

CHAPTER 8

Culture and Consent in Clinical Care

*A Critical Review of Nursing and
Nursing Ethics Literature*

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ABSTRACT

The duty to obtain informed consent carries significant weight within the dominant normative frameworks for healthcare research and clinical care. Informed consent is seen as an important expression of a patient's freedom of choice in healthcare decision-making. However, some clinicians and researchers have raised concerns that the implementation of a normative framework in clinical care that assigns considerable moral weight to patient autonomy and informed consent for all patients, regardless of their cultural identities and values, might be incompatible or in tension with culturally congruent care. The authors of this chapter conducted a review of 83 peer-review nursing and nursing ethics articles that focus on cultural identity and informed consent for treatment within clinical practice settings. The purpose of this review is to identify salient themes in nurses' characterizations of the influence of cultural identity and values on clinicians' and patients' perceptions of informed consent in clinical contexts, as well as of elements of the consent process such as truth-telling and decisional authority. The authors identify and describe multiple themes running

through this literature, and provide a critical analysis of these characterizations and ways to rethink how cultural considerations modulate communication of clinical information and affect clinicians' interpretation of patient autonomy and informed consent.

INTRODUCTION

The duty to obtain informed consent carries significant weight within the dominant normative frameworks for medical research and clinical care. From the perspective of many bioethicists, nurses, and clinical researchers, a patient's informed consent to treatment and care is an important expression of freedom of choice in healthcare decision-making (Faden & Beauchamp, 1983; Grace, 2018; Wear, 1998). Working to ensure that patients are accurately informed and free to make their own decisions is an important way in which clinicians promote and protect patient autonomy. Traditionally, four elements are considered necessary to ensure that clinicians obtain informed consent; namely, patient competence for making healthcare decisions, full and accurate disclosure of diagnostic, prognostic, and treatment information to the patient, patient understanding of this information, and a voluntary decision by the patient. These conditions, it is commonly argued, must be met in order to obtain a patient's informed consent, though some bioethicists also underscore the importance of relationships of trust between clinicians and patients for the consent process (O'Neill, 2002).

Some bioethicists, clinicians, and researchers have raised questions regarding the compatibility of informed consent, and the principle of respect for patient autonomy broadly, with recognition and respect for cultural identities and traditions that do not give prominent places to these values (e.g., Candib, 2002; Levine, 1991). This concern often arises when considering the implementation of a normative framework in clinical care that assigns considerable moral weight to patient autonomy and informed consent for all patients, regardless of their cultural identities and values. One might be concerned that this amounts to a sort of normative imperialism, unfairly burdening patients who do not hold a Western conception of individual autonomy or who are accustomed to making important clinical decisions with friends, families, or their broader communities.

This burden might be especially acute when it involves the communication of diagnostic or prognostic information that is potentially distressing. For example, patients who come from cultural backgrounds in which families or prominent community members are the primary decision-makers about serious medical matters, or in which direct communication about such information is considered inappropriate or harmful, might experience an array of negative

psychosocial effects. Thus, any discussion of the role of informed consent in clinical care, as well as of elements of informed consent such as truth-telling and decisional responsibility, must include consideration of patients' cultural identities, values, and practices.

The goal of this critical review is twofold (Grant & Booth, 2009). First, the review aims to provide a broad overview of how the nursing and nursing ethics literature characterizes the influence of cultural identity and values on clinicians' and patients' perception of informed consent in clinical contexts, as well as on elements of the consent process such as truth-telling and decisional authority. Second, the review provides both a critical analysis of this characterization and ways to rethink how cultural considerations modulate communication of clinical information and affect clinicians' interpretation of patient autonomy and informed consent.

METHOD

We conducted a review of the peer-review nursing and nursing ethics literature in April 2018, to identify articles that focus on cultural identity and informed consent for treatment within clinical practice settings. We conducted the literature search utilizing CINAHL and PubMed databases. We restricted the search to peer-reviewed, English-language articles published between 2007 and 2018 (roughly one decade), and further limited the search through the use of keywords selected in consultation with the head of research engagement at a university library.

The following keywords limited the search of the CINAHL database:

((MH "Cultural Competence") OR (MH "Culture+") OR (MH "Religion and Religions+") OR (MH "Transcultural Care") OR Cultur* OR Religion*)
 AND
 ((MH "Consent+") OR (MH "Patient Autonomy") OR (MH "Treatment Refusal") OR Consent* OR "Patient Autonomy" OR "Treatment Refusal" OR "Patient autonomy")
 AND
 (Nurs* OR (MH "Nurses+") OR (MH "Nursing Care+") OR (MH "Nursing Role"))

The following keywords limited the search of the PubMed database:

("Informed Consent"[Mesh] OR "Personal Autonomy"[Mesh] OR "Treatment Refusal"[Mesh] OR Consent*[ot] OR Consent*[tiab] OR "Patient Autonomy"[ot] OR "Patient Autonomy"[tiab] OR "Treatment Refusal"[ot] OR "Treatment Refusal"[tiab])

AND
 (“Culture”[Mesh] OR “Religion”[Mesh] OR “Transcultural Nursing”[Mesh]
 OR Cultur*[ot] OR Cultur*[tiab] OR Religion*[ot] OR Religion *[tiab])
 AND
 (Nurs*[ot] OR Nurs*[tiab] OR “Nurses”[Mesh] OR “Nursing Care”[Mesh]
 OR “Nursing”[Mesh])
 AND
 (bioethics[sb] OR jsubsetn[text])

The searches identified 423 citations, of which we identified 356 as unique. We uploaded these citations, and any accompanying abstracts were uploaded to Covidence for screening.

Through Covidence, we employed a four-stage screening process. The first screening stage consisted of independent review of all 356 article abstracts. For citations that were not accompanied by an abstract, we pulled and reviewed the full text. We independently voted “Yes,” “Maybe,” or “No” for inclusion of each article in the review. The second screening stage involved discussion and resolution of any discrepancies in first-stage voting. At the end of the second screening stage, we excluded 213 citations, thereby reducing the number of citations for additional screening to 143. We uploaded the full text of these 143 citations to EndNote X7 for the next screening stage.

During the third screening stage, we independently reviewed 143 full-text articles. We agreed on the following inclusion criteria:

- An article must substantively discuss patient informed consent for treatment or a constitutive aspect of patient informed consent for treatment (e.g., clinician truth-telling; patient understanding)
- An article must substantively discuss the relation between patient informed consent for treatment and cultural identity or cultural issues
- An article must be authored or coauthored by a nurse, or contain explicit implications for nursing practice

We agreed to exclude any article that did not clearly meet these three criteria, including articles primarily focused on pediatric care, surrogate-decision-making, and informed consent in research contexts. After reviewing each of the 143 remaining articles, we independently voted “Include” or “Exclude” through Covidence for the review. At the fourth screening stage, we discussed and resolved any discrepancies that resulted from the voting. At the conclusion of the fourth screening stage, 83 articles remained for the review (see Figure 8.1).

