Asia-Pacific Journal of Oncology Nursing 11 (2024) 100586

Contents lists available at ScienceDirect

Asia-Pacific Journal of Oncology Nursing

journal homepage: www.apjon.org

Commentary

When western concept meets eastern culture: Exploring the impact of Confucianism on shared decision-making in China

Meiqi Meng [a,b,c,#], Xuejing Li [a,b,c,#], Junqiang Zhao [d,e,*], Yufang Hao [a,b,c,*]

[a] School of Nursing, Beijing University of Chinese Medicine, Beijing, China
[b] Beijing University of Chinese Medicine Collaborating Centre of Joanna Briggs Institute, Beijing, China
[c] Beijing University of Chinese Medicine Best Practice Spotlight Organization, Beijing, China
[d] Waypoint Research Institute, Waypoint Centre for Mental HealthCare, Ontario, Canada
[e] Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

ARTICLE INFO

Keywords
Confucianism
Shared decision-making
Chinese healthcare
Family harmony
Patient empowerment

ABSTRACT

This commentary explores how Confucian values influence shared decision-making (SDM) in Chinese healthcare, particularly in oncology. It highlights two key cultural foundations: **Family Harmony and Filial Piety**, which underscore the deep-rooted involvement of families in medical decision-making, often prioritizing collective decisions over individual autonomy; and **Ritual Governance**, which explains the cultural roots of power imbalances in healthcare relationships, where patients typically defer to the authority of doctors, and the role of nurses in SDM is limited. The paper argues that for SDM to be effectively integrated into Chinese healthcare, strategies must be adapted to align with cultural norms while encouraging patient empowerment. It also calls for a nuanced understanding of the evolving Chinese culture and emphasizes the need for global healthcare providers to develop cultural competence to better support Chinese patients, especially in the context of oncology, both domestically and internationally.

Introduction

Shared decision-making (SDM) is a health care decision-making model that emphasizes communication and information exchange between health care professionals (HCPs) and patients. The goal of SDM is to collaboratively develop the most appropriate treatment plan that aligns with patient's values and preferences.[1–3] This model has been widely adopted in Western health care systems and is considered a crucial approach to enhancing health care quality and patient satisfaction.[4,5] However, its acceptability and implementation can be significantly influenced by various cultural factors when introduced in non-Western contexts.[6]

China, with its long history and rich cultural heritage, possesses unique cultural and social structures that profoundly impact health care decision-making processes. Confucianism, a dominant force in traditional Chinese culture, is a philosophical system deeply embedded in Chinese society, shaping people's lifestyle, values, and behavior patterns. Confucianism advocates moral principles such as "仁为先 (benevolence first)" and "和为贵 (harmony as paramount)," emphasizing family responsibility, hierarchical order, respect for authority, and harmonious coexistence. These principles exert a significant influence on health care decision-making in China. However, research in this area remains limited.[7–10]

In the field of oncology, decision-making is inherently complex, involving a multitude of preference-sensitive choices that can profoundly impact both the quality and length of a patient's life.[11] Moreover, oncology decisions frequently involve issues such as patient autonomy, life-prolonging treatments, and palliative care, all of which are deeply influenced by cultural beliefs. Given these complexities, the integration of SDM into oncology clinical practice is not only essential but must be approached with careful consideration of cultural dynamics to ensure that treatment plans align with both medical best practices and the patient's cultural context. Furthermore, as Confucianism continues to influence Chinese communities worldwide, understanding its role in health care decisions is critical for HCPs globally. Therefore, this commentary aims to analyze how Confucianism shapes health care decision-making in China, particularly within oncology settings, explore its impact on SDM implementation, and propose practical suggestions. By understanding the influence of Confucian values in clinical environments, this article

* *Corresponding author*.
E-mail addresses: jzhao@waypointcentre.ca (J. Zhao), bucmnursing@163.com (Y. Hao).
# These authors contributed equally to this work.

https://doi.org/10.1016/j.apjon.2024.100586
Received 10 August 2024; Accepted 2 September 2024

offers practical suggestions for health care practitioners, not only in China but also for those in Western countries caring for Chinese patients or communities influenced by Confucian traditions.

Family harmony and filial piety: Cultural foundations of family involvement in decision-making

Confucian philosophy, as outlined in *The Book of Rites: The Great Learning,* emphasizes the principles of "修身, 齐家, 治国, 平天下" (self-cultivation, family harmony, state governance, and bringing peace to the world), with "齐家" (family harmony) being fundamental. This philosophy underscores the importance of familial unity and collective responsibility. In Chinese medical decision-making, this cultural framework prioritizes family involvement, granting them the right to be informed and to actively participate in decision making, thus establishing a norm where collective interests are placed above individual benefits. This cultural norm becomes particularly significant in oncology care, where decisions about disclosing a cancer diagnosis or choosing between aggressive treatments and palliative care often involve the family as key decision-makers.

