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Legal Education and Informed Consent Quality among Mastectomy and Breast Reconstruction Patients: A Mixed-Methods Study

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Abstract

Informed medical consent for mastectomy and breast reconstruction involves complex treatment decisions requiring adequate understanding, voluntary decision-making, and awareness of patients' legal rights. This study examined the relationship between legal education and the quality of informed medical consent among patients undergoing mastectomy and breast reconstruction and explored factors shaping their consent experiences. A mixed-methods study involved 145 patients and 12 informants, with quantitative data analyzed using descriptive statistics, Kolmogorov-Smirnov, Spearman's correlation, and multiple regression, and qualitative data thematically analyzed. Legal education showed a strong positive relationship with informed consent quality, with $r^2 = 0.524$. In the regression model, legal education demonstrated the strongest association, while education level was also significant. Age, type of surgery, and previous surgical experience were not significant. Qualitative findings identified time constraints, complex medical terminology, limited awareness of legal rights, and nurses' supportive communication as important influences. Strengthening legal education and patient-centered communication may improve the quality of informed medical consent among mastectomy and breast reconstruction patients. These findings suggest that strengthening legal education and patient-centered communication may improve the quality of informed medical consent.

Keywords

Informed Consent, Legal Education, Mastectomy, Quality of Consent, Surgical Experience.

1. Introduction

Informed consent is an essential component of ethical and legally accountable healthcare because it ensures that patients receive sufficient information and can make voluntary decisions regarding medical treatment (Del Carmen & Joffe, 2005; Isaac, 2024). In Indonesia, the legal framework governing informed consent emphasizes the protection of patient autonomy and the right to receive appropriate information before medical procedures. Law Number 17 of 2023 concerning Health and Minister of Health Regulation Number 290/MENKES/PER/III/2008 concerning Approval of Medical Procedures provide an important legal framework for informed consent, requiring consent to be voluntary, based on adequate information, and given by a competent patient. In the context of surgical care, these requirements are particularly important because patients must understand the nature of the procedure, its potential benefits and risks, available alternatives, and their right to accept or refuse treatment. Therefore, informed consent should not be regarded merely as the completion of a consent form but as a communication process that enables patients to understand their rights and participate meaningfully in decisions concerning their health (Firma et al., 2025).

However, the existence of a legal framework does not necessarily ensure that patients fully understand or can exercise their rights during the informed consent process. Limited health literacy, complex medical terminology, insufficient communication time, and differences in educational background may hinder patients' understanding of medical and legal information. Previous studies show that patients with lower educational attainment may have greater difficulty understanding informed consent information, while interactive communication strategies can improve comprehension (Breese et al., 2007; Convie et al., 2020; Glaser et al., 2020). These challenges are especially relevant in surgical settings, where patients must decide on procedures that may involve substantial physical, psychological, and legal implications.

From a legal perspective, informed consent also encompasses patients' rights to receive adequate information, make voluntary decisions, seek clarification or a second opinion, and participate in treatment decisions. Nevertheless, patients may understand informed consent primarily as an administrative requirement rather than as a mechanism for exercising their rights and protecting their autonomy. Inadequate legal education may therefore create a gap between the formal provision of patient rights and patients' practical ability to recognize and exercise those rights. Communication with healthcare professionals, including nurses, may help address this gap by clarifying information, identifying misunderstandings, and supporting patients throughout the preoperative process (Susilo et al., 2013; Axson et al., 2019).

Despite the importance of informed consent, research examining the relationship between legal education and informed consent quality, particularly by incorporating both quantitative and qualitative perspectives, remains limited. Previous studies by Tamariz et al. (2013) and Simonds et al. (2017) have generally focused on health literacy, readability, educational attainment, or general comprehension of consent information, while King and Moulton (2006) have examined the specific contribution of patients' legal education to the quality of informed consent comparatively less attention. This gap is important because understanding medical information alone may not be sufficient if patients do not understand the legal rights and protections associated with their consent.

