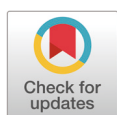


# What Is Shared in Shared Decision-Making? Sustaining Care Without Consensus

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**Abstract**

Hospice admission is often framed as a model of shared decision-making (SDM) at the end of life, yet disagreement can persist even after decisions are made. In South Korea, hospice care is governed by statutes prioritizing patient self-determination while remaining deeply embedded in expectations of family involvement and filial responsibility, complicating what is “shared” when hospice itself carries divergent meanings. Drawing on seven months of ethnographic fieldwork in a university-affiliated hospice ward in Seoul, including participant observation and interviews with patients, relatives, and healthcare professionals, this study examines two purposively selected cases of advanced cancer in which hospice decisions were repeatedly contested by family members. Disagreement centered not only on treatment preferences but on competing meanings and futures associated with hospice admission. Decision-making persisted post-admission as professionals adjusted conversations regarding dying and end-of-life preparation. Authority was relationally distributed, with claims grounded in embodied suffering, caregiving labor, financial responsibility, familial obligation, and professional expertise. These findings suggest that hospice SDM involves not merely achieving consensus, but also sustaining care amid enduring disagreement and negotiating relational authority when consensus remains unsettled.

**Keywords:** hospice care; decision making, shared; terminal care; family; ethnography; Republic of Korea

**1. Introduction**

Shared decision-making (SDM) is a collaborative process in which patients and health care professionals exchange information, deliberate over care options, and reach decisions that reflect both clinical evidence and patients’ values and preferences [1,2]. For patients with terminal illness, entering hospice care is often a major shared decision at the end of life. Contemporary hospice care encourages patients to articulate their preferences, invites family members to participate in deliberation, and relies on interdisciplinary teams to support ethically appropriate decision-making. In practice, however, hospice decision-making often reveals

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**Data availability**

Upon reasonable request, the datasets of this study can be available from the corresponding author.

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**Author contributions**

The article is prepared by a single author.

**Ethics approval**

All research procedures adhered to relevant ethical guidelines and institutional policies and received approval from the Institutional Review Board (IRB) of Washington University in St. Louis (Approval Number: 202402111; Approval Date: April 10, 2024). Informed consent, both written and verbal, was obtained from all participants at various stages of data collection.

a persistent tension. Even after a patient decides to enter hospice care, family members may continue to contest the decision. Conversations about dying may be postponed when families are not emotionally ready. Decisions that appear settled may remain disputed until death. Care continues, but consensus does not. Related tensions have been documented in end-of-life care, where formally settled decisions can remain socially contested [3,4], while empirical studies of hospice care describe SDM as fragmented and shaped by institutional and emotional constraints [5,6]. This tension raises a more fundamental question than whether patients and clinicians can make decisions together. As Choi argues [7], contemporary debates on SDM still leave unresolved what exactly is shared, who decides, and how decision-making authority is constituted. What is shared in SDM when participants never fully share the meaning of the decision?

This question is particularly salient in South Korea. The expansion of hospice and palliative care (HPC) following the enactment of the Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment has reshaped the organization of end-of-life care [8]. Survey research among middle-aged adults found substantial awareness of HPC but limited awareness of SDM [9]. Because HPC in South Korea has developed primarily in hospital settings rather than through community-based services [10], decisions about hospice admission often unfold over days or weeks through repeated interactions among patients, family members, physicians, nurses, social workers, chaplains, and volunteers. Korean end-of-life care also continues to be shaped by strong family involvement and expectations of filial responsibility [11]. Recent qualitative work with terminal cancer patients, families, and health care professionals further shows that cultural norms, emotional challenges, and ethical considerations shape SDM in end-of-life care [12]. Legal frameworks reinforce this dynamic by emphasizing respect for patient preferences while defining circumstances in which family members participate in decision-making [8,13]. In this context, SDM may become an extended social process embedded in institutional life rather than a single consultation. Similar tensions have also been noted in other hospice settings where SDM is promoted in principle but remains difficult to implement in practice [5,6].