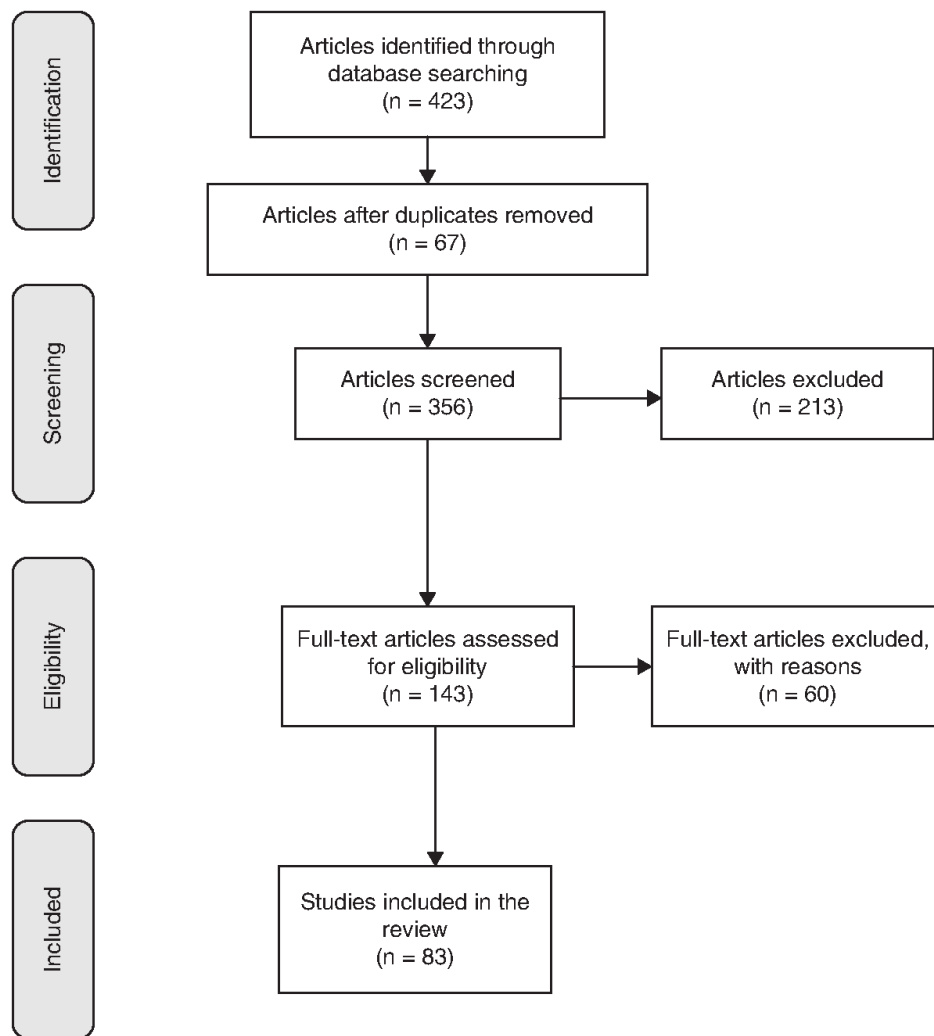


FIGURE 8.1 PRISMA 2009 flow diagram: Culture and consent in clinical care: A critical review of the nursing and nursing ethics literature. From “Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement,” by D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA group, 2009, *PLoS Med*, 6(6), e1000097. <http://dx.doi.org/10.1371/journal.pmed1000097>

For more information, visit www.prisma-statement.org.

RESULTS

We reviewed 83 peer-reviewed articles from nursing and nursing ethics journals. Of these 83 articles, 17 were quantitative studies (see Table 8.1), 26 were qualitative studies (see Table 8.2), and 40 are conceptual, ethics, or case-based discussion. Following Halkoaho et al. (2016), we classified this last group as “theoretical” articles (see Table 8.3).

TABLE 8.1
Selected Quantitative Studies (n = 17)

Author/Year	Aim	Method	Location
Bentwich, Dickman, and Oberman (2017)	To explore perspectives of different cultural groups on human dignity and autonomy of dementia patients	Questionnaire study (n = 197) of caretakers	Israel
Bülow et al. (2012)	To explore differences in end-of-life decisions and respect for patient autonomy among clinicians who are religious and those who are only affiliated with a religion	Questionnaire (n = 1,268) of clinicians and patients	Sweden, The Netherlands, UK, Czech Republic, Israel, Portugal
Carolan, Steele, and Margetts (2010)	To examine attitudes and beliefs of multiethnic sample of women with gestational diabetes	Questionnaire study (n = 143) of patients with gestational diabetes	Australia
Chang et al. (2008)	To identify how older Korean people seek information and desire to participate in healthcare decisions	Questionnaire study (n = 165) of men and women aged 65 or older	South Korea
Chima (2013)	To determine whether the quality of informed consent obtained by clinicians in South Africa is consistent with international ethical standards and local regulations	Questionnaire study (n = 946) of clinicians	South Africa
Clark (2007)	To examine informed consent process from perspectives of intensive care patients	Secondary analysis of quantitative data	N/A
Demirsoy, Elcioglu, and Yildiz (2008)	To investigate nurses' and patients' attitudes regarding truth-telling and patient needs and wants regarding information about diagnosis and prognosis	Survey study (n = 465) of nurses and patients	Turkey

Gorden et al. (2010)	To assess the extent of training in culturally and linguistically competent care in US transplantation centers	Survey study ($n = 280$) of kidney transplant administrators	United States
Holt et al. (2009)	To examine the effectiveness of spiritually based education on informed decision-making about prostate cancer screening among African American men	Survey study ($n = 49$) of African American men with no prostate cancer diagnosis	United States
Ingravallo et al. (2017)	To investigate nurses' views and practices in providing information to patients in a global context	Cross-sectional study ($n = 295$) of Korean and Italian nurses	Italy, Korea
Ito, Tanida, and Turale (2010)	To explore perspectives of Japanese patients their families on participation in ethical decision-making during hospitalization	Descriptive survey study ($n = 169$) of patients and family members	Japan
Lillie et al. (2014)	To characterize the perspectives of partners of patients with breast cancer in treatment decisions and describe racial and ethnic differences in decisional outcomes	Cross-sectional survey study ($n = 517$) of partners of patients with breast cancer	United States
Lopez-McKee, McNeill, Bader, and Morales (2008)	To examine the level of cancer fatalism and other behavioral determinants in Mexican American women identified as regular or infrequent mammography screeners	Cross-sectional, descriptive study ($n = 68$) of Mexican American women	United States
Lowther et al. (2014)	To assess the effectiveness of a nurse-led palliative care intervention for HIV positive patients on antiretroviral therapy: recruitment, refusal, randomisation and missing data	Randomized control trial and interview study ($n = 120$) of HIV positive patients on antiretroviral therapy	Kenya

(Continued)

TABLE 8.1
Selected Quantitative Studies (n = 17) (Continued)

Author/Year	Aim	Method	Location
Neary, Cahill, Kirwan, Kiely, and Redmond (2008)	To examine the impact a signature on a consent form has on patients' perception of the quality of the informed consent process	Randomized, prospective clinical trial of (<i>n</i> = 37) outpatient clinic patients	Ireland
Peretti-Watel et al. (2008)	To assess French district nurses' attitudes toward terminally ill patients' autonomy	Questionnaire study (<i>n</i> = 602) of French district nurses	France
Valente (2010)	To investigate cultural influences on HIV patients' preferences for end-of-life care	Survey study (<i>n</i> = 95) of veterans living with HIV disease	United States

TABLE 8.2
Selected Qualitative Studies (n = 26)

Author/Year	Aim	Method	Location
Alpers (2018)	To examine factors that build trust or create distrust between healthcare professionals and ethnic minority patients	Interview study (n = 10) of immigrant patients	Norway
Bentwich, Dickman, and Oberman (2017)	To explore differences among caretaker attitudes toward patient dignity and autonomy in dementia care	Interview study (n = 20) of caretakers	Israel
Davies Elwyn, Papadopoulos, Fleming, and Williams (2009)	To explore how clinicians view patient decision-making from an ethical perspective	Interview study (n = 13) of clinicians	UK
Davoudi, Nayeri, Zokaei, and Fazeli (2017)	To examine processes of and challenges to informed consent in the emergency ward	Field work, participant observation, and interview study of clinicians	Iran
Fernández-Sola et al. (2012)	To examine participation and responsibility assigned to nurses in end-of-life decision-making according to the <i>Rights to and Guarantee of Dignity for the Individual During the Process of Death Act</i>	Discourse analysis	Spain
Fitch, Beaudoin, and Johnson (2013)	To gain increased understanding about dialogue between cancer care clinicians and cancer patients regarding the topic of sexuality	Interview study (n = 44) of clinicians	Canada
Goodman, Edge, Agazio, and Prue-Owens (2015)	To describe cultural factors that impact military nursing care for Iraqi patients	Focus groups (n = 15) of military nurses and licensed nurses	Iraq