Confucian Familialism, rooted in Confucian philosophy, highlights the crucial role of the family in health decisions in China.[12] In this model, family members often make treatment decisions alongside or even on behalf of patients, especially in severe illness like cancer. To protect patients from distress or extreme reactions upon learning their cancer diagnosis, health care providers sometimes advise families to withhold information and act as proxies for the patient. If a patient seeks treatment independently, doctors often defer their obligation to inform the patient, and instead transfer this duty to the family. When patients themselves request information about their condition, HCPs often adopt a passive stance on disclosure.[13] Unlike Western medical ethics, which emphasize patient autonomy, in Chinese oncology settings, health care providers frequently collaborate with families to withhold information and may allow the family to make final treatment decisions and sign consent forms. This practice stems from a cultural emphasis on respecting familial harmony by informing the family first about adverse diagnoses.[14]

Patients often trust their families to make decisions that are in their best interest, fearing that personal decision-making could lead to family conflicts. In this cultural context, involving family members in care and decision-making is seen as promoting familial harmony and happiness. Conversely, family discord is seen as a failure in personal development.[15] As a result, patients in China generally accept this family-centered approach, viewing it as adherence to the values of "family-centeredness" and "harmony as paramount."[16] Consequently, patients often do not feel their rights are violated if their condition and treatment plan are not fully disclosed to them, as long as their family is informed.[17]

Influenced by the Confucian concept of familial harmony, the notion of family responsibility often compels patients to prioritize collective family interests over personal needs. This tendency is particularly evident among female and elderly patients, who may subordinate their own health decisions to the perceived well-being of their families or children, aligning their choices with their culturally defined roles. For instance, Chinese women with breast cancer often prioritize their roles as mothers or wives over their individual identities, which significantly shapes their decision-making process. When considering breast reconstruction, these women frequently assess its necessity based on factors such as their family's financial situation or the potential impact on marital harmony, rather than personal preferences.[18] Similarly, elderly patients might prioritize minimizing the economic burden on their families when making medical decisions, especially when faced with choosing between aggressive treatments and less costly palliative care.[16]

The Confucian principle of "孝道" (filial piety) also exerts a strong influence on family members' treatment decisions, driven by moral obligations, societal expectations, and the opinions of relatives and friends. Confucius stated in *The Classic of Filial Piety*, "夫孝，德之本也" (Filial piety is the root of virtue), highlighting its fundamental role in ethical behavior. Filial piety emphasizes respect, obedience, and care for parents and elders, requiring children to make their utmost effort to care for and support the elderly. In the context of oncology, this manifests as a tendency among children to choose aggressive treatment options to prolong their parents' lives, even when palliative care might be a better option.[16] This can create significant challenges for health care providers, who must navigate the complex interplay between respecting filial obligations and promoting patient-centered care.

To effectively address the aforementioned challenges in SDM, it is essential to adopt a balanced approach that respects cultural differences. This balance should be rooted in China's unique cultural and ethical context, finding common ground that harmonizes the roles of family and individual in medical decision-making. The goal is to develop a model of SDM that respects the universal values of individual autonomy in the modern world while also reflecting the traditional role of the family in Confucian culture, which we termed as "Family Autonomy model."[17]

This model emphasizes the importance of involving the family in the SDM process to maximize the patient's benefit while respecting the patient's autonomy. It advocates for family participation to help ease the patient's burden and fulfill family responsibilities, while ensuring that the patient retains the primary right to make decisions regarding their own care, with family involvement contingent upon the patient's consent. When discrepancies arise between the patient's and family's decisions, open communication among family members is vital. Such dialogue serves to clarify the patient's concerns or preferences, and allows family members to share their perspectives. The ultimate goal of such communication is to achieve consensus in decision-making.

The health care team plays an instrumental role in mediating and facilitating reconciliation when value conflicts emerge. When consensus is difficult to achieve, the patient's autonomy should always take precedence. The family's well-meaning intentions or other motives should never override the patient's rights. In cases where the family's decisions clearly contradicts the patient's best interests, legal limitations on family authority should be enforced. Thus, the development of clear legal guidelines that delineate the boundaries of family involvement is essential to protect patient rights while respecting cultural values. Health care providers are responsible for overseeing and safeguarding these rights, ensuring that family authority does not unduly infringe upon them. The appropriate use of this framework is expected to promote the effective implementation of SDM in China.