Recent scholarship has broadened this conventional account of SDM. Palliative care and relational autonomy scholarship increasingly describes decision-making as an ongoing, context-dependent process rather than a discrete event [14,15]. Korean medical ethics discussions align with this account, arguing that advance care planning and decisions about life-sustaining treatment cannot be reduced to completing forms or selecting hospice care but must be situated within continuing negotiations over care goals [16].

Nevertheless, three related aspects of hospice SDM remain insufficiently examined in daily clinical practice: shared understanding, the temporal boundaries of decision-making, and the grounds of decision-making authority.

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First, participants may disagree not only about treatment options but also about the meaning of the decision itself. Second, a formally documented treatment choice may not end decision-making, which can continue during implementation. Third, authority may not simply be shared among patients, families, and clinicians through communication and deliberation; participants may claim legitimate influence on different grounds. Recent Korean bioethics discussions have raised related questions [7,16]. However, these questions have been addressed largely at philosophical and normative levels, and far less is known about how they unfold in everyday clinical practice.

Relational autonomy scholarship has shown that autonomy is constituted within social relationships rather than exercised in isolation [17,18]. A systematic review, however, found that the literature remains primarily concerned with how relationships enable or constrain patient autonomy [15], while research on triadic clinical encounters focuses on how family members participate in and shape clinical communication and decision-making [19]. In South Korea, Jo et al. found that attitudes toward dignified death predicted SDM, whereas attitudes toward withdrawal of life-sustaining treatment did not [20]. Against this background, this study proposes relational authority as an analytic concept to address a distinct question: how do different participants claim and negotiate legitimate standing to influence a decision? Relational authority refers here to the practical legitimacy to participate in and influence decision-making that participants claim through embodied suffering, caregiving labor, financial responsibility, familial obligation, or professional expertise.

Drawing on seven months of ethnographic fieldwork conducted in a hospital-based HPC ward in Seoul, South Korea, this study examined how these gaps unfold in hospice practice. Rather than evaluating whether SDM succeeds or fails, the study focused on decision-making when consensus never fully emerged. Specifically, the analysis examined whether participants disagree about the meaning of hospice itself, whether decision-making continues beyond formal admission, and how authority is relationally distributed through claims grounded in embodied suffering, caregiving labor, financial responsibility, familial obligation, and professional expertise. By addressing these gaps, the study aims to provide an empirically grounded account of how SDM operates amid persistent disagreement and to clarify whether SDM in Korean hospice care may be understood less as the achievement of consensus than as the ongoing negotiation of relational authority. This perspective may also help clarify the ethical and practical challenges of sustaining hospice care when agreement remains unresolved.

## II. Methods

### 1. Study Design and Setting

This study drew on ethnographic fieldwork conducted in an HPC ward at a university-affiliated hospital in Seoul, South Korea. Fieldwork, which spanned seven months (June–December 2024), examined how decision-making about hospice admission unfolded when patients, family members, and health care professionals did not fully share a common understanding of hospice. In this ward, symptom management, psychosocial and spiritual support, and end-of-life care were provided by an interdisciplinary team. In this setting, decisions about hospice admission, conversations about dying, and ongoing care planning were routinely negotiated among patients, family caregivers, physicians, nurses, social workers, chaplains, and volunteers.

The material analyzed here was drawn from a larger ethnographic project conducted in the same ward (IRB No. 202402111). Two previous publications from this project addressed distinct aspects of hospice care: one examined the institutional classification of patients as “unclaimed” when their caregiving relationships were not legally recognized [21], and the other examined older husbands who served as primary caregivers for their terminally ill wives [22]. Neither study examined SDM as its analytic focus, and neither investigated the two focal cases analyzed here. These two cases have not been reported in either publication.

### 2. Rationale for Ethnographic Methods

Ethnographic methods were used to examine decision-making as it unfolded over time in routine hospice practice. Hospital ethnography is particularly useful for examining how clinical decisions unfold through everyday interactions within institutional settings [23]. Formal decisions, such as hospice admission, capture only one moment in a longer process; subsequent interactions may reveal continuing disagreement, changing interpretations, and shifts in who participates in conversations about care. Repeated observation across clinical encounters therefore made it possible to trace how patients, family members, and health care professionals revisited decisions after admission and responded to disagreement as patients neared the end of life [24]. This longitudinal attention to everyday interactions was particularly important for examining situations in which a formally documented decision did not produce a stable consensus among those involved.