Therefore, this study aimed to analyze the relationship between legal education and informed consent quality among patients undergoing surgical procedures and to identify factors associated with informed consent quality. In addition, the qualitative component explored patients' experiences of the informed consent process to provide deeper insight into communication barriers, understanding of

legal rights, accessibility of consent information, and the role of healthcare professionals. By integrating quantitative and qualitative findings, this study seeks to provide a more comprehensive understanding of how legal education contributes to meaningful and patient-centered informed consent.

2. Literature Review and Hypothesis Development

2.1. The Effect of Legal Education on Informed Consent Quality

Legal education matters to the quality of informed consent quality because meaningful consent requires more than a patient's signature on a medical document. Patients need to understand the information provided, their rights, the voluntary nature of the decision, and the implications of accepting or refusing a procedure. In surgical settings, informed consent is a communication and decision-making process through which patients receive information and participate in decisions about their treatment. Leclercq et al. (2010) emphasized that surgical informed consent should not be reduced to documentation because its quality depends on adequate information transfer, patient competence, and voluntary agreement. Similarly, Convie et al. (2020) identified knowledge, communication, trust, and decision-making as important domains shaping patients' experiences of surgical informed consent. These perspectives indicate that patients' understanding of the legal dimensions of consent may contribute to their ability to participate meaningfully in treatment decisions.

Legal education may therefore strengthen informed consent quality by helping patients recognize and understand the rights and responsibilities involved in medical decision-making. Evidence from interventions aimed at improving informed consent comprehension demonstrates that enhanced communication, extended discussions, written information, and feedback-based approaches can improve patients' understanding of medical and surgical procedures. Kinnersley et al. (2013) found that interventions designed to improve the consent process generally enhanced patient comprehension, particularly regarding risks and procedural information. Although these interventions do not directly measure legal education, they support the broader proposition that informed and comprehensible communication is central to high-quality consent. Thus, patients with greater legal education may be better positioned to understand and exercise their rights during informed consent, supporting the hypothesis that legal education is positively associated with informed consent quality.

H1: Legal education has a significant positive association with informed consent quality.

2.2. The Effect of Educational Level and Age on Informed Consent Quality

Educational level is frequently identified as an important factor in patients' understanding of informed consent. Patients with higher educational attainment may be better able to process written information, understand medical terminology, and evaluate information about risks, benefits, and alternatives. Breese et al. (2007) found that educational level was significantly associated with both comprehension and satisfaction with the informed consent process, with markedly lower comprehension among participants with lower educational attainment. Similarly, a prospective study of patients undergoing elective orthopaedic surgery found that patients with higher education achieved better comprehension scores, while lower education was associated with poorer understanding of consent information. These findings suggest that educational attainment may influence the ability to process and understand information required for meaningful informed consent.

Age may also be relevant because cognitive processing, information recall, and the ability to understand complex medical information can vary across age groups. In the prospective surgical study, patients younger than 50 years demonstrated higher comprehension than older patients, particularly at postoperative assessment, while greater age was associated with poorer comprehension. More recent evidence by Crepeau et al. (2011) among orthopaedic surgical patients similarly reported lower adequate comprehension among older patients compared with younger patients. However, age should not be interpreted as an independent determinant of consent quality because comprehension is also influenced by education, communication, and the manner in which information is delivered. Nevertheless, the existing evidence provides a theoretical basis for examining age as a factor associated with informed consent quality.

H2: Educational level has a significant positive association with informed consent quality.

H3: Age has a significant positive association with informed consent quality.

2.3. Type of Surgery and Surgical Experience on Informed Consent Quality

The type of surgery may influence informed consent quality because different procedures involve different levels of complexity, risks, benefits, alternatives, and information requirements. Patients undergoing more complex or higher-risk procedures may need more comprehensive explanations to understand the information and make meaningful decisions. A systematic review of surgical informed consent identified the nature of the procedure, knowledge, communication, and decision-making as important components of patients' experiences with consent. Similarly, research on high-risk surgery found that surgeons discussed several elements of informed consent but did not consistently address patient understanding, uncertainty, preferences, and alternatives. These findings indicate that procedure characteristics can shape the amount and complexity of information that must be communicated, making the type of surgery a relevant factor to examine in relation to informed consent quality (Convie et al., 2020).