Given the complexity of integrating cultural, legal, and ethical considerations into SDM, there is a pressing need for systematic theoretical development and empirical research to refine SDM models that align with the unique Chinese cultural context. This effort should also involve the development of culturally sensitive assessment tools that evaluate the degree of patient involvement desired in decision-making and the role of family in this process. Such tools would provide valuable insights for formulating care plans that are both culturally appropriate and ethically sound.

Additionally, it is worth reconsidering the scope of SDM, particularly for patients with severe illnesses in China. One critical question is whether family members should take on the role of primary decision-makers and, if necessary, withhold the diagnosis from the patient. This issue underscores the intricate relationship between SDM and truth-telling. Truth-telling is fundamental to SDM, but its acceptance varies widely across different cultures, affecting how actively patients can participate in SDM.[14,19] In certain cultural contexts, particularly where family involvement is the norm, engaging patients directly in decision-making may cause distress or overwhelm them. Therefore, the approach to SDM should be flexible, culturally sensitive, and tailored to the individual needs of each patient. Oncology nurses play a crucial role in navigating these complex dynamics by facilitating communication between patients and their families, and ensuring that care decisions reflect both the patient's and the family's values.[20] This requires not only a deep understanding of the patient's cultural background but also the ability to assess the patient's willingness and capacity to engage

in decision-making. Moreover, it is important to acknowledge that this is a highly complex issue, involving not only cultural considerations but also legal and ethical dimensions. Therefore, the current discussion represents a preliminary reflection rather than a definitive solution.

Ritual governance: Cultural roots of power imbalance in health care relationships

Ritual governance, or "礼治," is a fundamental aspect of Confucian thought, emphasizing ritual propriety and hierarchical order. As Confucius stated in the Analects, "君君臣臣，父父子子" (A ruler should act as a ruler, a minister as a minister, a father as a father, and a son as a son). This statement underscores the belief that individuals should fulfill their roles and responsibilities according to their social positions to maintain order and harmony in both society and the family. In contemporary society, this perspective translates into high respect for authority and a strong desire to maintain harmonious social relationships.

In health care decision-making, this emphasis on ritual and order often leads patients to adopt a passive role, which can hinder the implementation of SDM. Patients deeply influenced by Confucian values may exhibit considerable respect and deference toward doctors, relying heavily on their professional opinions. This deference can manifest as hesitancy in asking questions or expressing concerns, driven by a desire to avoid disrupting the perceived harmonious relationship with doctors. For instance, patients may sometimes consent to a recommended treatment plan without seeking additional opinions or thoroughly exploring other options, particularly when they perceive the physician's recommendation as the most authoritative choice. This compliance can create an asymmetry of information, where patients are not fully informed about all aspects of their medical decisions, ultimately affecting the quality of those decisions.

Moreover, the lack of questioning or feedback from patients might lead doctors to assume that patients and their families are satisfied with the information provided, perpetuating a cycle of inadequate communication. This dynamic can be further exacerbated by the paternalistic attitudes that some doctors, consciously or unconsciously, adopt in decision-making processes, perceiving SDM as a potential threat to their traditionally authoritative role. Conversely, nurses in Chinese society often occupy roles of lower authority due to institutional, cultural, and situational constraints, positioning them as subordinates relative to doctors. Professional stereotypes, such as "the doctor's mouth, the nurse's legs" and "mere injectors and medicine dispensers," further undermine their significance, hindering their capacity to play a significant role in SDM.[20]

To address the challenges posed by power imbalances in health care relationships, stemming from Confucian "Ritual Governance," the following strategies have been proposed to promote patient empowerment and strengthen the role of nurses in patient-centered care. Firstly, strengthening patient empowerment education is crucial to promoting equality in doctor-patient relationship. Hospitals can organize education seminars and distribute patient rights handbooks to boost patients' confidence in participating in medical decisions. Secondly, patients should be encouraged to express themselves candidly while respecting traditional etiquette. Promoting open communication is essential in ensuring that patients fully understand their treatment options and feel comfortable discussing their concerns. In this context, health care providers need to be trained to recognize and respect the cultural nuances that influence patient behavior and communication styles. Thirdly, establishing patient support systems with decision support tools can help patients better comprehend and evaluate medical information during the decision-making process. Such tools can help demystify complex medical information, making it more accessible and understandable for patients, empowering them to make well-informed decisions. Additionally, introducing neutral third parties, such as medical consultants, can provide objective advice to patients, reducing their fear of challenging medical authority and promoting a more balanced dialogue between patients and health care providers.[21]

Furthermore, the role of nurses in oncology nursing, where the patient-nurse relationship is often central to care, should be expanded to enhance patient-centered care. Empowering nurses with greater decision-making authority could lead to more effective care by leveraging their strengths in understanding patient psychology and daily interactions. To achieve this, efforts should be made through media campaigns and policy protections to dismantle stereotypes about nurses. For example, recognizing the vital role nurses play in patient care and decision-making can transform them into key players in promoting SDM. The currently piloted policy in China granting nurses independent prescription rights[22] could potentially allow them to assume more autonomous and multifaceted role, streamlining the SDM process and facilitating its implementation in clinical practice.

