant question is not whether a decision is "religious" or "cultural," but whose commitments are being enacted, through what allocation of authority, and with what consequences for the patient.

These questions require a theory of responsibility that reaches beyond the moment of consent. Relational responsibility accounts emphasize that responsibility is

distributed across social environments rather than exhausted by the conduct of a single chooser [8]. In clinical care, family members, clinicians, interpreters, institutional protocols, disclosure conventions, consent forms, visiting practices, and escalation pathways can all influence whose voice becomes operational. A family's preference gains different ethical significance when a clinician treats it as advisory, when a hospital makes it a de facto consent requirement, or when a patient lacks a realistic means of challenging it. Responsibility therefore attaches not only to the person who voices a preference but also to the actors and arrangements that translate that preference into practical control.

This article examines the boundary at which culturally responsive accommodation ceases to support relational agency and begins to transfer harm to the patient. Its central claim is conditional. Accommodation remains ethically defensible when patients can meaningfully authorize, revise, or reject the roles assigned to family members, religious commitments, and other relational influences. Its justification weakens when practical authority moves elsewhere while the patient absorbs unchosen burdens, loses access to material information, faces coercive pressure, or cannot effectively contest the arrangement. The analysis is neither a defence of atomistic autonomy nor a presumption against family-centred care. It asks a more specific question: when clinical institutions recognize culturally or religiously grounded forms of participation, what conditions must remain in place for that recognition to count as accommodation rather than ethically harmful authority displacement?

#### *Ethical value and limits of cultural accommodation*

Cultural accommodation has genuine moral value because it can enable patients to exercise agency in ways that fit the relationships, commitments, and identities through which they understand illness and responsibility. Relational-autonomy research shows that family influence can form part of autonomous decision making when patients themselves understand those relationships as constitutive of how they deliberate [9-11]. A patient who wants a spouse to speak first, prefers adult children to participate in discussions, asks a family member to help interpret prognosis, or chooses to defer aspects of decision making is not necessarily surrendering autonomy. Such arrangements may express autonomy precisely because the patient decides that autonomy should be exercised through trusted relationships rather

than through solitary control. The ethical value lies in preserving the patient's authorship of the relational arrangement, not in requiring the patient to make every decision independently.

This distinction matters because clinical participation has several separable components. Patients may want detailed information while preferring family-assisted deliberation; they may value extensive discussion while wishing a relative to communicate the final choice; or they may prefer clinicians to recommend a course while retaining a veto over options that violate religious or personal commitments. Evidence from shared decision-making research shows that patient experience is shaped by communication and opportunities for participation [12], while patient-centred communication can influence trust partly through participation and may operate differently among patients with more passive decisional preferences [13]. Ethical evaluation therefore cannot use maximal individual control as the sole measure of good care. What matters is whether the pattern of information, deliberation, recommendation, delegation, and final control corresponds sufficiently to what the patient wants and remains open to revision.

Existing shared decision-making models offer useful resources but do not eliminate this problem. A systematic review and formal representation of theoretical models in oncology found substantial heterogeneity in how shared decision making is conceptualized and in the determinants, processes, and outcomes incorporated into those models [14]. That heterogeneity is important for culturally plural care. A generic requirement to "include the patient" may leave unanswered who controls information before a decision, how family disagreement is handled, whether silence reflects preference or constraint, and whether a patient can withdraw previously granted family authority. Conversely, a generic requirement to maximize direct patient control may wrongly classify patient-authorized delegation as deficient. Cultural accommodation requires greater functional precision than either formula provides.

The same point applies at organizational level. Patient and family engagement is more durable when healthcare systems create structures that support meaningful participation rather than relying on goodwill during individual encounters [15]. Institutions shape who receives information, who is invited into consultations, whether private conversation with the patient is routine, how interpreters are selected, how conflict is escalated, and whether clinicians have time to elicit preferences before family roles become fixed. Cultural responsiveness is therefore partly an institutional achievement. It requires services capable of recognizing legitimate relational participation while avoiding an automatic transfer of authority to whichever family member is most available, senior, assertive, or culturally legible to clinicians.

