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Responding to Patient Requests for Hastened Death: Physician Aid in Dying and the Clinical Oncologist

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Abstract

Physician aid in dying (PAD) or assisted suicide is becoming legal in more US jurisdictions. Meanwhile, the needs of terminally ill patients with cancer are receiving greater attention, including the integration of palliative care into oncology practice. This article highlights a case vignette of a patient with advanced cancer who requests PAD from her oncologist, as a backdrop to help the practicing oncologist examine his or her moral stance regarding participation in aid in dying. The article concludes by offering a framework within which the practicing oncologist can receive and process a patient's request for PAD.

INTRODUCTION

For more than 15 years, certain states have permitted physicians to prescribe medication that a patient can take to end his or her life. In this vignette, we refer to this practice as physician aid in dying (PAD), also commonly known as physician-assisted suicide. The practice is legal in seven US jurisdictions (as of this writing, Oregon, Washington, Montana, Vermont, the District of Columbia, Colorado, and California) and is on the legislative agenda in a number of others.

Physician participation in assisted dying has generated public policy and professional debate for decades, with no resolution in sight. In light of increased public attention on PAD and heightened professional emphasis on the needs of terminally ill patients with cancer, this article highlights a case vignette to help the practicing oncologist examine his or her moral stance regarding participation in aid in dying. Physicians who care for those with terminal diagnoses may encounter patient requests for information on or assistance with PAD and will ask themselves how they ought to respond. Whether physicians view PAD as unethical or are supportive of the practice, they must have a framework within which to receive and process a patient's request for PAD.

CASE VIGNETTE

J.F. is a 56-year-old woman who presented 5 years ago with stage IIB infiltrating ductal breast cancer, estrogen and progesterone receptor positive and human epidermal growth factor receptor 2 negative by fluorescent in situ hybridization. She underwent mastectomy followed by four cycles of docetaxel and cyclophosphamide. She became amenorrheic and tolerated adjuvant tamoxifen poorly because of hot flashes.

Two years ago, J.F. developed sternal and hip pain and was found to have metastatic disease to multiple bony areas but no visceral disease. She received radiation therapy to her sternum, left iliac bone, and left hip, with improvement in pain. She started goserelin therapy and was prescribed letrazole, which she did not take because of fear of adverse effects. She

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refused bisphosphonates and denosumab because of fear of osteonecrosis of the jaw in the setting of poor dentition. She requested PAD from her primary oncologist, who refused to consider it. As a result, she sought an opinion from a second oncologist.

Her second physician determined that she had decisional capacity and was not depressed. She did have some unrelated mental health history. She had spent many years taking care of her disabled father, who had dementia. A thin and frail woman, J.F. had no evidence of visceral, nodal, or chest wall disease. At that time, her physician suggested further anticancer treatment and felt that the trajectory of her bone-dominant breast cancer was neither appropriate for PAD nor hospice care. The patient agreed and started therapy with goserelin and fulvestrant. She received further irradiation of the thoracic spine, lumbar spine, and ribs. She improved and gained weight, with some decrease in serum tumor markers.

One year ago, she developed increasing pain in her right hip and femur and received palliative reirradiation. However, within months, she developed worsening debilitation and was referred to hospice. Shortly thereafter, she again requested PAD. The second physician wrote a prescription for secobarbital 10 g, 1 year after the patient's original request for PAD. At the time of her last visit, J.F. stated, "I'm not sure I will ever use the secobarbital, but I want it as a backup plan."

PAD AND THE PRACTICE OF CLINICAL ONCOLOGY

As demonstrated in this case, the issue of prescribing for the purpose of ending life is important to practicing oncologists. Evidence from several states demonstrates that a majority of patients who receive such a prescription have been diagnosed with cancer.[1] Many oncologists will encounter patients who will request this assistance if the cancer becomes terminal and sometimes even before. Oncologists may be unsure how to respond to the request. Important questions for oncologists to grapple with include: What is especially fearsome or terrible about death resulting from cancer? How are oncologists meeting or failing to meet the needs and fears of patients?