Previous surgical experience may also influence how patients process information during subsequent consent processes. Patients who have previously undergone procedures may be more familiar with healthcare environments, surgical terminology, or general procedural expectations. A recent systematic review of procedure-specific consent forms noted that patients with prior experience of a procedure may understand and retain information about complications and risks more quickly, although the available evidence was limited and should be interpreted cautiously. Conversely, evidence from high-risk surgical consultations found that a history of previous surgery was not associated with the content of informed decision-making discussions, suggesting that prior experience does not necessarily guarantee better communication or understanding (Norvill et al., 2025). Therefore, surgical experience remains an empirically relevant variable, and its relationship with informed consent quality requires further examination.

H4: Type of surgery has a significant positive association with informed consent quality.

H5: Surgical experience has a significant positive association with informed consent quality.

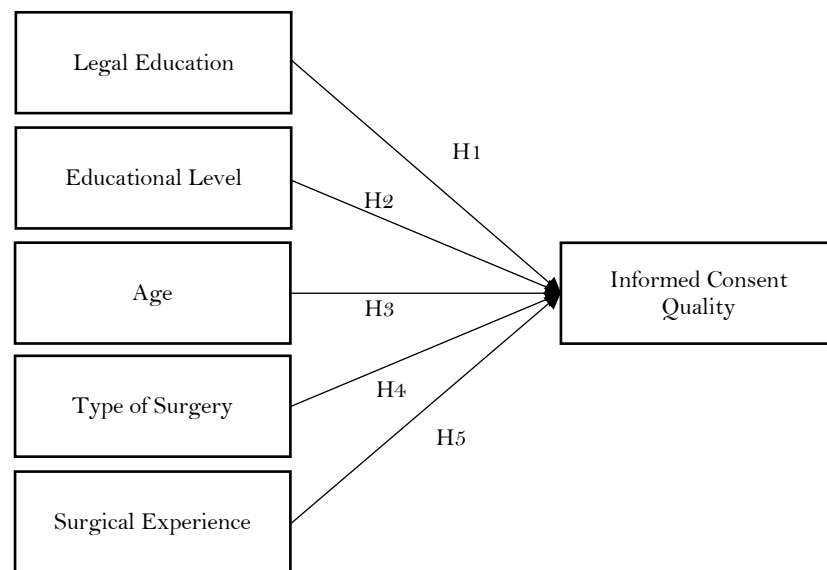


Figure 1. Research Framework

Figure 1 illustrates the research framework, showing that legal education, educational level, age, type of surgery, and previous surgical experience are proposed to influence the quality of informed consent among mastectomy and breast reconstruction patients. Among these factors, legal education is positioned as the primary predictor, while the other variables represent additional patient characteristics that may contribute to informed consent quality.

3. Methods

The study was conducted at Astrini General Hospital (RSU Astrini), Wonogiri, Central Java, Indonesia, from January 1 to December 31, 2025. Astrini General Hospital is a Type B accredited hospital featuring specialized surgical oncology and plastic and reconstructive surgery units. The target population consisted of all female patients who underwent mastectomy (total, modified radical, or skin-sparing) and/or breast reconstruction at the research site during the study period. The inclusion criteria were: female patients aged ≥ 18 years, diagnosed with breast cancer and scheduled for or having undergone mastectomy/reconstruction, having signed the surgical consent form, able to communicate in Indonesian, and willing to participate. Exclusion criteria included severe cognitive or psychiatric disorders, emergency surgery, inability to read or write, and undergoing active chemotherapy or radiotherapy that could alter cognitive capacity.