The need for functional precision is reinforced by evidence that patients differ across distinct dimensions of participation. Chinese cancer patients have shown differing preferences for information, deliberation, and decisional control rather than one uniform preference for being either "active" or "passive" [16]. A patient may want to know everything yet prefer family-led deliberation, or may want relatives present while reserving the final treatment choice. Cultural accommodation should consequently be assessed component by component. The fact that a patient values family involvement does not by itself establish that relatives may control disclosure, exclude the patient from deliberation, or refuse treatment on the patient's behalf. Equally, a wish to delegate final choice does not imply a wish to be denied information. These distinctions identify the moral value of accommodation while also revealing its limit: relational involvement remains ethically defensible only so long as it tracks the patient's own authorized pattern of participation.

The distinction can be stated more precisely by separating the forms of accommodation that clinical practice often collapses into the single category of "family involvement."

**Table 1** summarizes the distinctions discussed above.

**Table 1.** Moral functions and limiting conditions of cultural accommodation when patients authorize relational involvement

| Relational function being accommodated | What patient-authorized accommodation can legitimately permit                                | Moral value preserved             | Signal that the accommodation is approaching its ethical limit                       | Question clinicians should resolve before extending the arrangement                        |
|----------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Information mediation                  | A trusted relative may help receive, interpret, translate, or sequence difficult information | Comprehension, emotional support, | The patient loses access to information they want, or relatives determine disclosure | Has the patient authorized this person to mediate information, and does that authorization |

|                                                | according to the patient's stated preference                                                                                              | culturally intelligible communication                             | without reliable evidence of patient preference                                                                                                     | include withholding or sequencing information?                                                                     |
|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Deliberative support                           | Family members may help identify obligations, values, religious commitments, practical consequences, and acceptable options               | Relational reflection and value clarification                     | One family interpretation becomes the only permissible account of the patient's interests or duties                                                 | Can the patient disagree with the family's interpretation without penalty or loss of care?                         |
| Decisional delegation                          | A patient may ask a relative to communicate or make some treatment choices while retaining the ability to revise that delegation          | Self-directed dependence and relational agency                    | Delegation is treated as permanent, inferred from kinship, or expanded beyond the role the patient assigned                                         | What exactly has been delegated, for how long, and can the patient reclaim control?                                |
| Religious or moral interpretation              | Family or community figures may assist the patient in understanding treatment through religious or moral commitments the patient endorses | Integrity, identity, continuity of meaning                        | Another person's religious judgment is substituted for the patient's own interpretation or used to close off options the patient wishes to consider | Whose commitment is being enacted: the patient's, the family's, or the institution's assumption about the culture? |
| Emotional and practical caregiving             | Relatives may support coping, transport, medication routines, communication, and treatment implementation                                 | Solidarity, continuity, practical feasibility                     | Caregiving dependence becomes leverage for securing compliance with family preferences                                                              | Could the patient reject the family's preferred option without losing essential support or protection?             |
| Representation when participation is difficult | A patient may ask someone to restate preferences, advocate during stressful encounters, or help communicate when illness limits endurance | Effective voice and protection against communicative disadvantage | Representation becomes substitution even though the patient remains able and willing to participate                                                 | Is the representative amplifying the patient's voice or replacing it?                                              |

Note: The distinctions in this table are the article's normative synthesis of relational autonomy, preference-sensitive participation, shared decision making, and patient-family engagement evidence. They do not establish quantitative thresholds or presume that any particular family structure is ethically preferable.

### *Religious commitments, family authority, and treatment refusal*

The ethical importance of separating relational functions becomes clearer when family authority is exercised through information control. In Chinese clinical settings, physicians have described family roles in informed consent that differ substantially from a direct clinician-patient model, while studies of cancer disclosure show that families can actively negotiate whether, when, and how patients receive diagnostic information [17-19]. These practices may arise from concern that disclosure will cause despair, destabilize treatment, or impose an unbearable psychological burden. Protective intent, however, does not determine ethical permissibility. When relatives become the gatekeepers of information, the patient's practical ability to form, revise, or communicate a treatment preference can be altered before any formal consent encounter begins. Authority can therefore shift upstream of the visible decision.

A culturally responsive approach must still distinguish such authority from family-centred care that the patient actually wants. Ethical analysis from Saudi medical settings has argued that patient preference can provide a way to reconcile family-centred decision making with

respect for autonomy [20]. That insight is especially important because "family-centred" practice is otherwise ambiguous. It may describe a patient's chosen form of decision making, a social expectation the patient accepts, a convention the patient tolerates, or a pattern imposed by relatives and reinforced by clinicians. These possibilities should not be assigned the same ethical status. Patient-authorized family involvement may express relational agency; family authority inferred solely from kinship, gender, age, or cultural convention requires a different justification.