Recent public polling finds slightly more than half of Americans support PAD when a patient has severe pain and/or a terminal prognosis. A 2013 Pew Research Center public poll found a 47% approval rate and 49% disapproval rate of laws that allow physicians to prescribe life-ending medication to terminally ill patients.[2] In May 2015, a Gallup poll found that 68% of the public believes that physicians should be able to help a person end his or her life if the person has an incurable disease and is living in severe pain. Among adults age 18 to 34 years, 81% approved of PAD under these circumstances.[3]

Physicians facing ethical, moral, and legal dilemmas about PAD have expressed a wide range of opinions. A 2013 reader poll in *New England Journal of Medicine* found that 67% of US respondents opposed PAD.[4] In a 2014 Medscape poll, 31% of physicians were opposed to the continued legalization of assisted dying when presented with a case about a patient with terminal metastatic cancer.[5]

As the discipline of palliative care has become more integrated into the specialization of oncology, care for terminally ill patients with cancer has evolved dramatically. However, there is still much progress to be made.[6-8] The ASCO position paper on individualized care for the patient with advanced cancer recommends that the physician assess the patient's needs, goals, and preferences throughout the course of the illness, with particular attention to symptom management and quality of life.[6] However, challenges including workforce barriers and reimbursement constraints are among the many obstacles preventing patients from obtaining the benefits of specialized palliative care. Patients like J.F. who have had excellent access to palliative care may nevertheless seek PAD near the end of life. Other patients may wish to discuss the option of PAD with their clinical oncologists, even if PAD is something that they would not ultimately pursue. Oncologists who care for patients with terminal diagnoses should prepare for these discussions, especially those practicing in states where PAD is or may soon become legal.

LEGAL STATUS OF AND REQUIREMENTS FOR PAD

Our aim in this section is not to opine on the proper public policy approach to PAD, but rather to inform practicing oncologists of the existing legal landscape. We predict that an increasing number of states will move in a permissive direction, heightening the salience of this issue to the oncology community as a whole.

The legal status of PAD in the United States is currently decided at the state level. Two landmark Supreme Court decisions in the late 1990s affirmed that the aid of a physician in ending one's life is not a right protected by the US Constitution, leaving the states to decide whether the practice should be permitted and under what circumstances. In *Vacco v Quill* and *Washington v Glucksberg*, groups of physicians and terminally ill patients challenged their states' ban on assisted suicide, arguing that patients' constitutional liberty interest

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requires that their physicians be able to help them decide the timing and manner of death. In 1996 and 1997, the Supreme Court rejected these arguments. The Court ruled that although patients have the right to refuse life-sustaining treatment, they do not have a Constitutional right to end their lives with physicians' assistance. According to the Court, "the distinction between letting die and making that patient die is important, logical, rational, and well established: It comports with fundamental legal principles of causation"[9] and that the interest in deciding "how, rather than whether" to

Table 1. Characteristics of State PAD Laws and Policies

	Features of Law				
State	Diagnosis	Patient Requirements	Waiting Period and Residency	Capacity	Witnesses
Oregon (1997)[12]	Death within 6 months likely; agreed on by two physicians	Two oral and one written request	Residency required; 15-day wait between second written request and prescription	Able to make and communicate health decisions unimpaired; referrals required if judgment or capacity is in question	Two required; cannot be relatives, beneficiaries, or employees of facility
Washington (2009)[13]	Death within 6 months likely; agreed on by two physicians	Two oral and one written request	Residency required; 15-day wait between oral request and prescription; 48 hours between written request and prescription	Referrals required if judgment or capacity is in question	Two required; cannot be relatives, beneficiaries, or employees of facility
District of Columbia (2016; to be effective 2017)[14]	Death within 6 months likely; agreed on by two physicians	Two oral and one written request	Residency required; 15-day wait between oral request and prescription; 48 hours between written request and prescription	Capacity determination required; counseling required if physician suspects psychological disorder affecting judgment	Two required; at least one cannot be relative, beneficiary, or employee of facility or attending physician
Colorado (2016)[15]	Death within 6 months; confirmed by two physicians	Two oral and one written request	Residency required; oral requests must be ≥ 15 days apart.	Capacity determination required	Two required; at least one cannot be relative, beneficiary, or employee of facility or attending physician
California (2015)[16]	Death within 6 months likely; agreed on by two physicians	Two oral and one written request	Residency required; 15-day wait between second written request and prescription	Referrals required if judgment or capacity is in question	Two required; cannot be relatives; one cannot be beneficiary or employee of facility
Vermont (2009)[17]	Death within 6 months likely; agreed on by two physicians	Two oral and one written request	Residency required; 15-day wait between second written request and prescription	Prescribing physician can confirm capacity and refer for mention health consultation if necessary	Two who are not "interested persons"
Montana (2009)[18]	Court decision states terminal illness; pending legislation to implement court ruling	—	—	—	—

Abbreviation: PAD, physician aid in dying.