### 3. Data Collection: Participant Observation and Interviews

The broader ethnographic project included interviews and observations addressing multiple aspects of hospice care. The present analysis draws on approximately 24 hours per week of participant observation, as well as semi-structured interviews conducted during the seven-month study period, with particular attention to the two focal cases and disagreements surrounding hospice decision-making. Across this period, the researcher followed 20 patient-family cases in sufficient depth to document family perspectives and interactions surrounding hospice care. Observations were conducted in patient rooms, ward corridors, nurses' stations, family consultation rooms, and weekly interdisciplinary team meetings. Participant observation included hospice admission consultations and family meetings led by social workers, as well as conversations about prognosis, treatment options, and transitions to palliative care. Informal conversations with chaplains, volunteers, and agency caregivers provided additional perspectives on how disagreements about hospice care were understood and managed in everyday ward practice.

Some of these exchanges developed into semi-structured interviews conducted in private consultation rooms. Participants included patients able and willing to participate, family members (spouses and adult children), and health care professionals (physicians, nurses, social workers, chaplains, and volunteers). For each focal case, two to three interviews were conducted, each lasting approximately 30 minutes. Sampling was purposive and opportunistic, guided by staff referrals, observed disagreements or tensions surrounding hospice admission, and participant availability, with particular attention to cases in which family members continued to contest or resist hospice care after admission.

Interviews focused on how participants understood and evaluated hospice care, including their support for or opposition to hospice admission, and on conflicts between those wishing to continue curative or life-prolonging treatment and those preferring comfort-oriented hospice care. All interviews were conducted face-to-face in a consultation room in the hospice ward. With participants' consent, interviews were audio-recorded and transcribed; when audio recording was not possible, detailed notes were taken during and immediately after each interview and were subsequently developed into narrative records. Throughout the fieldwork, key interactions and conversations, as well as the ward's affective and moral atmosphere were documented in fieldnotes. These notes captured how participants spoke about hospice care, how participants framed responsibilities and hopes, and how decisions were revisited over time; they also helped identify moments when SDM was strained or reconfigured.

#### 4. Researcher Positionality and Language

Before formal fieldwork began, the researcher had volunteered in the hospice ward for approximately three years. This prior involvement provided familiarity with the ward's routines and institutional practices and facilitated relationships with staff and volunteers, thereby supporting access to everyday interactions surrounding end-of-life care. However, such familiarity could also make established practices appear ordinary or self-evident and shape how participants understood the researcher's presence in the ward. Throughout the fieldwork and analysis, attention was therefore given to how the researcher's prior role and relationships might influence what participants shared and how familiar practices were interpreted.

All participant observation, informal conversations, and interviews were conducted in Korean. Interviews were transcribed and fieldnotes were written in Korean. During manuscript preparation, quotations selected for publication were translated into English by the researcher and checked against the original Korean transcripts or fieldnotes to preserve their contextual meaning and tone. For quotations central to the analysis, the original Korean text is provided alongside the English translation.

#### 5. Focal Cases and Analytic Approach

From the broader corpus of fieldnotes, interviews, and documents, two cases, Mr. Han and Mr. Park, were selected for detailed analysis. Both cases involved patients with advanced cancer whose decisions to discontinue curative treatment and enter hospice care were formally respected yet repeatedly contested by close family members. Each case allowed longitudinal engagement over several weeks of the hospice stay. This longitudinal engagement made it possible to trace how the meanings of hospice care, family disagreements, and claims to authority evolved over time as multiple family members and health care professionals participated in observed encounters and interviews.