However, as China's population becomes increasingly globalized, the application of Confucian values within different cultural environments grows more complex. It is crucial to adopt a dialectical and dynamic perspective when discussing how HCPs worldwide, including nurses, scholars, and administrators, can integrate Confucian thought into caring for Chinese patients. This integration is not just about deeply understanding the core principles of Confucianism but also about continually adapting and reflecting on these principles to suit diverse cultural contexts. According to Kim et al.'s cross-cultural adaptation theory,[23] cultural adaptation is a gradual and dynamic process. In nursing practice, HCPs learning and internalizing Confucian thought may experience stages of cultural shock, adjustment, and integration. This process aligns with the anthropological understanding of cultural adaptation, which is not a simple cultural transplant but a dynamic process achieved through continuous reflection and practice. Thus, in practice, HCPs must be vigilant against the pitfalls of cultural essentialism. They should not simplistically assume that all Chinese patients strictly adhere to Confucian traditions. Instead, a culturally relativistic stance is required, recognizing that each patient's values and behaviors are shaped by multiple factors, including but not limited to cultural background, education, personal experiences, and social environment. Therefore, while understanding and respecting the core values of Confucianism, health care providers must also respect individual differences and provide more personalized and appropriate care.

Conclusions

In conclusion, while the integration of SDM into medical practice is a burgeoning global trend, its successful implementation across different cultural contexts necessitates careful adaptation to the unique values, norms, and expectations of the patient population. In China, the influence of Confucian philosophy—particularly the principles of familial harmony, filial piety, and ritual governance—profoundly shapes the SDM process, requiring culturally sensitive strategies to ensure genuine patient involvement in decision-making. Such a culturally attuned approach not only enhances the quality of health care but also more effectively addresses the nuanced emotional and cultural needs of oncology patients and their families.

Moreover, Chinese culture is a complex and multifaceted system that cannot be fully explained from a single lens. While this commentary emphasizes the impact of Confucian thought on family involvement in decision-making and the power imbalance in health care relationships, it represents only one aspect of the broader cultural influences at play. Future research should aim to construct a comprehensive analytical framework that captures the diverse cultural factors shaping medical decision-making in China. This would enable a more in-depth and nuanced analysis of the challenges and opportunities, providing valuable insights for effectively implementing SDM in oncology nursing within China.

Furthermore, as the Chinese population becomes more globally dispersed, it is crucial to recognize the broader implications of Confucian values in health care decision-making. For Western health care practitioners, developing cultural competence in Confucian principles is essential not only to provide culturally appropriate oncology care but

also to build trust and foster understanding with Chinese patients. By bridging cultural gaps through this understanding, health care providers can ensure that Chinese patients receive care that respects their cultural heritage while promoting their active participation in SDM, regardless of their geographical location.

CRediT authorship contribution statement

Meng Meiqi: Conceptualization, Writing - Original Draft. **Li Xuejing:** Conceptualization, Writing - Original Draft. **Hao Yufang:** Supervision, Writing - Review & Editing. **Zhao Junqiang:** Supervision, Writing - Review & Editing. All authors had full access to all the data in the study, and the corresponding author had final responsibility for the decision to submit for publication. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

Ethics statement

Not required.

Funding

This study received no external funding.

Declaration of competing interest

The authors declare no conflict of interest.

Declaration of generative AI and AI-assisted technologies in the writing process

The authors did not use any generative AI tools or services during the preparation of this work.