Purposive sampling in the quantitative phase was justified based on two methodological reasons: the study required participants who had directly experienced the informed consent process, and purposive sampling ensured the substantive relevance of the data. Creswell et al. (2003) indicated that purposive sampling is justified when the target population has strictly defined characteristics, and this approach aligns with health-law research practices. The sample size was calculated using the correlation formula with $Z\alpha/2 = 1.96$, $Z\beta = 0.842$, and $r = 0.40$, yielding a minimum of 46 subjects. After incorporating a 20% attrition tolerance, the required sample size was 56 participants. The final sample consisted of 145 patients, substantially exceeding the minimum requirement and thereby increasing statistical power.

Two custom-designed Likert-scale instruments were utilized. The first was the Legal Education Questionnaire (LEQ), an 18-item instrument covering five dimensions: understanding of patient rights (4 items), understanding of the consent process (5 items), voluntariness and freedom from coercion (3 items), legal protection

aspects (3 items), and quality of educational communication (3 items). Scores were categorized as High (66–90), Moderate (42–65), or Low (18–41). The second was the Informed Consent Quality Questionnaire (ICQQ), a 20-item instrument encompassing five dimensions: completeness of information, patient understanding, voluntariness, patient competence, and satisfaction with the consent process. Scores were categorized as High (73–100), Moderate (47–72), or Low (20–46).

Quantitative data were analyzed using IBM SPSS Statistics version 25. Normality was assessed using the Kolmogorov–Smirnov test. Because the LEQ and ICQQ scores were non-normally distributed ($p < 0.05$), Spearman's rank correlation (ρ) was used. Multiple linear regression was performed to identify independent predictors of informed consent quality. Qualitative data were analyzed using Braun and Clarke's six-phase reflexive thematic analysis. Inter-rater reliability yielded a Cohen's $\kappa = 0.81$. Member checking and peer debriefing enhanced credibility.

4. Results

4.1. Quantitative Results

Before examining the relationship between legal education and informed consent quality, it is important to first describe the socio-demographic and clinical characteristics of the respondents. Table 1 presents the distribution of respondents according to age, education level, marital status, type of surgical procedure, and previous surgical experience.

Table 1. Socio-demographic

Characteristics Respondent	Frequency	Percentage
Age	< 30 years	8
	31–40 years	22
	41–50 years	65
	51–60 years	36
	> 60 years	14
Education Level	No Formal Education/Primary School	12
	Middle School	25
	High School / Vocational School	68
	Diploma / Bachelor's Degree or Higher	40
	Marital Status Married	118
Type of Surgery Procedure	Unmarried/ Divorced/ Widowed	27
	Modified Radical Mastectomy (MRM)	89
	Total Mastectomy	28
	Mastectomy and Reconstruction Previous Surgical Experience	28
	No Prior Surgery	88
	Prior Surgery	57

Table 1 presents the socio-demographic and clinical characteristics of the 145 respondents. Most respondents were aged 41–50 years, accounting for 65 respondents (44.8%), followed by those aged 51–60 years with 36 respondents (24.8%), 31–40 years with 22 respondents (15.2%), >60 years with 14 respondents (9.7%), and <30 years with 8 respondents (5.5%). Regarding education level, the highest proportion of respondents had completed high school/vocational school, with 68 respondents (46.9%), followed by those with a diploma/bachelor's degree or higher, with 40 respondents (27.6%). Meanwhile, 25 respondents (17.2%) had completed middle school, and 12 respondents (8.3%) had no formal education or had only completed primary school. Regarding marital status, 118 respondents (81.4%) were married, while 27 respondents (18.6%) were unmarried, divorced, or widowed.

For surgical procedures, MRM was the most frequently performed procedure, involving 89 respondents (61.4%), followed by total mastectomy and mastectomy with reconstruction, each involving 28 respondents (19.3%). Regarding previous surgical experience, 88 respondents (60.7%) had no prior surgery, whereas 57 respondents (39.3%) had previous surgical experience.