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die does not extend to a protected right to legal assisted suicide[10].

These cases established that the Constitution does not require legal access to PAD; however, a 2006 case solidified the legal standing of the practice in the states. In *Gonzalez v Oregon,* the Supreme Court found that the federal government cannot prevent states from including PAD within the scope of medical practice by regulating PAD medications used for the purpose of PAD.[11] As a result of this series of decisions stating that PAD cannot be required or prevented by national law, the legality of PAD continues to be decided at the state level. In some states, action has been taken by litigation to remove laws that make assisted suicide a criminal offense (as seen in New Mexico and other states) or by state ballot initiatives and legislation to protect physicians who participate and affirmatively give rights to patients (as seen in California and other states). Table 1 lists state laws and policies regarding PAD.

ETHICS AND PAD

In this section, we offer guideposts from ongoing ethical debates for oncologists to consider their own moral and ethical views in preparing to respond authentically to patients. We then discuss the aforementioned case and provide recommendations for how practicing oncologists can respond to PAD requests from patients.

Autonomy

A leading ethical principle among supporters of PAD is respect for persons and patient autonomy. Some modern descriptions of autonomy in medical ethics see the patient as a lone individual capable of making decisions about the general course of his or her life. Autonomy requires the ability to discern, understand, and decide among options without coercion or the undue influence of others, either in accordance with moral law or with the individual's discerned preferences and values. Supporters of an individualistic notion of patient autonomy consider it a prominent health care value, whereas detractors caution against using claims to autonomy as a way to prevent appropriate consideration of other relevant values or decrease clinician responsibility. Some newer theories of autonomy known as relational autonomy expand the individualistic notion and envision a patient within his or her relationships and social context. Relational autonomy acknowledges that people make decisions in the contexts of their families and communities and are influenced by factors like religion, race, gender, economics, and other interconnected elements of identity. In these conceptualizations of autonomy, the autonomous patient truly understands the available options and chooses in accordance with his or her preferences and values.

The proliferation of advance directives, health care powers of attorney, living wills, and the Medical or Physician Orders for Life-Sustaining Treatment provides examples in which US law has conformed to a notion of autonomy that holds that people have the right to control their care at the end of life according to their own wishes. In these legal frameworks, patients can nearly always decide to decline treatment that is burdensome.[19] Hospice care and other end-of-life services are further evidence of the societal support for individuals who decline burdensome care or who have no curative care options available. PAD is seen by some as an extension of the patient's right to make his or her own choices, coupled with the "desire to protect seriously ill people from intolerable suffering."[19(p1961)]

PAD exceeds a simple right to refuse treatment because it requires the participation of a health care provider, challenging even the staunchest supporters of modern autonomy. Some ethicists have raised concerns about the implications of determining the timing and manner of death on patients' and clinicians' liberty, privacy, equality, and other values.[20,21]

Beneficence and Nonmaleficence

Beneficence refers to the ethical imperative that physicians act in the best interest of their patients, whereas nonmaleficence asserts an obligation not to inflict harm. These duties can be difficult to reconcile. For those who view PAD as a legitimate option of last resort for terminally ill patients, the duty to protect seriously ill people from intolerable suffering requires that physicians honor patients' refusal of treatment and, when asked, provide prescriptions that are intended to cause death. A patient's decision to stop dialysis or mechanical ventilation may be based on a desire to relieve suffering by hastening death; PAD likewise relieves suffering for a patient whose death is imminent but not immediate. In this view, there are comparable moral implications of participation in either act.[20] Because physicians have a duty to act as responsive and compassionate caregivers throughout the end-of-life process, some see PAD as a manner of providing comfort to the dying.

However, others believe that the obligation of beneficence forecloses the option of aiding in an actively hastened death, insofar as the intention to cause death is not a good. A clear line is seen between withholding or stopping an unwanted therapy to allow a person to die and acting with the intention of causing

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death by prescribing a specific drug with the specific purpose of ending the patient's life. For those who view PAD as unethical, the more appropriate response from the perspective of doing no harm is to remain with the patient throughout the full course of his or her illness and provide emotional support, comfort care, adequate pain control, respect for patient autonomy and good communication.[22]

Justice

Oncologists may have a more or less favorable view on whether they would participate in PAD when considering the conditions in which patients would request aid. Some may have concerns about disproportionate impact on disabled or socially disadvantaged individuals who would request to die under pressure, duress, or lack of social support. Others who support PAD may be concerned that disadvantaged patients may not be able to access PAD because of constraints such as the cost of medications, onerous procedural requirements in legal states, or inability to relocate to a state where PAD is legal. Physicians may also find moral relevance in the power differences between themselves as physicians and their patients, between the sick and the well, or between the dying and not dying.