The analysis proceeded iteratively, moving between fieldnotes and interview transcripts to identify recurring patterns of disagreement, ways in which decision-making extended beyond formal admission, and claims to authority grounded in different forms of responsibility and suffering. Coding and memo-writing tracked how participants described hospice care, when decisions were revisited after admission, and how family members and health care professionals justified their roles in decision-making. Particular attention was paid to how embodied suffering, caregiving labor, financial responsibility, and professional expertise served as bases for claims to authority. Rather than judging specific decisions as ethically right or wrong, the analysis aimed to clarify how SDM unfolded amid persistent

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disagreement and how care was sustained when consensus never fully emerged. All coding and analysis were conducted by the researcher. Analytic credibility was supported by comparing fieldnotes, interviews, and informal conversations across patients, family members, and health care professionals and by revisiting emerging interpretations through iterative memo-writing during analysis.

## 6. Human Participant Protections

The study adhered to relevant ethical guidelines and institutional policies and was approved by the Institutional Review Board (IRB) of Washington University in St. Louis (Approval No. 202402111; Approval Date: April 10, 2024). The host hospital did not require separate local IRB review for this study. Formal institutional permission to conduct ethnographic fieldwork in the hospice ward was obtained before data collection. The researcher's role was openly disclosed to ward staff, and interdisciplinary team meetings were observed with the knowledge and permission of the clinical team. Information from these observations was recorded and reported only in de-identified form. Written and verbal informed consent was obtained from all participants at the relevant stages of data collection. Interviews were audio-recorded only after participants provided explicit consent. Participants received verbal and written information about the study's objectives, the voluntary nature of participation, their right to withdraw at any time, and the measures used to protect confidentiality. All personal identifiers were removed; pseudonyms were used for all participants, and the hospital was not named to preserve institutional privacy.

## III. Findings

### 1. Competing Meanings of Hospice

Mr. Han was a 73-year-old man with recurrent non-small-cell lung cancer. More than 20 years earlier, he had been diagnosed with the same cancer, received intensive treatment following early detection, and achieved complete remission. Approximately two years before the observation period, a routine health examination revealed recurrence. At that time, the cancer had progressed to stage III. His family remained closely involved in his treatment over the following 18 months. The cancer eventually metastasized to the brain and liver, and he was informed that further curative treatment was no longer possible.

Exhausted by years of treatment and aware that his chances of survival were extremely limited, Mr. Han requested transfer to the HPC ward, and the transfer proceeded in accordance with his wishes. Throughout the observation period, Mr.

Han repeatedly stated that he had “done enough” chemotherapy and consistently expressed a wish to remain in hospice rather than pursue further treatment. In conversations during fieldwork, he often said, “I’ve had enough. I have no regrets.”

Although the decision to enter hospice care formally reflected Mr. Han’s wishes, it held very different meanings for his family members. Mr. Han’s family included his wife, two daughters, and one son. His wife and eldest daughter strongly opposed discontinuing chemotherapy, and their opposition was evident in conversations with hospice staff.

## 1) Interview with a hospice nurse

*Hospice nurse: “His eldest daughter came again this morning, asking whether it would really be impossible for him to continue chemotherapy while staying in hospice. She asked whether he could at least receive medications from the Department of Hematology and Oncology.”*

*Researcher: “They understand that once patients enter hospice, they can no longer receive invasive treatment beyond palliative care, don’t they?”*

*Hospice nurse: “Yes, they do. We explained everything during the initial consultation. His wife and eldest daughter were present. Yesterday, they also wanted him to see a dermatologist because his skin had become itchy and he had developed a rash.”*

*Hospice physician: “But I clearly explained that opioid analgesics can cause itching and skin rashes. They still wanted a dermatology consultation?”*

*Hospice nurse: “Yes…”*

In interviews with Mr. Han’s wife and eldest daughter, their hope for continued treatment was even more apparent.