(Continued)

TABLE 8.2
Selected Qualitative Studies (n = 26) (Continued)

Author/Year	Aim	Method	Location
Granero-Molina, Fernández-Sola, and Aguilera-Manrique (2009)	To present and discuss findings of application of sociolinguistic SPEAKING model to informed consent documents for laparoscopic surgery	Documentary analysis	Spain
Harrison, Logar, Le, and Glass, (2016)	To identify global health ethics issues in professional training with resource-limited regions	Focus groups and one interview (n = 18) of healthcare professionals	United States
Jafree, Zakar, Fischer, and Zakar (2015)	To identify aspects of the hidden curriculum that encourage ethical violations	Interview and focus group study (n = 42)	Pakistan
Lee, Li, Arai, and Puntillo (2009)	To describe a formal process of translating documents for use by research participants and patients	Translation process utilizing 3-point Flaherty scale	United States
Lee, Lee, Kong, Kim, and Kim (2009)	To investigate nurses' perceptions of informed consent and role in improving consent processes in Korea	Interview study (n = 12) of nurses	Korea
Lin, Huang and Chen (2016)	To discover reasons for family involvement in adult patients' decision-making about surgery	Interview study (n = 24) of family members and surgery patients	Taiwan
Lowther et al. (2014)	To assess the effectiveness of a nurse-led palliative care intervention for HIV positive patients on antiretroviral therapy: recruitment, refusal, randomisation and missing data	Randomized control trial and interview study (n = 120) of HIV positive patients on antiretroviral therapy	Kenya

McLaughlin, Elahi, Ciesielski, and Pomerantz (2016)	To explore attitudes of Muslims living in the United States toward long-term care decision-making	Interview study ($n = 167$) of members of Muslim mosques	United States
Oliveira and Oliveira (2013)	To investigate factors that interfere with follow-up of treatment for hypertensive patients	Interview study ($n = 25$) of hypertensive patients	Brazil
Rio-Valle et al. (2009)	To explore clinicians' perspectives on communication of terminal prognosis to patients	Interview study ($n = 42$) of clinicians	Spain
Sialubanje, Massar, Hamer, and Ruiter (2015)	To identify reasons that women give birth at home and seek the assistance of traditional birth attendants	Focus group and interview study ($n = 130$) of women of reproductive age	Zambia
Sneesby, Satchell, Good, and van der Riet (2011)	To obtain information to support palliative care healthcare workers in end-of-life care for Sudanese patients	Focus group study ($n = 15$) of members of a Sudanese community in Australia	Australia
Sullivan (2017)	To examine informed consent and disclosure practices among Japanese healthcare professionals	Interview study ($n = 15$) of Japanese healthcare professionals	Japan
Sun, Hsia, and Sheu (2008)	To understand patterns and interpretations of women's experiences of amniocentesis in Taiwan	Interview study ($n = 20$) of women 35 years of age or older	Taiwan
Susilo, van Dalen, Chenault, and Scherpbier (2014)	To investigate clinicians' views about the informed consent process and nurse' roles in this process	Questionnaire study ($n = 745$) of clinicians	Indonesia
Susilo et al. (2013)	To investigate clinicians' views about the informed consent process and nurse' roles in this process	Focus group study ($n = 27$) of hospital managers	Indonesia

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TABLE 8.2
Selected Qualitative Studies (n = 26) (Continued)

Author/Year	Aim	Method	Location
Toda, Sakamoto, Tagaya, Takahashi, and Davis (2015)	To explore implications of Japanese psychiatric nurses' decisions to intervene as patient advocates	Interview study ($n = 21$) of nurses	Japan
Watts et al. (2017)	To identify oncology clinicians' challenges in communicating to patients from minority backgrounds	Interview study ($n = 38$) of oncology clinicians	Australia
Zhang, Wong, and Zheng (2017)	To explore the experience of rectal cancer patients who will undergo colostomy surgery	Interview study ($n = 18$) of patients with diagnosis of primary rectal cancer and expectation of colostomy surgery	China

TABLE 8.3
Selected Theoretical Studies (n = 40)

Author/Year	Aim
Baeke, Wils, and Broeckaert (2011)	To explore Jewish perspectives on withholding and withdrawing life-sustaining treatment
Barwell (2011)	To examine issues surrounding truth-telling in cancer care
Blackman (2009)	To discuss importance of role of nurses in diminishing negative effects of perceived racism felt by patients
Braithwaite, Chichester, and Reid (2010)	To examine issues in care for Jehovah's Witness patients and multicultural approaches to care
Brown (2014)	To explore impact of religion and culture on truth-telling and futile treatment in end of life care
Brownie, Horstmanshof, and Garbutt (2014)	To identify factors that impact residents' transition and adjustment to, and experience of, long-term care
Browning (2009)	To address key issues in spiritual assessment in end-of-life care
Calloway (2009)	To examine applicability of informed consent requirements from a multicultural perspective
Chater and Tsai (2008)	To examine the notion of truth telling and its place in nursing care for patients from minority cultures
Chichester (2007)	To provide information on cultural and religious groups to nurses seeking consent for perinatal autopsy
Clabots (2012)	To identify strategies to overcome barriers to end-of-life discussions in acute care
Clancy (2013)	To consider how cultural awareness and sensitivity relate to genetics in nursing practice
Collins et al. (2018)	To synthesize nursing knowledge regarding cultural perspectives of end-of-life care and advance care planning among African Americans
Cooper, Chidwick, Cybulski, and Sibbald (2015)	To demonstrate effectiveness of the <i>Checklist for meeting Ethical and Legal Obligations</i> in the intensive care unit
Coyle (2014)	To provide background for addressing dilemmas in palliative and end-of-life care from a Western ethical perspective
Doolen and York (2007)	To describe cultural differences that nurses might encounter in end-of-life care

(Continued)

TABLE 8.3
Selected Theoretical Studies (n = 40) (Continued)

Author/Year	Aim
Druml et al. (2016)	To provide a critical summary of the ethics of artificial nutrition and hydration therapy
Effa-Heap (2009)	To examine legal and consent issues surrounding blood transfusion in Jehovah's Witness patients
Evans and Ndirangu (2009)	To provide an overview of provider-initiated HIV testing and counseling policy guidance and examine its implication for nursing in sub-Saharan Africa
French and Narayanasamy (2011)	To develop a discourse on the ethics of prayer as a spiritual intervention in clinical care
Greenberger (2011)	To describe how ethical issues in healthcare are approached within a Jewish bioethical framework
Guyen (2010)	To examine critically the "cultural incompatibility" argument about disclosure of information to cancer patients in Turkey
Hodge (2015)	To describe and evaluate rationales for administering spiritual assessment in clinical care
Johnstone and Kanitsaki (2009)	To explore cross-cultural considerations in end-of-life care planning
Kidd, Colbert, and Jatoi (2015)	To describe issues related to mammography screening in young African American women
Lech (2008)	To consider how sexual assault nurse examiners can provide culturally competent care to victims of sexual assault
Leever (2011)	To explore the moral normative foundations of cultural competence and their relationship to patient autonomy and welfare
Ling, Yu, and Guo (2017)	To provide ethical guidance to Chinese nurses regarding truth-telling to patients about terminal illness
Marrone (2016)	To examine the concept of informed consent in care for Saudi patients and families in the United States
Mor and Oberle (2008)	To explore the moral direction of Jewish law to women regarding decision-making about genetic testing
Narruhn & Schellenberg (2013)	To examine how care ethics can be applied to a cross-cultural reproductive dilemma