Treatment refusal exposes the same distinction at a higher level of clinical risk. A competent patient may reject a treatment for religious, existential, or moral reasons that clinicians consider unwise. The unusual or disputed nature of those reasons does not itself establish incapacity. Ethical and legal analysis of a contested refusal case has emphasized the danger of allowing judgments about the wisdom of a choice to substitute for careful assessment of decision-making capacity [21]. This boundary protects culturally and religiously grounded refusal from paternalistic correction. At the same time, it does not follow that every refusal expressed by a relative should be treated as the patient's

autonomous refusal. Patient-authored refusal, supported relational refusal, valid surrogate refusal, and third-party obstruction are different authority states and must remain distinguishable.

End-of-life care demonstrates why these categories cannot be reduced to a contest between patient autonomy and family authority. Chinese research on decisions to enter inpatient hospice describes decision making as a dynamic process involving patients, family caregivers, and healthcare professionals, shaped by cultural beliefs, prognostic communication, healthcare-system conditions, and changing perceptions of what care can achieve [22]. Family involvement in such settings may supply practical knowledge, emotional continuity, and interpretive resources that no formal consent procedure could replace. Families also participate in constructing narratives of what constitutes a “good death,” giving relational meaning to choices about place of care, suffering, obligation, and preparedness [23]. Such narrative authority deserves ethical recognition. Yet narrative authority is not identical to decisional authority. A family may help define what a good death means while the patient retains the strongest claim to determine whether that account fits their own life.

The multilevel character of family influence is also visible outside treatment refusal. Participatory research on deceased organ donation in China has shown that family consent can be shaped simultaneously by individual, familial, community, and societal considerations, including consensus, conflict, obligation, trust, and cultural understandings of the body [24]. These findings cannot be transferred directly to competent treatment decisions, but they clarify why family authority is rarely generated by a single conversation. Clinical institutions interact with broader norms about who should speak, whose distress counts, what constitutes responsible kinship, and whether disagreement should remain private or become visible to professionals. A patient may therefore face family influence that is socially distributed even when no individual relative issues an explicit threat.

The critical ethical issue is consequently not whether clinicians permit families or religious commitments to influence care. Influence is unavoidable and can be valuable. The issue is whether the form of influence remains connected to the patient’s own relational agency. A patient may authorize others to interpret values, carry information, deliberate, advocate, or even exercise delegated decisional authority. Those roles become

ethically different when they are inferred without authorization, expanded beyond what the patient intended, maintained after the patient objects, or supported by institutional practices that prevent meaningful contestation. The next analytical task is therefore to identify the conditions under which culturally responsive accommodation changes character: from support for a patient’s chosen relational life into a transfer of burdens and authority that the patient did not choose.

#### *A normative framework for identifying harm-transferring accommodation*

Family-oriented informed consent shows why cultural familiarity cannot itself establish ethical legitimacy. In two northern Chinese megacities, patients, caregivers, and professionals described benefits of family involvement alongside treatment delay, psychological abandonment, and reduced opportunities for self-management [25]. These findings shift the ethical question from whether family participation is culturally recognizable to whether accommodation relocates practical authority while leaving the patient to bear substantial unchosen costs.

Interpersonal influence remains compatible with autonomy until the patient’s ability to authorize or reject the arrangement is materially constrained. Coercion marks an important limit because interpersonal justification cannot rescue consent where pressure undermines voluntariness [26]. Time and information require the same conditional treatment. Temporising may create space for reflection but may also allow others to consolidate control,[27] while therapeutic privilege cannot become a general licence for withholding information from a capable patient because relatives anticipate distress [28]. Delay and nondisclosure are therefore defensible only where their scope is justified, reversible, and compatible with the patient’s own preferences.

Authority also depends on capacity. Surrogate decision making is different from family participation around a capable patient, and surrogates require preparation to represent rather than replace the patient’s values [29]. Kinship alone cannot establish authority. Where capacity remains, family authority should arise through patient authorization; where capacity is absent, surrogate authority remains representational.