## 2) Interview with Mrs. Oh (wife) and the eldest daughter

*Mrs. Oh: “I’ve only just learned about hospice, but it feels like they don’t give him any treatment at all here. You always hold on to that tiny bit of hope. He got better once before after chemotherapy, and medicine has come so far since then… maybe if we could just keep trying a little longer.”*

*Eldest daughter: “I think my father gave up too soon. Even people with advanced lung cancer can live for 5 years, and sometimes even longer, if the treatment goes well. I do not understand why he’s already giving up. He’s still young.”*

*For Mrs. Oh and her eldest daughter, hospice symbolized relinquishing the possibility of prolonged survival. Continued chemotherapy represented perseverance, hope, and a moral obligation to keep fighting.*

Mr. Han's younger daughter interpreted the decision differently.

### 3) Interview with his younger daughter

*Younger daughter: "I understand why my mom and my older sister feel that way. Of course, I want my father to live longer, too. However, I've seen how much he suffered during chemotherapy and how much he worried about money. I just want him to spend whatever time he has left in comfort, without worry. Is this not what a hospice ward should be for? In the end, I think it is my father's decision, and what we should do is respect his choice."*

*(Original Korean: "엄마랑 언니가 왜 저러는지 이해는 돼요. 아빠가 오래 살길 저도 당연히 바래요. 근데 아빠가 항암하면서 얼마나 힘들었는지, 돈 때문에 힘들어했는지 봤잖아요. 전 그냥 아빠가 남은 시간만이라도 걱정 없이 편안했으면 해요. 그러라고 호스피스에 있는 거잖아요? 결국 다 아빠 결정에 달린 거고, 우리가 할 일은 그 선택을 존중하는 거잖아요.")*

Although all family members participated in discussions about hospice admission, they held fundamentally different interpretations of what hospice represented. For Mrs. Oh and the eldest daughter, hospice meant relinquishing the possibility of survival and accepting that further curative treatment was no longer an option. For the younger daughter, by contrast, hospice signified respecting Mr. Han's wishes and prioritizing his comfort over life-prolonging interventions. For Mr. Han, hospice represented the end of repeated chemotherapy and an opportunity to spend his remaining days without further aggressive treatment. Thus, what appeared to be a single shared family decision was shaped by divergent moral understandings of hospice. These interpretations did more than coexist; they generated ethical tension over who had legitimate authority to decide, illustrating how relational authority can be contested when family members experience caregiving, suffering, and responsibility differently.

## 2. Decisions Remained Unsettled Long after Hospice Admission

Although Mr. Han had decided to enter hospice care, the decision remained unsettled. Family members continued to interpret hospice admission differently, and these disagreements persisted well after transferring to the hospice ward.

In South Korea, hospice stays average approximately three weeks [25]. Individual stays, however, may range from a few days to several months. Consequently, discussions of end-of-life preparation, including funeral arrangements, financial affairs, and bereavement planning, often begin soon after admission.

For Mr. Han's family, however, these conversations did not follow the usual timeline. Two weeks after admission, Mr. Han's wife and eldest daughter continued

to resist the transition to hospice. His eldest daughter openly challenged her father and the hospice team, insisting, "Shouldn't we at least keep trying until the very end? Why is the hospital not doing everything possible to save him?"

Recognizing that some family members had not yet accepted the transition to hospice care, discussions about post-death preparations were deliberately delayed by the hospice team. The timing and content of social work consultations were adjusted in response to individual differences in family members' willingness to discuss death. Conversations about funeral arrangements and other practical preparations were postponed when Mr. Han's wife and eldest daughter were present. Instead, the social worker sought opportunities to discuss these topics with the younger daughter, who was not the primary caregiver but was the family member most accepting of Mr. Han's decision.

One consultation illustrated how the hospice decision continued to shape everyday interactions well after hospice admission.

#### 1) Fieldnote: November 12, 2024

Today, the social worker met with Mr. Han and his family. Organizing financial affairs is routine in hospice consultations, and the topic is often introduced gradually as future preparations are discussed. The consultation included Mr. Han, his wife, his eldest daughter, and his younger daughter. The social worker said cautiously:

*"Mr. Han, it would be helpful if you could let your wife and daughters know the passwords for your bank accounts or mobile phone in advance. This can make things much easier for your family later."*

(Original Korean: "한\*\*님, 아내분과 따님들께 미리 은행계좌나 핸드폰 비번 알려주면 도움이 돼요. 후에 가족분들이 수월하실 거예요.")