(Continued)

TABLE 8.3
Selected Theoretical Studies (n = 40) (Continued)

Author/Year	Aim
Ortiz and Casey (2017)	To explore a case in which cultural beliefs impact a patient's ability to exercise autonomy
Padela Malik, Curlin, and De Vries (2015)	To analyze two accounts of surrogate decision-making with little input sought from patient
Pugh (2014)	To discuss the ethical and legal issues surrounding care for dying patients in Australia
Rising (2017)	To examine history and assumptions of preference for truth-telling in the United States, and to introduce the concept of cultural humility
Sagbakken, Frich, Bjune, and Porter (2013)	To consider ethical implications of directly observed treatment of in a cross-cultural perspective
Starr (2015)	To explore legal considerations when a patient refuses treatment on cultural or religious grounds
Thompson (2011)	To describe cultural differences regarding truth-telling to patients
Wilson et al. (2014)	To examine understandings of autonomy and choice in palliative and end-of-life care
Zalon, Constantino, and Andres (2008)	To illustrate ethical and practical conflicts nurses might experience in critical care

Through our review and analysis of these 83 articles, we extrapolated six dominant themes in studies and discussions of the influence of cultural identity and values on perceptions of informed consent and its constitutive elements:

- (1) cross-cultural applicability of dominant conceptions of patient autonomy and informed consent
- (2) culture and barriers to informed consent in clinical contexts
- (3) influence of culture on clinicians' perspectives on patient autonomy and informed consent
- (4) influence of culture on patients' perspectives on patient autonomy and informed consent
- (5) culturally appropriate communication
- (6) professional codes of ethical conduct

Theme 1: Cross-Cultural Applicability of Dominant Conceptions of Patient Autonomy and Informed Consent

A recurring theme raised in the peer-review nursing and nursing ethics literature is the degree to which dominant conceptions of patient autonomy and the ethical requirement to obtain informed consent fit within cultural value systems in which individual autonomy and decision-making do not occupy prominent places. Some clinicians abstractly suggest that there is incompatibility between “Western,” individualistic notions of individual autonomy and some cultural traditions. One frequently finds expression of such doubts over their compatibility like the following:

“The Western traditions based on concepts of individual autonomy, informed consent, and truth telling do not fit all cultures and societies.” (Coyle, 2014, p. 6).

“Respecting patient choices may be foreign and even antithetical to patients and families from cultural groups who do not share or accept the principles and value assumptions that underpin much of mainstream Western bioethics discourse on end-of-life decision making.” (Johnstone & Kanitaski, 2009, p. 407)

“Is the Anglo-American ethic of individual autonomy the right value that should be incorporated into other cultural belief systems in order to elevate their ethical standards?” (Calloway, 2009, p. 69)

Other clinicians and researchers are more specific with regard to where the conflict of values possibly lies. Some locate the potential tension arising from Western medicine’s commitment to disclosure of medical information directly to the patient (Clabots, 2012; Clark, 2007; Doolen & York, 2007; Rising, 2017; Watts et al., 2017). Insofar as informed consent is typically conceptualized as involving accurate disclosure of information to the patient, there is potential value conflict in cases in which patients and their families are accustomed to family- or community-oriented disclosure and decision-making. Others suggest that Western perceptions of urgency in care undergird the assumption that a patient wants diagnostic and prognostic information in order to make a decision quickly about care. However, patients who do not identify with this Western notion of time might not perceive a similar urgency in deciding how to respond to such information and resolve a health condition (Clark, 2007).

Researchers suggest that in some cultures individuals are shielded from information about terminal diagnosis or end-of-life care planning. Instead, within these cultures there is a tendency to defer to the patient’s

family or cultural leaders regarding decisions about both care planning and communication of health information to a patient. For example, researchers found that families of Taiwanese and Chinese cultural backgrounds often seek to make clinical decisions for their loved-ones, or protect them from potential harm of distressing diagnoses, such as terminal cancer, by concealing that information (Lin, Huang, & Chen, 2017; Ling et al., 2017). In the context of end-of-life care, African American patients often express a desire to forego control over clinical decision-making, delegating authority over care to family members, close friends, or community leaders (Collins et al., 2018). Researchers have also observed that some distinct cultures, including Somali and Mexican-American cultures, tend to see important decision-making in clinical contexts to be a family-oriented or communitarian process, as opposed to the more individualistic process that seems tied to the ethical requirement to obtain informed consent from patients themselves (Lopez-McKee et al., 2008; Narruhn & Schellenberg, 2013).

Researchers have also noted tensions arising within some countries undergoing shifts in healthcare values and policies, particularly where the ethics education of clinicians is modelled on Western pedagogical models and normative frameworks. For example, Chang et al. (2008) note that nurses in Korea are now taught basic nursing ethics from a Western viewpoint. This has led to challenges for younger clinicians in implementing a normative framework in care that promotes individual autonomy within a culture that traditionally values the protection of individuals from distressing information (Chang et al., 2008). This challenge is especially acute in countries with multicultural populations, such as Australia, where Western bioethics has progressively dominated ethics education for clinicians (Chater & Tsai, 2008; Padela et al., 2015).

Clinicians, researchers, and ethicists differ, however, with respect to recommended responses to potential tensions between the ethical requirement of informed consent and multicultural values among patient populations. One study found that some clinicians perceive a need to abandon a commitment to informed consent and respect for patient autonomy when caring for patients whose cultural identities and values assign little importance to individualistic decision-making (Harrison et al., 2016). Some instead recommend that despite some tension, clinicians should ultimately respect the dominant ethical framework of the institution in which they practice (Coyle, 2014). The recommendation that clinicians generally, and nurses particularly, ought to be aware of cultural differences among patients and seek ways to accommodate patient

preferences remains a dominant view in the literature (Fernández-Sola et al., 2012; Mor & Oberle, 2008).

Theme 2: Culture and Barriers to Informed Consent in Clinical Contexts

Some researchers and ethicists note that aspects of culture might indirectly contribute to the formation of barriers to informed consent within certain clinical contexts. For example, Fitch et al., (2013) note that critical discussions of sexuality are considered to be taboo in some cultures. Patients who identify with this cultural norm might be reticent to discuss sexual health with a nurse or other healthcare provider, or with a healthcare provider of a different gender (McLaughlin et al., 2016). This can make clinical discussions about conditions and treatments that affect sexual identity and behavior difficult. Some cultures might have taboos relative to discussions about death and risk of harm, creating challenges to discussion of high-risk interventions or end-of-life care planning with patients (Calloway, 2009; Sun, Hsia, & Seu, 2008). These and similar taboos might generate barriers to disclosing health information and explaining risks of treatments to patients, thereby precluding patient informed consent.

Language barriers between patients and clinicians can also generate difficulties in obtaining informed consent (Lee et al., 2009). A study of military nurses providing care to Iraqi patients found that nurses saw language barriers that resulted in suboptimal communication with patients, even when a translator assisted. This is because nurses may not be able to verify that health information is accurately translated, or whether a translator might be biased regarding what the patient needs to know (Goodman et al., 2015). A national survey of US transplantation centers shows that few provide culturally and linguistically competent care training to their nurses, despite often having multicultural or large Hispanic transplant patient populations (Gordan, Caicedo, Ladner, Reddy, & Abecassis, 2010). About a third of the survey responses in this study reported that staff receive some form of cultural competency training. Perception of linguistic difficulties, including complex wording or difficult terminology, might lead nurses or other healthcare professionals to bypass consent procedures when initiating testing or treatment for patients (Granero-Moline et al., 2009; Ortiz & Casey, 2017).