Data from Oregon on patients who have died as a result of ingesting PAD medication suggest that patients tend to be well educated and have similar levels of insurance coverage as other terminally ill patients.[23] In 2015, 99.2% of patients receiving PAD had some form of health insurance and were enrolled in hospice care. Similar to previous years, the three most frequently mentioned end-of-life concerns were: decreasing ability to participate in activities that make life enjoyable (96.2%), loss of autonomy (92.4%), and loss of dignity (75.4%).[23] The justice-based concerns that the practice of PAD will unfairly target individuals who are disadvantaged in terms of access to hospice care, education, and insurance are not supported by available evidence. There may be other ways in which certain patients who choose to obtain PAD are socially or otherwise disadvantaged, and these concerns warrant further study.

Honesty and Transparency Between Physician and Patient

The patient-physician relationship will be another important consideration for oncologists evaluating PAD. Patients with terminal illnesses often seek open conversation about end-of-life options with physicians they trust. Debate and empiric research are ongoing about the impact of legal PAD on the underlying trust between physicians and patients. It could be said that without PAD available, terminally ill patients could feel more confident that physicians will offer all other options before agreeing to PAD. A patient could develop greater trust in a physician's end-of-life care plan, knowing that the physician has been transparent about whether he or she will willingly participate in PAD. Physician involvement in the decision to proceed with PAD requires counseling regarding the expected trajectory of the illness and the timing or need for PAD, as seen in the case of J.F.

Professionalism and Role of the Physician

Many view the historical role of physician as healer to be incompatible with PAD, going back to the Hippocratic Oath to refuse deadly remedies and avoid doing harm. Most of organized medicine in the United States has opposed such assistance on the grounds that a physician should not kill or be a party to killing.[24] Until the late 20th century, virtually all societies clearly condemned PAD. The American Medical Association Code of Medical Ethics describes PAD as fundamentally incompatible with the physician's role as healer, difficult or impossible to control, and would pose serious societal risks.[22] According to this view, the physician who participates in PAD abandons his or her professional duty to the patient and society. The issue of PAD also raises concerns that the physician will become a mere vendor to a customer, losing essential aspects of the caretaking role.[25]

Oncologists who are willing to participate in PAD may see patients who seek them out specifically for that purpose, particularly where patients travel to a new state to access the option. Such providers may use the PAD encounter as a way to build new relationships with patients who are unable to access PAD from their primary oncologists or other care providers.

Physicians must be healers of pain and providers of comfort where they cannot cure disease. Some will view PAD as fundamentally incompatible with the practice of professional medicine. Others will find that PAD is compatible with their role as healer when the tools of medicine can no longer offer curative treatment. Professionalism demands that the physician respond honestly about his or her willingness to participate in PAD and offer to continue caring for a patient who has requested PAD.

An oncologist's decision that he or she is willing to offer PAD need not mean that he or she would honor all such requests. The moral acceptability of the act of PAD may depend on the

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Table 2. How Do I Respond to a Request for PAD?

Response
Recognize the emotional state of the patient and the nature of the request. Frequently, a mention of PAD could be an opportunity for exploration of the patient's desires and concerns about the end of his or her life. For the practicing oncologist, a patient's wish to end his or her life might be a good occasion to review the status of the illness, the prognosis, and what to expect as the cancer advances.
When the request is definite, try to understand the request in the context of the patient's illness, prognosis, family and community support, understanding, and expectations. Schedule additional meetings as needed.
Enlist the help of other professionals for the patient and his or her family or support persons. This is a situation where a multidisciplinary team can be of great value.[26,27] Seek multidisciplinary involvement by mental health professionals and palliative care consultation. A trained palliative care specialist may be able to offer more than the primary palliative care provided by most oncologists. Specialty expertise from a palliative care provider may help alleviate the suffering that prompted the request for PAD. Provide the patient with resources for psychological and social support, pastoral care, and palliative care.
Thoroughly address the patient's mental health, and get a mental health evaluation. Recognize that mental health disorders commonly occur in patients with cancer, even if there is not a formal prior diagnosis.
Thoroughly address the patient's ability to consent. Assist the patient in completing an advance directive.
Seek and use resources for self-care. Dealing with a request for PAD is emotionally, ethically, and even physically demanding for the physician.[20]

NOTE. Whether an oncologist finds himself or herself legally permitted and/or morally able to write a PAD prescription or refer the patient to another clinician, the responses listed in this table are consistent with good practice.