Mr. Han quietly nodded and glanced at his wife. Mrs. Oh also nodded, although she appeared hesitant. Without saying a word, the eldest daughter stood and walked out of the consultation room. She appeared unwilling to hear the discussion. The social worker appeared visibly tense, and the atmosphere in the room changed immediately.

Ordinarily, the social worker discussed funeral arrangements, such as whether the family had a burial site or family grave, along with other practical preparations following death. However, none of these topics could be raised on this occasion. Later, a volunteer who had been present on the ward recounted a conflict between Mr. Han and his eldest daughter over his bank account. Mr. Han tried to give her the balances and passwords for his accounts, but his daughter protested that she did not want to hear them and questioned why he was telling her such things. Mr. Han could not discuss these matters while his eldest daughter was in the room.

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This incident was relayed to the social worker, who noted in Mr. Han's chart that future conversations about these topics should take place when the eldest daughter was absent. The family's disagreement over hospice admission therefore extended well beyond the initial decision. Rather than proceeding directly with routine end-of-life planning, social workers first considered which family members were willing to discuss death. These concerns were also discussed in weekly interdisciplinary team meetings, where physicians, nurses, social workers, chaplains, and volunteers revisited Mr. Han and his family as a recurring case. Notes beside his name reminded team members to avoid comments that might unintentionally distress his wife or eldest daughter in subsequent encounters.

Hospice admission therefore did not conclude decision-making. Instead, it marked the beginning of a new phase in which decisions were revisited while decision-making authority continued to be contested and recalibrated. As disagreement persisted, decision-making authority was repeatedly negotiated through decisions about who should be involved, what could be discussed, and when those conversations could proceed.

### 3. Decision-Making Authority Was Relationally Distributed

Mr. Park was a 68-year-old man with terminal gastric cancer. Following years of treatment, including 13 rounds of chemotherapy, his cancer had metastasized to the peritoneum and bones. When he was informed that further curative treatment was no longer possible, he was admitted to the HPC ward and remained there for 28 days until his death. Mr. Park had a wife and two adult children, including his eldest son.

Unlike Mr. Han's family, whose disagreements centered on the meaning of hospice admission, the conflict within Mr. Park's family concerned which claims should carry weight in the decision. Mrs. Lee remained at her husband's bedside throughout his illness and accepted his decision to discontinue chemotherapy and enter hospice care. Their eldest son, however, found the decision difficult to accept.

For many years, Mr. Park had depended financially on his eldest son, who paid for much of his medical treatment. Mr. Park occasionally expressed concern about the financial burden his illness placed on his son. His son, however, did not share these concerns and hoped that his father would continue treatment for as long as possible. Although his wife had accompanied him throughout his illness, Mr. Park remained acutely aware of his financial dependence on his eldest son. That continued willingness to pay future medical bills made his son's opinion difficult to disregard. Disagreements between Mrs. Lee and her eldest son about hospice admission were initially intense.

### 1) Interview with Mr. Park's eldest son

*Son: "I wanted my father to continue chemotherapy. Even now, I regret that he stopped. I've paid all of his medical expenses, which has never been a problem for me. I don't understand why he wanted to stop. If I've supported him financially for the past three or four years, shouldn't my opinion be heard, too? Don't you think?"*

*(Original Korean: "아버지가 항암을 계속하길 바랬어요. 저는 지금도 멈춘 걸 후회해요. 아버지가 항암을요. 치료비도 지금까지 다 냈고, 비용이 문제 된 적도 없어요. 근데 왜 (아버지가) 멈춘 건지. 제가 지난 삼 사년을 경제적으로 해왔으면, 제 의견도 들어줘야 하는 거잖아요. 안 그래요?")*

Mrs. Lee viewed the situation differently.

### 2) Interview with Mrs. Lee (wife)

*Mrs. Lee: "I'm deeply grateful to our son. However, my husband went through chemotherapy for nearly 3 years. He suffered so much. I respect his decision. Even now, with only pain medication, I can see the difference in his face. He sleeps comfortably again. I just hope the time he has left here lasts a little longer."*

Mr. Park himself described the decision from another perspective.