Breakdowns in trust due to cultural identity and tradition can also create obstacles to informed consent. Nurses are among the most trusted professionals and are thus well suited for patient advocacy in informed consent and healthcare decision-making (Brenan, 2017). Trust is a mutual fundamental characteristic of the nurse–patient relationship and should be respected by all parties (Zalon et al., 2008). However, discrimination and lack of access to high

quality health care have resulted in a historical distrust of healthcare professionals by minority populations (Isaacson & Lynch, 2018; Johnstone, Rawson, Hutchinson, & Redley, 2018).

This review revealed a significant subtheme concerning patients of a minority culture or language who fear that decision-making in mainstream health care may leave them disadvantaged or denied proper access to healthcare interventions (Johnstone & Kanitsaki, 2009). Historical circumstances where a lack of consent occurred have contributed to long term patient distrust, hostility and feelings of lack of control (Jafree et al., 2015). This has an adverse effect on informed consent, communication and shared decision-making (Blackman, 2009; Neary et al., 2008). Some minority cultures automatically view the informed consent process with distrust. Others still have confidence, not specific to the provider, but in the institution where care is being delivered (Neary et al., 2008). Extra time must be taken to establish trust in these instances to ensure that informed consent is fully appreciated (Lech, 2008). For example, many Muslim patients value interpersonal relationships, and trust must be developed before decision-making and meaningful communication occur (Marrone, 2016).

A lack of cultural competence in healthcare professionals, real or perceived, may cause wavering trust or distrust from patients (Alpers, 2018). Research suggests that shared cultural identity between the healthcare professional and the patient strengthens the patient–provider relationship (Alpers, 2018; Blackman, 2009). Patients are more likely to trust healthcare professionals who are the same gender, age, race, and culture (Alpers, 2018). Lee et al. (2009) discovered that nurses can be instrumental in cultivating trust between patients and the entire healthcare team and are valuable advocates in the informed consent process. Truth telling and ensuring patients are fully informed according to their preference are obligations of trust that nurses must deliberately meet in order to balance the principles of beneficence and autonomy in practice (Ling et al., 2017; Thompson, 2011).

Theme 3: Influence of Culture on Clinicians' Perspectives on Informed Consent

Empirical studies show that the cultural identities and values of nurses can significantly influence the way in which they perceive and discharge the duty to obtain informed consent from patients. The peer-review nursing and nursing ethics literature suggests that clinicians bring these identities and values to bear either consciously or tacitly in their assessments of patient competence, what information is appropriate to disclose and withhold, and whom to inform about health information. Lack of awareness of this influence and refusal to take critical

distance from culturally entrenched biases might negatively impact patient buy-in and lead to failure in providing holistic and culturally congruent care (Hodge, 2015; Lech, 2008; Ortiz & Casey, 2017).

Researchers have found that nurses in certain countries and geographical regions often carry underlying assumptions about a patient's ability to comprehend health information based on the patient's cultural, racial, or religious background. For example, the discussion sections of two unrelated studies—one of Australian clinicians and another of American intensive-care patients—suggest that clinicians sometimes assume that a patient's comprehension of conditions and risk assessments varies according to the cultural or racial group in which the patient is assumed to belong (Carolan et al., 2010; Clark, 2007). The Australian study in particular generalizes this assumption, suggesting that women from “non-Caucasian” backgrounds are at risk of poorer self-management and lower health literacy regarding gestational diabetes than Caucasian patients.

In a study of maternity clinicians in the UK, some participants characterized “Asian” and “Muslim” patients as having limited cognitive capacity to understand information, constrained choice in their decisions to marry, failing to regulate fertility due to cultural values and practices, and taking little responsibility in their child-bearing decisions. In contrast, participants tended to valorize the choices of white, wealthy patients who made the same child-bearing decisions as Asian and Muslim mothers. Participants characterized the former's decisions to be autonomous and responsible, while characterizing the latter's decisions about pregnancy and child-raising as less informed and passively made (Davies et al., 2009). Such assumptions about patients' competence based on their cultural identity or background might affect clinician decisions about when and to what degree health information is communicated to patients. Furthermore, stereotyping patients' responsibility, control, and competence strictly on the basis of cultural classification might lead to differential provision of health information within multicultural patient populations (Davies et al., 2009).

Some researchers and ethicists also discuss tendencies among clinicians from non-Western cultures to withhold information from patients, especially in end-of-life care settings or when information is about a serious condition or terminal diagnosis (Browning, 2009; Doolen & York, 2007). Withholding information in this context, however, is not considered to be deceptive or inappropriate. In some non-Western cultures, beneficent care sometimes outweighs the duty to disclose complete and accurate information to the patient, and withholding information that is potentially distressing for a patient is thought to be a way to promote patient well-being and avoid psychological and emotional harm (Barwell, 2011; Doolen & York, 2007; Harrison et al., 2016).

However, such broad theoretical claims about how non-Western cultures view patient autonomy and informed consent might miss important nuances of individual cultures. For example, an empirical study of Indonesian nurses' perspectives on clinical authority and informed consent shows that the participants regard obtaining informed consent to be a duty attached to the nursing profession, but hierarchical structures in healthcare organizations sometimes prevent them discharging this duty (Susilo et al., 2013). A more detailed picture of clinicians' perspectives on truth-telling and information provision also emerges from a large study of Turkish nurses and patients in a university hospital. This study shows that there is considerable support among nurses for providing accurate information to patients, considering truth-telling to be a moral duty of clinicians. In cases in which distressing information is communicated, the nurses advocated not for withholding information, but for tailoring communication according to individual patients' preferences about disclosure and decision-making (Demirsoy et al., 2008). Interestingly, this perspective appears to conflict with prominent clinical textbooks utilized in the training of clinicians in Turkey. A prominent ethics textbook asserts that clinicians ought not to engage in direct communication to patients about serious conditions (e.g., terminal cancer) because, unlike European patients, Turkish patients are not psychologically or emotionally capable of handling this information (Güven, 2010). These two studies suggest that broad generalizations about truth-telling and information disclosure in non-Western cultures should be more nuanced than is often supposed in nursing and nursing ethics literature.

Researchers have also found that the cultural identities and values of nurses and other healthcare professionals influence their decisions about to whom they communicate health information. Studies of clinicians in Italy, Korea, and Japan report that they frequently deliver complex health information to a patient's family rather than to the patient (Ingravallo et al., 2017; Toda et al., 2015). Cultural values might also influence a nurse's perception of patient autonomy in certain healthcare fields. A study of Israeli-born nursing home staff found that Arab caretakers tended to view nursing home and dementia patients as possessing autonomy and to involve their patients in decision-making about care, whereas their Sabra and Russian peers did so to a much lesser extent. (Bentwich, et al. 2017; Bentwich & Oberman, 2018). This study shows that cultural identities, values of clinicians, and geographic region do not always covary with respect to influence on perception of patient autonomy and informed consent.

A minor subtheme that emerged in this review is the way in which the informed consent process might be impacted by nurses' religious identities or their view of a patient's religious identity. Nurses who endorse a particular religious or spiritual identity might feel compelled to pray over or with their patients

as a form of healing. However, initiating prayer without a patient's consent not only disregards a patient's consent to participate in such "treatment," but might impose spiritual views that are not held in common (French & Narayanasamy, 2011). With respect to the religious views of patients, nurses should not assume that spiritual beliefs and religious views are well-integrated in a patient's deliberation about health care, particularly complex decisions about critical or end-of-life care. Exploration of patients religious beliefs might enable nurses to assist patients in connecting religious views with decisions about care (Browning, 2009; Hodge, 2015).