References

1. Elwyn G, Frosch D, Thomson R, et al. Shared decision making: a model for clinical practice. *J Gen Intern Med*. 2012;27(10):1361–1367. https://doi.org/10.1007/s11606-012-2077-6.
2. Legare F, Adekpedjou R, Stacey D, et al. Interventions for increasing the use of shared decision making by healthcare professionals. *Cochrane Database Syst Rev*. 2018;7:CD006732. https://doi.org/10.1002/14651858.CD006732.pub4.
3. Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or It takes at least two to tango). *Soc Sci Med*. 1997;44(5):681–692. https://doi.org/10.1016/S0277-9536(96)00221-3.
4. Pieterse AH, Finset A. Shared decision making—much studied, much still unknown. *Patient Educ Couns*. 2019;102(11):1946–1948. https://doi.org/10.1016/j.pec.2019.09.006.
5. Allen M. The value of values: shared decision-making in person-centered, value-based oral health care. *J Public Health Dent*. 2020;80(Suppl 2):S86–S88. https://doi.org/10.1111/jphd.12394.
6. Li XJ, Zhao JQ, Zhang XY, et al. The concept and clinical implementation status of Ottawa decision support framework—a scoping review. *Chin J Nurs*. 2022;57(6):756–762. https://doi.org/10.3761/j.issn.0254-1769.2022.06.017.
7. Chen W, Zhang H, Xu M, Huang R. Differences in shared decision-making: the East-West divide. *BMJ Evid Based Med*. 2023. bmjebm-2023-112451. https://doi.org/10.1136/bmjebm-2023-112451.
8. Alden DL, Friend J, Lee PY, et al. Who decides: me or we? Family involvement in medical decision making in Eastern and Western countries. *Med Decis Making*. 2018;38(1):14–25. https://doi.org/10.1177/0272989X17715628.
9. Gao S, Corrigan PW, Qin S, Nieweglowski K. Comparing Chinese and European American mental health decision making. *J Ment Health*. 2019;28(2):141–147. https://doi.org/10.1080/09638237.2017.1417543.
10. Yang Y, Qu T, Yang J, Ma B, Leng A. Confucian familism and shared decision making in end-of-life care for patients with advanced cancers. *Int J Environ Res Public Health*. 2022;19(16):10071. https://doi.org/10.3390/ijerph191610071.
11. Politi MC, Studts JL, Hayslip JW. Shared decision making in oncology practice: what do oncologists need to know? *Oncologist*. 2012;17(1):91–100. https://doi.org/10.1634/theoncologist.2011-0261.
12. Li DP, Zuo W. Confucian familism in medical decision-making. *Acad Forum*. 2016;39(8):18–22. https://doi.org/10.16524/j.45-1002.2016.08.004.
13. Yang M. Survey and analysis of the implementation of informed consent by clinical nurses. *J Nurs*. 2007;22(3):61–63. https://doi.org/10.3969/j.issn.1001-4152.2007.03.033.
14. Zhang HS, Yang LL. Familial model of cancer diagnosis disclosure. *Med Philos*. 2020;41(9):17–19. 33. https://doi.org/10.12014/j.issn.1002-0772.2020.09.05.
15. Li Q. *The Role of Family in Medical Decision-Making [Doctoral Dissertation]*. Jinan, China: Shandong University; 2014. doi: Not available.
16. Wang L. *Ethical Issues in the Contemporary Chinese "family Joint Decision-Making Model" in Healthcare [Master's Thesis]*. Nanjing, China: Southeast University; 2022. doi: Not available.
17. Wang L. The issue of autonomy in medical decision-making under Confucian culture. *Med Soc*. 2022;35(1):26–30. 35. https://doi.org/10.13723/j.yxysh.2022.01.006.
18. Li X, Meng M, Yang D, et al. "All about the value?" Decisional needs of breast reconstruction for breast cancer patients in the Chinese context: a mixed-methods study. *Patient Educ Couns*. 2024;120:108102. https://doi.org/10.1016/j.pec.2023.108102.
19. Searight HR, Gafford J. Cultural diversity at the end of life: issues and guidelines for family physicians. *Am Fam Physician*. 2005;71(3):515–522. doi: Not available.
20. Li XJ, Zhang XY, Zhou YJ, Hao YF. Progress in the research on the roles and functions of nurses in cancer-related shared decision-making. *J Nurs Contin Educ*. 2021;36(19):1808–1812. https://doi.org/10.16821/j.cnki.hsjx.2021.19.016.
21. Qi YH, Ju ZB, Shao HF, et al. Social work intervention in shared decision-making: bridge issues and platform exploration. *Chin Med Ethics*. 2022;35(9):959–964. 970. https://doi.org/10.12026/j.issn.1001-8565.2022.09.06.
22. Kang Y, Chen ZY, Chen X. Current status and strategy exploration of nurse prescribing rights. *J Nurs Contin Educ*. 2024;39(10):1029–1034. https://doi.org/10.16821/j.cnki.hsjx.2024.10.004.
23. Kim Young Y. *Becoming Intercultural: An Integrative Theory of Communication and Cross-Cultural Adaptation*. Thousand Oaks, CA: SAGE Publications, Inc.; 2001. https://doi.org/10.4135/9781452233253.