### 3) Informal conversation with Mr. Park

*Mr. Park: "People who are going to die sometimes die even when receiving chemotherapy. Being able to make decisions like this—to come to a hospice—is a privilege. I've gone through 13 rounds of chemotherapy. I took breaks because it was so hard, but altogether, I have been receiving treatment for 3 or 4 years. Chemotherapy is unimaginably miserable. At some point, I realized I simply could not do it anymore. I really could not. Living like that made me feel like I would rather die."*

These disagreements extended beyond differing treatment preferences. Each participant grounded a claim to decision-making authority in a different source of legitimacy. The son's claim rested on years of financial responsibility. Mrs. Lee's claim was rooted in prolonged caregiving and witnessing her husband's suffering. Mr. Park grounded his decision in the embodied experience of enduring years of chemotherapy and pain. Decision-making authority was therefore relationally distributed, with claims to legitimacy arising from financial responsibility,

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caregiving labor, and embodied suffering. Even after Mr. Park's death, his eldest son continued to believe further treatment would have prolonged his father's life.

## IV. Discussion

This ethnographic study suggests that a central ethical challenge in hospice SDM lies not only in achieving consensus but also in sustaining care when disagreement persists. Deliberation does not necessarily end with hospice admission; rather, admission marks the start of an ongoing process in which patients, family members, and health care professionals continually negotiate meanings, relationships, and authority. In this sense, what is "shared" may be less a stable understanding of the decision than the relational work of living with non-consensus.

The cases suggest that disagreement in hospice SDM can concern not only treatment preferences but also fundamentally different imagined futures associated with the same clinical choice. In Mr. Han's family, hospice was variously understood as ending burdensome chemotherapy, abandoning the moral obligation to "keep trying," or respecting the patient's wish for comfort over further suffering and financial strain. These divergent horizons of prolonged survival, comfortable dying, and moral perseverance may not be reconciled simply by providing more information. Together, these differences position hospice decision-making as a negotiation among incompatible temporal and moral orientations toward life, death, and responsibility.

The findings also complicate the assumption that decision-making ends when hospice admission is formally documented. In practice, discussions of financial affairs, funeral arrangements, and other end-of-life preparations were repeatedly adjusted in response to persistent family disagreement. Social workers and nurses assessed individual family members' willingness to discuss death, adjusted the timing of conversations, introduced topics selectively, and modulated their language while the meaning of the hospice decision remained contested.

However, relational recalibration is not necessarily ethically justified simply because it reduces conflict or preserves family relationships. Mr. Han's case illustrates this limitation. Delaying discussions may have accommodated some family members who were not prepared to acknowledge his approaching death, but also constrained Mr. Han's own efforts to prepare for death, including his attempt to share financial information with his family. In hospice, where the remaining time for such conversations may be short, postponement is therefore ethically consequential rather than a neutral adjustment of timing. These observations suggest several considerations for distinguishing relational recalibration from paternalistic information management: patients should be informed when and

why conversations are being paced; their expressed wishes to undertake end-of-life preparation should remain central when relatives' preferences favor avoiding such discussions; and postponement should remain temporary and be actively revisited rather than becoming indefinite deferral. The ethical question, therefore, is not only how communication can be adapted to relational circumstances, but whether such adaptations preserve the patient's opportunity to speak, prepare, and exercise agency during the limited time that remains.

The findings further suggest that relational authority can be distributed rather than located in a single participant. In Mr. Park's family, competing claims to influence decisions were based on different forms of responsibility and suffering: the patient's embodied experience of chemotherapy, his wife's caregiving labor, and his son's financial support. In these interactions, authority emerged not as a fixed property but as something claimed and negotiated through relationships in which caregiving, financial responsibility, and suffering were unequally distributed.