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circumstances, and "a physician who in principle accepts the permissibility of assistance in bringing about death may still refuse to honor a particular request if there is good moral reason for doing so."[20(p438)] For such a physician, other factors justifying his or her personal involvement could include: whether the patient has been adequately counseled about and has access to palliative options, the depth or length of the relationship with the patient, whether the physician knows that the patient's request has not been coerced and is sincere. For other oncologists, any participation in or referral for PAD will be seen as a violation of professional, religious, moral, or other convictions. Such refusals should be respected, and no physician should be pressured to participate. This discussion is limited to active participation in PAD and does not address referral as a form of participation. Table 2 lists steps that all oncologists can consider when responding to patient requests for PAD. JOP

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References

1. Loggers ET, Starks H, Shannon-Dudley M, et al: Implementing a death with dignity program at a comprehensive cancer center. N Engl J Med 368:1417-1424, 2013

2. Pew Research Center: Views on end-of-life medical treatment: Growing majority of Americans say doctors should do everything possible to keep patients alive. http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/

3. Dugan A: In U.S., support up for doctor-assisted suicide. http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx

4. Colbert JA, Schulte J, Adler JN: Physician-assisted suicide: Polling results. N Engl J Med 369:e15, 2013

5. Kane L: Medscape ethics report 2014, part 1: Life, death, and pain. http://www.medscape.com/features/slideshow/public/ethics2014-part1

6. Peppercorn JM, Smith TJ, Helft PR, et al: American society of clinical oncology statement: Toward individualized care for patients with advanced cancer. J Clin Oncol 29(6): 755-760, 2011

7. Temel JS, Greer JA, Muzikansky A, et al: Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 363:733-742, 2010

8. Smith TJ, Temin S, Alesi ER, et al: American Society of Clinical Oncology provisional clinical opinion: The integration of palliative care into standard oncology care. J Clin Oncol 30:880-887, 2012

9. Vacco v. Quill, 521 U.S. 793 (1997)

10. Washington v. Glucksberg, 521 U.S. 702 (1997)

11. Gonzalez v. Oregon, 546 U.S. 243 (2006)

12. Oregon: Or Rev Stat §§127.800-127.897

13. Washington: Rev Code Wash §70.245

14. District of Columbia: B21-0038

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15. Colorado: §25-48-101

16. California: AB-15 (2015-2016)

17. Vermont: Vt. Stat. Ann. tit. 18 §§5281-92

18. Montana: Baxter v Montana, 224 P3d 1211 (Mont 2009)

19. Orentlicher D, Pope TM, Rich BA: The changing legal climate for physician aid in dying. JAMA 311:1961-1962, 2014

20. Beauchamp TL: The medical ethics of physician-assisted suicide. J Med Ethics 25: 437-439, 1999

21. Austin CA, Mohottige D, Sudore RL, et al: Tools to promote shared decision making in serious illness: A systematic review. JAMA Intern Med 175:1213-1221, 2015

22. American Medical Association: AMA Code of Medical Ethics, opinion 2.211/5.7: Physician-assisted suicide. https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf

23. Oregon Public Health Authority: Oregon Death With Dignity Act: 2015 data summary. http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf

24. Snyder L, Sulmasy DP; Ethics and Human Rights Committee, American College of Physicians-American Society of Internal Medicine: Physician-assisted suicide. Ann Intern Med 135:209-216, 2001

25. Yang YT, Curlin FA: Why physicians should oppose assisted suicide. JAMA 315: 247-248, 2016

26. Georges JJ, The AM, Onwuteaka-Philipsen BD, et al: Dealing with requests for euthanasia: A qualitative study investigating the experience of general practitioners. J Med Ethics 34:150-155, 2008

27. Quill TE, Back AL, Block SD: Responding to patients requesting physician-assisted death: Physician involvement at the very end of life. JAMA 315:245-246, 2016

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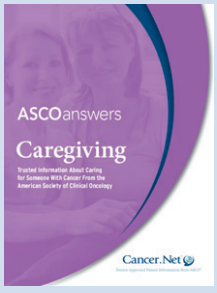
Help Caregivers Learn About the Importance of Their Role in Cancer Care



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