Table 2. Distribution of Legal Education Scores

Dimension	Min	Max	Mean $\pm$ SD	Possible Max
Understanding of Patient Rights	4	20	14.2 $\pm$ 3.1	20
Understanding of IC Process	5	25	16.8 $\pm$ 4.0	25
Voluntariness & Freedom from Coercion	3	15	10.5 $\pm$ 2.8	15
Legal Protection Aspects	3	15	9.1 $\pm$ 2.6	15
Quality of Educational Communication	3	15	12.4 $\pm$ 2.1	15
Total LEQ Score	28	88	56.4 $\pm$ 11.2	90
Category: Low (18–41)	26 (17.9%)			

Table 2 presents the distribution of Legal Education Questionnaire (LEQ) scores among patients. The total LEQ score ranged from 28 to 88, with a mean score of 56.4 ± 11.2 out of a possible maximum score of 90. The mean scores were 14.2 ± 3.1 (range 4–20) for understanding of patient rights, 16.8 ± 4.0 (range 5–25) for understanding of the IC process, 10.5 ± 2.8 (range 3–15) for voluntariness and freedom from coercion, 9.1 ± 2.6 (range 3–15) for legal protection aspects, and 12.4 ± 2.1 (range 3–15) for quality of educational communication. Regarding LEQ scores, the majority of patients (55.2%; $n = 80$) were in the moderate category (score 42–65), while 39 patients (26.9%) were in the high category and 26 patients (17.9%) were in the low category with scores of 18–41.

Regarding ICQQ scores, the majority of patients (62.1%; $n = 90$) demonstrated a high quality of informed consent (score 73–100). The mean total ICQQ score was 74.3 ± 12.8 (range 38–100). Among the ICQQ subdimensions, Patient Competence had the lowest mean score (10.9 ± 3.0 out of 15), whereas Voluntariness had the highest mean score (17.2 ± 2.4 out of 20).

The Kolmogorov–Smirnov test indicated non-normal distributions for both LEQ scores ($D = 0.112$; $p = 0.023$) and ICQQ scores ($D = 0.098$; $p = 0.041$). Spearman's rho showed a strong positive correlation between LEQ and ICQQ scores ($\rho = 0.724$; $p < 0.001$). The coefficient of determination ($r^2 = 0.524$) indicates that legal education scores explain approximately 52.4% of the variance in consent quality.

Table 3. Spearman's Rank Correlation

Variable	rs	r ²	p-value	Interpretation
LEQ $\times$ ICQQ	0.724	0.524	< 0.001	Strong positive
Patient Rights $\times$ IC	0.651	0.424		Moderate–Strong
IC Process $\times$ IC	0.689	0.475		Strong
Voluntariness $\times$ IC	0.598	0.358		Moderate
Legal Protection $\times$ IC	0.612	0.375		Moderate
Communication $\times$ IC	0.703	0.494		Strong

Table 3 presents the Spearman's rank correlation analysis between legal education and informed consent quality. The results showed that the overall LEQ score was strongly and positively correlated with ICQQ ($r_s = 0.724$, $p < 0.001$), with an r^2 of 0.524. Among the individual dimensions, patient rights showed a moderate-to-strong positive correlation with IC ($r_s = 0.651$, $p < 0.001$; $r^2 = 0.424$), while the IC process demonstrated a strong positive correlation ($r_s = 0.689$, $p < 0.001$; $r^2 = 0.475$). Voluntariness showed a moderate positive correlation ($r_s = 0.598$, $p < 0.001$;

$r^2 = 0.358$), as did legal protection ($r_s = 0.612$, $p < 0.001$; $r^2 = 0.375$). Communication showed a strong positive correlation with IC ($r_s = 0.703$, $p < 0.001$; $r^2 = 0.494$). All dimensions demonstrated positive and statistically significant correlations with informed consent quality.