This relational configuration of authority is especially salient where South Korea's legal emphasis on patient self-determination [8,13] intersects with enduring expectations of filial piety and family responsibility [11]. Law and policy formally emphasize patient preferences while defining circumstances in which family members participate in decision-making [8,13]. In practice, however, these decisions are embedded in wider moral economies of debt, obligation, and gratitude. Financially supportive children and caregiving spouses may experience hospice decisions as evaluations of their own devotion. A patient's choice to stop treatment may thus be experienced as relieving family members of impossible burdens or, conversely, as a rejection of the family's efforts to "do everything possible." The tension between self-determination and filial piety may therefore be enacted within specific relationships, where responsibility has been taken up asymmetrically over time, rather than as a simple clash between abstract principles.

Understanding SDM in hospice care through relational authority has several ethical and practical implications. First, it suggests that clinical encounters should explicitly acknowledge the multiple bases on which different participants claim decision-making standing, including embodied suffering, caregiving labor, and financial responsibility, rather than treating disagreement solely as a failure of autonomy or communication. Second, it invites clinicians to acknowledge family members' moral experiences without allowing any single claim of responsibility to override the patient's expressed wishes. For example, spouses' and children's contributions can be acknowledged, while recognizing that their devotion does not obligate the patient to continue burdensome treatment. Third, it highlights the need for institutional guidance on how to proceed when patient self-determination and familial claims of duty remain in tension, such as when a patient insists on hospice admission while a child invokes financial support and filial obligations to

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argue for continued chemotherapy.

These findings also caution against evaluating SDM solely in terms of whether stable consensus is achieved. In these cases, the clinical teams did not resolve the conflict; instead, they continued care while disagreement persisted. These cases therefore suggest that the ethical quality of SDM may depend not only on whether consensus is achieved but also on how disagreement is managed while preserving patients' expressed wishes and opportunities for preparation.

This study has several limitations. It draws on a single hospital-based hospice ward and focuses on patients with advanced cancer, which limits the transferability of these insights to other regions, institutions, and diagnostic groups. The two focal cases were purposively selected because disagreement surrounding hospice care was particularly visible and persistent. The analysis therefore does not suggest that such conflict characterizes hospice decision-making generally but rather uses these cases to examine how SDM unfolds when consensus remains unsettled. The study also focuses on families with relatively strong involvement and therefore offers less insight into patients who lack close relatives or whose relatives are geographically or emotionally distant. Despite these limitations, by tracing how divergent meanings of hospice, ongoing negotiation, and relational authority shape decision-making, this study reframes SDM in hospice care not simply as the achievement of agreement but as the everyday ethics of caring amid enduring disagreement. Future research could extend the analysis to home-based hospices, non-cancer diagnoses, and comparative settings, and examine how institutional policies might better support clinicians who must navigate the complex interplay of self-determination, filial piety, and relational authority at the end of life.

## V. Conclusion

This study examined hospice SDM in a hospital-based ward in South Korea, with a focus on situations in which patients, family members, and health care professionals did not fully share the meaning of hospice itself. Ethnographic attention to everyday interactions suggested that what is “shared” in SDM may be less a unified understanding or stable consensus than the ongoing relational work required to sustain care amid persistent disagreement. In these cases, decisions about hospice admission remained open to reinterpretation, and decision-making authority was repeatedly renegotiated as participants invoked embodied suffering, caregiving labor, financial responsibility, and professional expertise.

By foregrounding relational authority and the tension between self-determination and filial piety, this study contributes to contemporary debates on SDM beyond idealized models of rational agreement. The findings suggest that, in Korean hospice care, patient autonomy can be enacted within dense

networks of obligation, gratitude, and family responsibility. They also suggest that clinical teams engage in temporal and communicative work to sustain care when consensus cannot be achieved. In this sense, the ethical significance of SDM lies not only in reaching agreement but also in sustaining relationships and care when agreement remains out of reach.

These findings have implications for future research and policy on end-of-life decision-making. Rather than assuming that SDM culminates in consensus, ethical and institutional frameworks should account for the possibility that disagreement may persist after hospice decisions have been formally documented. Such frameworks should support clinicians in navigating conflicting claims of self-determination and family duty while sustaining care. 

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