Theme 4: Influence of Culture on Patients' Perspectives on Informed Consent

Patients' cultural identity and values might influence how they view their own role in clinical decision-making about care. Cultures may differ considerably from one another with respect to the value they place on individual autonomy generally and informed consent in clinical contexts specifically. Researchers frequently contrast American, UK, and Australian promotion of individual decision-making and patient empowerment with non-Western cultures' non-individualistic approaches to these outcomes (Chater & Tsai, 2008; Chichester, 2007; Rising, 2017; Sullivan, 2007). For instance, in a study of patients with gestational diabetes in Australia, Caucasian and Filipino women reported greater valuing of patient autonomy than Indian and Vietnamese women, with educational background having little effect on participants' responses (Carolan et al., 2010).

This review revealed that not all cultures value individual autonomy and decision-making to the same degree as dominant medical communities in the United States, UK, and Australia. Broadly speaking, this review showed that several cultures traditionally value family decision-making in clinical contexts (especially critical care and end-of-life care circumstances) more than individual patient decision-making, or promote respect and deference to healthcare professionals in decisions about care. For example, researchers have found that desires among Korean elderly patients to participate in decisions about their health care was relatively low compared to their desire to include family members in decision-making (Chang et al., 2008), and that discounting the family's input for end-of-life care decisions can be isolating and emotionally distressing for the patient (Doolen & York, 2007). Researchers and clinicians have also found that in Chinese traditional culture the family is considered to be a single unit rather than a group of related individuals, and each member is integrally involved in important decisions for the other members (Chater & Tsai, 2008; Jafree et al., 2015).

In some cultures, the disclosure of potentially distressing health information to the patient is considered to be harmful and inappropriate (see Theme 5). In such scenarios, nurses and other health professionals might experience moral distress over fulfilling families' preferences for information disclosure at the potential cost of violating patient autonomy (Jafree et al., 2015; Lee et al., 2009; Starr, 2015; Watts et al., 2017).

Some nurses and ethicists caution their peers regarding whether to withhold information from patients whose cultural background is one in which decision-making and information disclosure is family-oriented. Barwell (2011), for instance, advocates accurate disclosure of information to patients and autonomy promotion in serious or terminal cases, unless the patient expressly declines to receive that information. Padela et al. (2015) warn that a patient's passive delegation of decision-making to family might appear to be informed by the patient's values, but might in fact be compelled by external familial or social expectations. Similarly, Sialubanje et al. (2015) note that Zambian women's deference to their husbands and other family members in decision-making about childbirth may be a function of cultural disempowerment and social barriers rather than strict cultural identity. A study of ICU patients in the United States found no significant correlation between racial identity and patients' evaluations of the informed consent process (Clark, 2007). In light of these nuances, nurses are advised to refrain from initially deferring to families and to assess and respond to the values and preferences of the individual patient in order to prevent as much as possible the patient's experience of guilt, distress, or shame (Browning, 2009).

This review also showed that the family-oriented and individualistic models of decision-making do not track with "non-Western" and "Western" cultural distinctions. Hispanic, African American, and Native American cultures, for example, also place great importance on the participation of family and even close associates in important healthcare decisions (Clark, 2007; Doolen & York, 2007). A study of Japanese patients' perspectives of medical decision-making shows that some patients in Japanese hospitals sometimes regard important healthcare decision-making to be a process between the patient and the physician, and much less so a process between the family and patient (Ito, Tanida, & Turale, 2010). A systematic review of the literature on patient transition and adjustment to long-term care shows that patients from multiple cultural backgrounds who were transferred to long-term care without consent or participation in decision-making were more likely to experience negative psychosocial effects, including sadness, depression, and anger (Brownie et al., 2014; Wilson, Ingleton, Gott, & Gardiner, 2014).

Some cultures promote strong deference to healthcare professionals with respect to decisions about clinical care. Rather than seek information about their condition or wish to make their own healthcare decisions, some patients might instead view the clinician as the authoritative decision-maker about care. Deference to clinical authority in decisions about care has been associated abstractly with Asian cultures and Iranian, Iraqi, and Somali patient populations (Davoudi et al., 2017; Goodman et al., 2015; Narruhn & Schellenberg, 2013; Sun, Hsia, & Sheu, 2008).

Other studies, however, show that within commonly identified cultures and geographic regions there is considerable variation in the degree to which clinically paternalistic decision-making is endorsed. A study of immigrant patient populations in Norway shows that while some African and Asian immigrant patients were hesitant to participate in healthcare decisions, others expressed preference for the more egalitarian and shared decision-making approach of Norwegian clinicians (Alpers, 2018). Deference to clinician authority in decision-making is also strongly exhibited among patients in southern European countries, Portugal, and Sweden (Brown 2014; Doolen & York, 2007), where northern European clinicians tend to respect patient preferences to a higher degree, particularly with regard to end-of-life care decisions (Bülow et al., 2012). However, Peretti-Watel et al. (2008) found that a significant proportion of French district nurses tend to overlook patient wishes in clinical contexts, such as care for patients with advanced amyotrophic lateral sclerosis.

Thus, deference to clinician authority or culturally endorsed autocratic decision processes do not appear to map neatly onto the conventional distinction between “Western” and “non-Western” understandings of informed consent. Further, deference to clinician authority might not always be an expression of a patient’s actual preferences, but instead conformity to cultural and social expectations, or even institutional structures. Accordingly, some researchers warn that patients within cultures that ascribe great respect and authority to healthcare professionals might be subject to a significant power imbalance that is reinforced by organizational practice. This might make patients feel they must acquiesce to healthcare professionals’ recommendations (Evans & Ndirangu, 2009; Kidd et al., 2015). Moreover, patients from regions that are resource-impooverished or experience political oppression and violence might be forced into assuming dependent roles on authority figures (Goodman et al., 2015; Harrison et al., 2016; Sagbakken et al., 2013).

Religious and spiritual traditions also impact how the moral weight of informed consent is perceived. Orthodox Jewish patients who follow *Halacha* (Jewish Law) might follow closely the Halachic responsibility for self-care, which extends to seeking all information available in order to make a decision for oneself

(Greenberger, 2011). However, on some Orthodox Jewish interpretations, the duty of self-preservation outweighs patient autonomy, even to the extent that the family or religious leaders ought to attempt to coerce a patient to accept life-sustaining interventions (Baeke et al., 2011; Mor & Oberl 2015). In a study of three religious views, Protestant clinicians more frequently respected patient refusal of life-sustaining treatment, while Jewish professionals were least likely to follow patient refusals and most likely to go against patient refusal (Bulow et al., 2012). However, Reformed Jewish patients might not hold the same view on the moral weight of sustaining life as Orthodox Jewish patients (Baek, Wils & Broeckaert 2011). In contrast to both forms of Jewish practice, a major study of attitudes of Muslims living in the United States showed that half of the participants favored informing the family of the patient about a cancer or terminal diagnosis without the individual's consent (McLaughlin et al., 2016). Accordingly, clinicians should be cautious about making assumptions regarding what a patient's faith tradition means for care, or making broad generalizations about the preferences of patients who identify with a religious tradition.

Spiritual and religious identity and practices can also modulate communication between clinicians and patients. One study found that African American men who attend church regularly reported reading more carefully printed educational materials from healthcare providers that were provided at a spiritually based education session as opposed to a non-spiritually based session (Holt et al., 2009). As noted above (Theme 2), some Muslim patients expect interpersonal relationships and trust with clinicians to be established before important healthcare decisions and significant communication about health information commences (Marrone, 2016). Similarly, on some interpretations of the Confucian directive to preserve one's health, it is believed that the manner in which clinicians communicate health information will affect the quality of a patient's life (Zhang et al., 2017).