Table 4. Multiple Linear Regression

Variable	B	SE	β	t	p-value
Constant	8.24	4.11	—	2.01	0.047
LEQ Score	0.68	0.08	0.61	8.50	< 0.001*
Education Level	3.12	1.22	0.17	2.56	0.012*
Age	0.21	0.14	0.09	1.50	0.136
Type of Surgery	1.84	1.56	0.08	1.18	0.241
Surgical Experience	2.45	1.38	0.11	1.78	0.078

Table 4 presents the results of the multiple linear regression analysis examining factors associated with informed consent quality. The results showed that LEQ score was the strongest significant predictor, with a positive coefficient ($B = 0.68$; $\beta = 0.61$; $t = 8.50$; $p < 0.001$), indicating that higher legal education scores were associated with higher informed consent quality. Education level also showed a significant positive association with informed consent quality ($B = 3.12$; $\beta = 0.17$; $t = 2.56$; $p = 0.012$). In contrast, age ($B = 0.21$; $\beta = 0.09$; $t = 1.50$; $p = 0.136$), type of surgery ($B = 1.84$; $\beta = 0.08$; $t = 1.18$; $p = 0.241$), and surgical experience ($B = 2.45$; $\beta = 0.11$; $t = 1.78$; $p = 0.078$) were not statistically significant predictors. The constant was statistically significant ($B = 8.24$; $t = 2.01$; $p = 0.047$).

4.2. Qualitative Results

Thematic analysis of 12 in-depth interview transcripts, with a mean duration of 42 minutes, identified four themes related to patients' experiences of informed consent. The first theme, time constraints in consent communication, showed that explanations were often delivered hastily, typically within 10–15 minutes and close to the scheduled surgery. This limited time may reduce opportunities for patients to ask questions and clarify information before making decisions. Previous research has identified time constraints and clinical workload as barriers to effective informed consent communication (Berg et al., 2001; Schenker et al., 2011).

The second theme, language accessibility of consent forms, indicated that informants with lower education levels experienced difficulties understanding medical terminology in consent documents. These findings suggest that providing written information alone may not ensure adequate understanding when the language is complex or unfamiliar. Previous research by Schenker et al. (2007) and Clark et al. (2011) emphasized that the readability and linguistic complexity of informed consent forms can influence patients' comprehension, particularly among individuals with limited health literacy.

The third theme, limited patient awareness of legal rights, indicated that most informants were unfamiliar with their rights to seek a second opinion, access grievance mechanisms, or obtain information about the credentials of the attending surgeon. This finding is consistent with the quantitative result showing a relatively low mean score for legal protection aspects (9.1 ± 2.6 out of 15). Previous studies by Keristian (2025), Ramdani (2025), and Sitepu (2025) highlighted that patients may understand informed consent primarily as authorization for treatment while having limited awareness of its broader legal and autonomy-related dimensions.

The fourth theme, the bridging role of nursing staff, showed that more satisfied informants frequently identified nurses as an important source of clarification and support during the preoperative period. This finding is consistent with previous qualitative research by Malley et al. (2015), which indicates that nurses may function as information providers, patient advocates, and facilitators during informed

consent. Taken together, these themes suggest that informed consent quality depends not only on the formal information provided but also on communication time, language accessibility, awareness of legal rights, and nursing support.

5. Discussion

The findings indicate that legal education is an important determinant of informed consent quality, extending consent beyond formal documentation toward meaningful patient understanding and participation. Knowledge of patient rights, consent procedures, voluntariness, legal protection, and communication may strengthen patients' involvement in surgical decisions. Breese et al. (2007) found that educational level was associated with informed consent comprehension and satisfaction, while Glaser et al. (2020) showed that interactive approaches such as feedback and teach-back improved comprehension. Thus, legal education should be integrated into informed consent as an active communication process. The regression results further show that legal education remained the strongest predictor after controlling for education level, age, type of surgery, and previous surgical experience. Education level also showed a significant association, supporting Breese et al. (2007). These findings emphasize the importance of adapting consent communication to patients' levels of understanding, particularly for complex surgical decisions (Convie et al., 2020).