Mismatch between expected and actual family involvement provides a useful warning signal. Chinese

multicentre evidence shows that preferences can differ across information, deliberation, and decisional control and that desired and actual family involvement do not always coincide [30]. Mismatch alone is not coercion. It becomes ethically serious when practical authority shifts, patient-borne burdens increase, and the patient cannot effectively contest the arrangement. The proposed analysis therefore uses four interacting conditions:

authorization, burden distribution, practical authority, and contestability. Time and institutional design modify all four. Cancer decision-making literature shows that time can enable participation or become a barrier [31], while Chinese policy analysis emphasizes the institutional conditions needed to secure patient autonomy [32].

**Table 2** summarizes the distinctions discussed above.

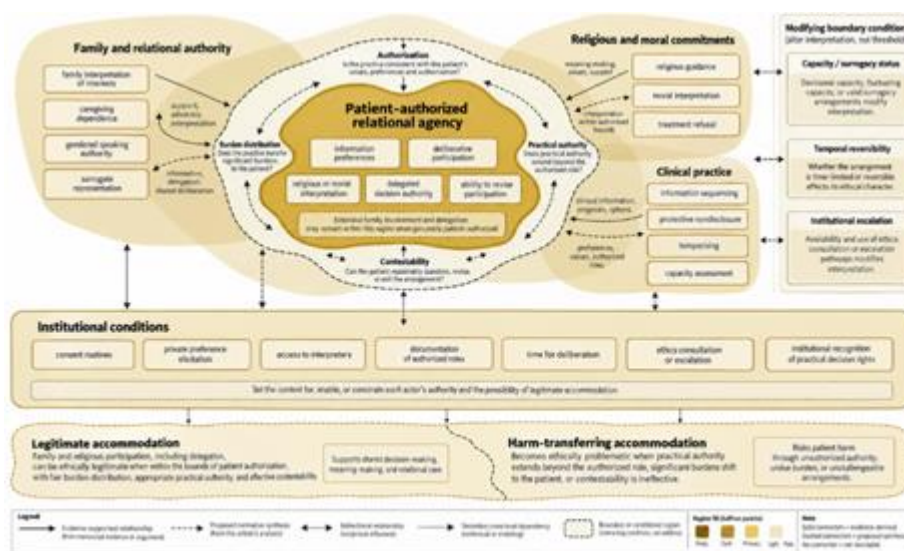
**Table 2.** Boundary conditions distinguishing culturally responsive accommodation from harm-transferring authority

| Condition           | Supportable accommodation                                          | Boundary warning                                             | Harm-transfer configuration                                                                                             | Required response                                            |
|---------------------|--------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| Authorization       | Family/religious role is patient-endorsed                          | Scope is ambiguous or outdated                               | Role persists despite objection or without credible authorization                                                       | Re-elicite preference and define scope                       |
| Burden distribution | Patient accepts burdens within their own values                    | Burdens become increasingly one-sided                        | Avoidable informational, psychological, decisional, or clinical costs fall on patient for others' preferred arrangement | Rebalance arrangement and reduce patient-facing harm         |
| Practical authority | Others advise, support, interpret, or exercise delegated authority | Informal actors begin controlling access, timing, or options | Others determine disclosure or treatment outside the authorized role                                                    | Restore patient decision rights or valid surrogate standards |
| Contestability      | Patient can revise or withdraw the arrangement                     | Contestation is possible but socially costly                 | Disagreement risks exclusion, abandonment, or loss of care                                                              | Provide confidential review, advocacy, or escalation         |
| Capacity and time   | Authority matches capacity; delay supports deliberation            | Capacity or urgency is insufficiently reassessed             | Kinship substitutes for capacity assessment or delay consolidates external control                                      | Reassess capacity, urgency, reversibility, and delegation    |

These conditions are not a numerical test. Their purpose is discriminating: accommodation becomes progressively harder to justify when authorization fails, burdens are transferred to the patient, practical authority

moves outside the authorized role, and contestability is ineffective.

**Figure 1** illustrates the relationships discussed above.



**Figure 1.** When accommodation changes ethical character: patient authorization, transferred burden, practical authority, and institutional contestability

### *Institutional implications*

Institutions should evaluate who actually controls information, access, timing, consent, and escalation rather than infer ethical adequacy from patient-centred language. Chinese community-health research shows that patient-centred care can coexist with professional and organizational power asymmetries [33]. Qualitative evidence from Malaysia likewise identifies communication, cultural expectations, paternalism, workforce constraints, and goals of care as barriers to shared decision making [34]. Systems should therefore make private preference elicitation feasible, record the scope of patient-authorized family roles, revisit that authorization when circumstances change, and provide escalation when family, religious, and clinical interpretations conflict.