Theme 5: Culturally Appropriate Communication

Attitudes toward truth telling and communication of poor prognosis vary depending on religious and cultural factors in different countries and ethnic communities (Brown, 2014). This review emphasized the importance of healthcare providers critically assessing cultural values and norms of patients and families. Family autonomy and family decision-making is the accepted cultural norm for many patients, families, and communities. For example, clinicians must be cognizant that families and community members, such as priests or rabbis, might play a significant role in decision-making (Baeke et al., 2011).

Some African and Asian patients are accustomed to health information being delivered primarily and directly to the family (Alpers, 2018; Brown, 2014).

Disclosure of healthcare information directly to the family is often done to protect the patient, especially in circumstances of poor prognosis, such as terminal illness (Chater & Tsai, 2008). This is consistent with Vietnamese and traditional Chinese culture, and congruent with the Confucian practice of benevolence and compassion (Calloway, 2009; Chater & Tsai, 2008). Doolen and York (2007) identified that Afghan American elders believed that healthcare decision-making is the responsibility of the head of the family. Conventional findings of autonomy and self-determination for families, rather than patients, are identified in the following:

“Some cultures see autonomy as directed by the group, not the individual. This has to be respected by the treatment team as long as the collective autonomy does not harm the patient’s voluntary will” (Druml et al., 2016, p. 9).

“Unlike in western countries, where patients’ self-determination in medical decision-making is respected, it is common in China for the family to be fully engaged in the decision-making process” (Zhang et al., 2017, p. 111).

In some circumstances patients may not receive information about the poor diagnosis first, or even at all. In Russia, families are often notified prior to the patient regarding terminal diagnosis (Calloway, 2009). Yet in some cultures, patients do not receive any communication about a poor prognosis or terminal illness. For example, in Spain and other Mediterranean countries, it is common to conceal a diagnosis from the patient (Rio-Valle et al., 2009).

Although family decision-making is sometimes the cultural norm in non-western communities, research suggests that some patients prefer direct and primary truth telling and disclosure. In a study of Japanese patients and families, almost half of patients believed that healthcare professionals should disclose everything to the patient, even if the family is opposed it (Ito, Tanida, & Turale, 2010). A similar study of Korean elders found that patients desired information concerning health, contrasting the traditional idea that families should receive information on their behalf (Chang, et al., 2008). McLaughlin (2016) also found that the majority of healthcare professionals felt that patients should be directly and primarily informed of a poor diagnosis or imminent death, before family members.

Western healthcare professionals disclose terminal diagnosis to patients out of respect for patient autonomy; yet this principle is not universally shared among Muslims, some of whom emphasize that families and physicians are responsible for healthcare decision-making (McLaughlin et al., 2016). Some of the literature suggests that Caucasian Americans communicate end of life decisions through

formal advance directives, yet African Americans are more likely to confide in family members and trusted clergy to communicate preferences at end of life (Collins et al., 2018). However, in both populations, self-determination and decision-making autonomy remain with the patient.

Another aspect of the communication theme emerged in this review, regarding the manner in which healthcare professionals deliver information in a culturally sensitive manner. Some clinicians do not feel comfortable or proficient in effective emoting in cultural contexts, resulting in misunderstandings (Alpers, 2018). For example, in Canada, minority cultures want information to be delivered in culturally sensitive ways (Thompson, 2011). However, because communication and expression across cultures vary, gestures such as eye contact or questioning an authority figure may preclude a patient from truly being informed and result in the perception of an uninterested or incompetent patient by Western healthcare professionals (Alpers, 2018). Communication can be impacted further by rules around verbal and nonverbal communication within a culture, such as tone, volume, inflections, pauses, eye contact, and emotional expressions (Clancy, 2013; Pugh, 2014). For example, Saudi Arabian women who communicate with a male healthcare professional often speak directly and try to avoid eye contact, yet erudite Saudis generally respect eye contact as a sign of honesty and integrity (Marrone, 2016). Some Iranian women find that communication, especially delicate information, can be delivered too directly and can crush the spirit (Thompson, 2011).

Based on these findings, healthcare professionals must not make assumptions about a patient's cultural preference. A proper assessment is necessary to obtain the patient's preference for truth telling and information disclosure. Nurses communicate beliefs consciously and unconsciously to their patients and therefore must be cognizant of verbal and nonverbal communication and behavior to understand the delicate nature of conveying healthcare information (Lech, 2008). If preferences in relation to truth telling are not known, nurses might be unable to properly care for patients in a culturally appropriate and sensitive manner (Ling et al., 2017). Expectations and preferences for truth telling, disclosure and communication vary drastically and must occur in light of recognized differences in beliefs and values that patients hold (Clark, 2007; Sneesby et al., 2011).

Theme 6: Professional Codes of Ethical Conduct

Globally, nurses recognize the professional ethical obligations to advocate for patient's rights during the informed consent process. The ethical duty to advocate for patients applies in multiple facets of informed consent, including the respect for patient autonomy, protection of human rights, safeguarding patients

from inappropriate paternalistic situations, respecting confidentiality and self-determination, duty for primary commitment to the patient and high quality nursing care, respect for kindness in self and others, and respect for the cultural diversity in patient care (Ingravallo et al., 2017; Jafree et al., 2015; Marrone, 2016; Pugh, 2014; Susilo et al., 2013; Susilo et al., 2014; Toda et al., 2015; Wilson et al., 2014).

Nurses frequently confront these ethical obligations, especially in cultures where families have a significant role in healthcare decision-making. The nurse's role in advocacy in decision-making is valuable in the protection of dignity and human rights. For example, the Japanese code of ethics for nurses does not expressly exclude the obligation to advocate for individual patient decision-making; yet, decision-making in the Japanese culture is often a family decision rather than solely a patient decision (Toda et al., 2015). Nurses are essential in educating families about confidentiality and respect of patient autonomy (Toda et al., 2015). Cultural norms do not justify a breach in confidentiality. Therefore, Japanese nurses often face this ethical dilemma in practice. The American code of ethics for nurses identifies the nurse's responsibilities in medical interpretation through cultural humility (Ortiz & Casey, 2017). Western culture is reflected in the American ethical code for nurses, which outlines the nurse's primary commitment to the patient through delivery of care with compassion and respect for dignity (Marrone, 2016). Additionally, nurses have a significant role in establishing that patients participate in the planning and implementation of their care (Mor & Oberle, 2008). The Korean and Italian codes of ethics for nurses emphasize the nurse's role in ensuring that patients have necessary and sufficient information so that they are supported in decision-making (Ingravallo et al., 2017). In addition, the Nursing Midwifery Council Code of Conduct, which governs nursing practice in the United Kingdom, states that nurses must uphold a patient's right to be fully informed and participate in decision-making (Clancy, 2013; Wilson et al., 2014). The ethical code of conduct governing Australian nurses requires respect and kindness for the diversity of people, in addition to culturally sensitive and appropriate advocacy for patient self-determination and autonomy (Pugh, 2014). Failure to comply challenges the ability to provide ethically sound care (Pugh, 2014).

Although nurses may be aware of professional ethical obligations, the actual or perceived inability to follow through can result in neglect of cultural competence or avoidance of patient advocacy during informed consent. For instance, nurses in India were reluctant to advocate on behalf of patients subjected to inappropriate paternalism during the informed consent process, and feared being blamed or unsupported by their hospital (Susilo et al., 2013).