The qualitative findings help explain why communication conditions may influence informed consent quality. Patients described explanations that were often provided shortly before surgery and within a limited period, while medical terminology in consent forms created additional difficulties, particularly for patients with lower educational backgrounds. These experiences are consistent with a systematic review of qualitative evidence on surgical informed consent, which identified time pressure as a recurring barrier and showed that patients may hesitate to ask questions when they perceive clinicians as having limited time. More recent qualitative research by Michael et al. (2025) among patients undergoing preoperative consent similarly identified insufficient information, time constraints, limited opportunities for questions, and medical jargon as major concerns affecting the consent process. The difficulty with consent forms is also supported by a 2025 systematic review, which found that 76.3% of analyzed medical and surgical consent forms had poor readability (García-Álvarez & García-Sánchez, 2025). Therefore, the findings indicate that improving consent quality requires sufficient communication time and language that patients can understand, rather than relying on standardized written forms alone (Arthanti, 2025).

The relatively weak position of legal protection within legal education also has important implications for patient autonomy. Patients' limited awareness of second-opinion rights, grievance mechanisms, and information concerning the credentials of healthcare professionals suggests that informed consent may still be perceived primarily as authorization for treatment rather than as a mechanism through which patients exercise their rights. This interpretation aligns with Indonesian research describing informed consent as sometimes treated as an administrative formality rather than meaningful two-way communication between patients and doctors (Wahyuni et al., 2020). Research by Susilo et al. (2013) examining patient rights in Indonesian health services likewise emphasizes that informed consent involves the provision of information before patients give consent to medical procedures. Consequently, legal education should explicitly communicate patients' rights and available mechanisms for clarification or complaint, thereby making the legal dimension of informed consent more practically accessible.

The findings highlight the importance of nurses as a complementary communication resource during informed consent. Patients who reported greater satisfaction identified preoperative interactions with nurses as important sources of

clarification and support. Nurses can help identify misunderstandings, facilitate communication, and support patient advocacy, while the primary responsibility for obtaining informed consent remains with the appropriate clinician. Qualitative research in Indonesia found that nurses may function as information providers, witnesses, and patient advocates, with their roles influenced by institutional culture, patient understanding, family involvement, and organizational policies. Susilo et al. (2013) similarly emphasized nurses' role in supporting patient understanding and advocacy during informed consent. These findings support a patient-centered approach integrating legal education, accessible communication, sufficient time, and coordinated healthcare support to strengthen informed consent quality (Axson et al., 2019).

6. Conclusion

This study demonstrates a strong positive relationship between legal education and the quality of informed medical consent among patients undergoing mastectomy and breast reconstruction. Legal education was strongly associated with informed consent quality and remained the strongest independent predictor after adjustment for education level, age, type of surgery, and previous surgical experience, while education level also showed a significant association. In contrast, age, type of surgery, and surgical experience were not significantly associated with informed consent quality. The qualitative findings complemented these results by identifying limited communication time, complex medical terminology, insufficient awareness of legal rights, and the supportive role of nurses as important factors shaping patients' consent experiences. These findings imply that informed medical consent in mastectomy and breast reconstruction should be approached as a patient-centered communication process rather than merely an administrative requirement. Healthcare institutions should strengthen legal education, provide understandable information, allocate sufficient time for discussion, and support coordinated communication among healthcare professionals while maintaining the clinician's responsibility for obtaining consent.

Several limitations should be considered. The cross-sectional quantitative design limits causal interpretation, while the study was conducted within a specific clinical context and included only 12 qualitative informants, which may limit generalizability. Future research should involve larger and more diverse samples across multiple healthcare institutions and employ longitudinal or intervention-based designs to examine whether structured legal education improves informed medical consent quality. Further studies could also evaluate specific communication strategies, including teach-back methods, simplified consent materials, and nurse-supported education, particularly for patients facing complex decisions regarding mastectomy and breast reconstruction.

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Data Disclosure Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.



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