A second institutional safeguard concerns role visibility. Clinical records often capture the presence of a relative without recording whether the patient wanted that person to receive information, interpret values, speak during

deliberation, or exercise delegated choice. Documentation should therefore distinguish presence from authorization and specify the function granted to the relative or religious adviser. That distinction makes later reassessment possible when prognosis, capacity, or family dynamics change. It also prevents an initially supportive role from silently expanding into control merely because the same person remains at the bedside. Education helps but cannot carry this responsibility alone. Shared decision-making training improves proximal outcomes such as knowledge, confidence, attitudes, and skills, while longer-term patient effects remain uncertain [35]. Training must therefore be coupled with time, interpreters, ethics support, and institutional permission to challenge unauthorized authority displacement. Responsibility should follow practical control: relatives, clinicians, and institutions have different duties because they control different parts of the arrangement.

**Table 3** summarizes the distinctions discussed above.

**Table 3.** Institutional responsibilities when accommodated roles affect patient authority

| Site of practical control | Preventive responsibility                            | Reassessment trigger                                         | Corrective responsibility                                                |
|---------------------------|------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------|
| Information access        | Establish how the patient wants information shared   | Patient seeks information being withheld                     | Restore access or renegotiate sequencing with patient                    |
| Family participation      | Record who is involved and in what role              | Support expands into de facto control                        | Clarify boundaries and renew authorization                               |
| Religious interpretation  | Enable advisers the patient recognizes               | Another person's interpretation is treated as binding        | Return interpretive authority to patient or valid surrogate process      |
| Treatment refusal         | Separate patient refusal from third-party refusal    | Relative blocks treatment despite retained capacity          | Re-establish direct clinician-patient decision process                   |
| Timing/contestation       | Provide deliberative time and a safe challenge route | Delay increases harm or disagreement cannot be voiced safely | Reassess urgency and use advocacy, senior review, or ethics consultation |

### **Results and Discussion**

The analysis rejects both solitary individualism and uncritical familism. Family and religious involvement can enlarge agency through meaning, trust, chosen dependence, and value clarification; the same arrangements become ethically different when the patient no longer determines the terms on which those relationships enter care. Family disagreement, delay, persuasion, or mismatch is not enough to establish harm. The stronger conclusion requires a convergence of authorization failure, practical authority displacement, significant patient-borne burden, and weak contestability.

A serious rival objection is that requiring patient authorization simply reinstates liberal individualism under relational language. That objection matters because patients may authentically wish others to decide, speak, or interpret values for them. The framework does not require continuous personal control. It requires authority over the terms of dependence: a patient may delegate extensively and still remain the author of the arrangement. The relevant failure occurs when delegation is inferred, expanded, or made practically irreversible without adequate evidence that the patient endorses it. This preserves strong forms of relational decision making while retaining a criterion for identifying imposed dependence.

The framework also weakens where the patient deliberately accepts burdens that clinicians might otherwise classify as avoidable. A patient may regard family harmony, religious fidelity, or protection of relatives from distress as goods worth personal cost. Such choices should not be redescribed as harm simply because clinicians would rank the burdens differently. The relevant question is whether the burdens are genuinely incorporated into the patient's own evaluative standpoint and whether refusal remains possible. This qualification is essential because a boundary analysis that treats all dependence as domination would reproduce the cultural insensitivity it is intended to correct.

The account also has clear limits. Much of the direct evidence comes from Chinese settings, with comparative evidence from Malaysia, Saudi Arabia, and other contexts. "Asian" cannot function as a unitary causal category. The framework is therefore a normative diagnostic for plural settings, not a description of characteristic Asian family behaviour and not an effectiveness model. It identifies what clinicians and institutions should examine when accommodation reallocates information, authority, time, and burden; it does not establish that any particular intervention will improve outcomes.

### Conclusion

Cultural accommodation is ethically defensible when it enables patients to act through relationships and commitments they recognize as their own. Its justification weakens when practical authority moves elsewhere while the patient bears unchosen informational, decisional, psychological, temporal, or clinical burdens. Respectful pluralism therefore requires neither solitary individualism nor presumptive family authority. It requires patient-authored relational agency, meaningful contestability, and institutional responsibility when accommodation becomes a mechanism for avoidable harm. This standard also leaves room for patients who choose deep dependence, provided that dependence remains theirs to endorse and is not institutionally imposed.

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