Notably, a study of Pakistani nurses revealed that although nurses were aware of the ethical obligations of informed consent and patient advocacy, a near absence of consent existed in nonsurgical procedures (Jafree et al., 2015). The lack of consent was originally hypothesized to be due to the cultural norm of family decision-making in Asian countries, but this study revealed that the rationale for failure to obtain consent was actually due to time constraints, patient health illiteracy, and the assumption that patient admission to a teaching hospital was a *de facto* consent for treatment (Jafree et al., 2015). The absence of obtaining proper consent significantly impacted the nurses' emotional and psychological well-being, resulting in a reduced commitment to high quality patient care (Jafree et al., 2015).

While some articles in the review acknowledged the ethical code applicable to the nurses in their respective countries, several articles highlighted the significance of the International Council of Nurses Code of Ethics and its broad application to nurses globally (Hodge, 2015; Ingravallo et al, 2017; Marrone, 2016; Susilo et al., 2013; Wilson et al., 2014). Nurses recognize both the global ethical obligations of providing sufficient information for adequate decision-making in a culturally sensitive manner and the significance of respecting patients cultural and religious beliefs (Hodge, 2015; Susilo et al., 2013; Wilson et al., 2014).

CRITICAL DISCUSSION

This review provides the first published analysis of how nurses and nurse researchers perceive the impact of aspects of culture on the process of obtaining patient informed consent. The review clearly shows that the cultural identities and values of both clinicians and patients, as well as assumptions and generalizations about a patient's cultural background, impact a number of elements in this process. These elements include whether and to whom patient health information is disclosed, whether patients wish to receive full and accurate diagnostic and prognostic information, whether clinicians differentially disclose information or seek patient consent due to classifying or stereotyping patients on the basis of cultural or religious identity, and whether barriers to consent due to cultural or linguistic differences are recognized and removed.

This review reveals wide consensus among clinicians and researchers that nursing care for multicultural patient populations demands that nurses cultivate competence and knowledge regarding patients' cultural and spiritual identities (Browning, 2009; Calloway, 2009; Doolen & York, 2007; Valente, 2010). Sensitivity to and awareness of different cultural perspectives on health, illness and death, on appropriate means for disseminating information, and on procedures and contexts for making important personal decisions will assist nurses in

tailoring their care to individual patients' needs, preferences, and expectations (Brownie et al., 2014; Calloway, 2009; Clabots, 2012; Clancy, 2013; Martin, 2016; Oliveira & Oliveira, 2013).

However, the literature contains far less consensus regarding how cultural competence and sensitivity would bear on clinicians' understanding of informed consent, including deliberation over whether to disclose information directly to the patient or to expect patients to make their own decisions about care. As we note above (Theme 1), some of the articles we reviewed claim that dominant conceptions of respect for patient autonomy and informed consent are incompatible with respecting the cultural values and practices of some patients. However, this claim is ambiguous.

On the one hand, the claim might mean that there will be occasions in clinical practice when nurses and other clinicians either will not be able to secure informed consent from a patient while also respecting that patient's cultural beliefs and values, or will not be required to obtain informed consent when caring for a patient whose cultural identity and traditions do not regard individual decision-making or direct disclosure of health information to be appropriate. However, several articles point out that respect for these cultural preferences need not preclude respecting a patient's autonomous decision-making and consent. One way to avoid possible practical conflict between a patient's cultural values and a nurses' sense of the importance of informed consent is for the nurse to conduct initial discussions with the patient regarding what information the patient wishes to have disclosed and whether the patient, the patient's family, or the family unit will be making healthcare decisions (Chater & Tsai, 2008; Goodman et al., 2015). As we noted above (Themes 4 and 6), such putative conflicts among clinicians' duties might occur more frequently in scenarios involving a terminal diagnosis, advanced care planning, and end-of-life care. But even in these scenarios, nurses and clinicians should not assume that cultural barriers are present in the care of multicultural patient populations, but instead should initiate discussion of patients' preferences for communication, information disclosure, and decision-making (Collins et al., 2018; Cooper et al., 2015; Lech, 2008). Through individualized consultation with patients, a nurse is respecting the autonomy and decisional authority of the patient, even when a patient confers that decisional authority to a family member or other close associate (Childress, 1993; Clabots, 2012; Guven, 2010; Leever, 2011). Empowering patients to express their cultural and spiritual beliefs and values, and subsequently respecting those beliefs and values, is an important way in which a nurse respects the exercise of a patient's autonomy to determine how consent processes will proceed. While it is important for nurses to be knowledgeable to some degree of different cultural and religious beliefs and values (Browning, 2009; Clabots, 2012), it is also important

that nurses not assume that patients endorse every belief and value of the culture with which they identify (Chang et al., 2018; Effa-Heap, 2009; Guven, 2010). Indeed, as we note above (Theme 4) there can be considerable variation among individuals from similar cultural and spiritual backgrounds in endorsement of cultural beliefs and values. Thus, nurses ought to couple culturally competent care with respect for individual patients' beliefs, values, and preferences.

On the other hand, the claim of incompatibility might be pointing to a conceptual tension between respect for patient autonomy and cultural preferences for non-disclosure or family- or community-oriented decision-making. For example, Calloway (2009) contrasts family-centered decision-making with individualistic notions of patient autonomy and informed consent. Padela et al. (2015) likewise trace the ethical principle of respect for patient autonomy and the requirement to obtain informed consent to individualistic conceptions of persons. One might accordingly infer that informed consent and the principle of respect for patient autonomy are conceptually tied to an overly individualistic picture of autonomy. This inference, however, would be incorrect. The conception of the individual as an atomistic, self-sufficient decision-maker is logically independent of a conception of individual autonomy and the duty to obtain a patient's informed consent. That is, one could endorse either conception and reject the other (Deem, 2016). Indeed, some of the articles we reviewed suggest that a broader view of individual autonomy—that is, a view of autonomy that does not simply take the individual to be a self-sufficient decision-maker—is compatible with respect for cultural preferences for nondisclosure or family-centered decision-making (Calloway, 2009; Chater & Tsai, 2008). One resource from which nursing ethics might draw to fill in this broader notion of autonomy is the feminist philosophical literature on relational autonomy (Mackenzie & Stoljar, 2000).

According to some relational conceptions of autonomy, autonomous decision-making is the product of social and cultural scaffolding. Our social relations and cultural backgrounds play determinant roles in the formation of our desires, preferences, and decisions. On a relational view of the principle of respect for patient autonomy, what matters is whether patients regard healthcare decisions as their own and not whether they complete the process of forming a decision in isolation from social and cultural influences. Even if healthcare decisions are made by family or community members without full disclosure of information to a patient, a patient's autonomy can still be respected and promoted whenever clinicians ensure that the patient endorses such decisions or processes for decision-making, and regards the outcome of the process as truly her/his own. When we view autonomy relationally, as opposed to individualistically, then

we might find that the conceptual tensions that some articles identify between informed consent and some cultural values are only apparent.

CONCLUSION

The nursing and nursing ethics literatures reveals the potential difficulties that arise for many patients, families, and healthcare professionals when recognizing patient cultures and values during the informed consent process. Cultures, religions, and spiritual traditions may vary regarding the value placed on individual autonomy and the involvement of families and communities in healthcare decision-making. Healthcare professionals who are accustomed and trained to respect individual patient autonomy are challenged when healthcare decision-making, truth telling, and information disclosure are modulated by a patient's cultural identity and values. These challenges can contribute to barriers or reluctance to obtain informed consent, dissolution of trust in the patient-provider relationship, and moral conflict from healthcare professionals who seek to safeguard patients' cultural identity.

This review emphasizes the role of nurses and the significance of identifying, respecting, and acknowledging the culture, needs and values of every patient. Nurses have a global ethical obligation to advocate for patients in healthcare decision-making and informed consent. They must also tailor communication of health information in a culturally appropriate and sensitive manner. In doing so, nurses will promote patient autonomy and empowerment in healthcare decision-making.

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