

When Financial Dependence Shapes Apparent Consent: A Framework for Distinguishing Voluntary Family Agreement from Economic Coercion in High-Cost Treatment Decisions

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Abstract

High-cost treatment decisions can expose a gap between the outward form of consent and the conditions that make agreement practically possible. A patient may endorse a treatment plan while depending on relatives for payment, housing, transport, caregiving, or other resources that make refusal materially consequential. Financial dependence alone, however, does not establish coercion, and family influence is not inherently autonomy-reducing. This article develops a conceptual account for distinguishing voluntary family agreement, financially constrained but still voluntary choice, undue economic influence, and coercive economic leverage. It integrates evidence on financial toxicity, treatment trade-offs, shared decision-making, relational autonomy, family involvement, and coercion. The ethical significance of dependence is argued to turn on patient-authored preferences, the source and form of influence, control over indispensable resources, the feasibility of refusal, and whether institutional alternatives can alter the patient's option set. Apparent agreement becomes more concerning when another actor conditions essential resources on compliance and refusal carries serious, practically unavoidable consequences. Even then, authenticity, context, and the origin of the constraint remain decisive. Financial dependence is therefore best understood as a vulnerability that can enable coercion without constituting coercion itself.

Keywords: Financial toxicity, Informed consent, Coercion, Relational autonomy, Family decision-making, Treatment costs

Introduction

Consent is rarely formed in social isolation. Patients rely on clinicians, relatives, and other sources of epistemic and practical support. Wilkinson and Levy describe autonomy as capable of being scaffolded through appropriate interpersonal and informational support, which means that influence alone cannot determine whether a decision is voluntary [1]. This becomes

especially important in high-cost treatment, where a relative may be adviser, caregiver, payer, transport provider, or housing provider at the same time. The ethical question is whether those relationships support the patient's choice or make disagreement materially unsafe.

A useful distinction must also work in practice. Kuehlmeier *et al.* argue that normative ethics must address how justified requirements can be translated into healthcare settings [2]. High-cost treatment decisions therefore require more than an abstract contrast between autonomous and coerced choice. A patient who willingly accepts family financial help, a patient who selects the only affordable treatment, and a patient whose relative threatens to withdraw indispensable support unless a preferred treatment is accepted may all outwardly agree, yet the ethical structure of those agreements differs.

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Financial-toxicity research establishes the material background. Financial toxicity includes direct costs, income loss, debt, distress, and coping behaviors associated with cancer treatment [3]. It is broader than coercion because it describes economic burden without identifying whether another person has wrongfully shaped the decision. Nonetheless, cost can influence treatment preferences. Among patients with multiple myeloma, financial toxicity was associated with lower willingness to pay and greater salience of cost in treatment trade-offs [4]. Such evidence does not prove involuntariness, but it shows why a clinically acceptable option may become practically unattractive or inaccessible.

The burden can be substantial. A global systematic review found a high pooled prevalence of catastrophic health expenditure among people with cancer, alongside extreme heterogeneity across settings [5]. Expert consensus likewise treats financial toxicity as involving both objective burden and subjective distress and recommends multilevel screening and management [6]. Neither financial-toxicity measures nor screening recommendations, however, identify coercion. They establish vulnerability and resource pressure.

This article addresses the resulting classification problem. When a patient relies on family resources for expensive treatment, apparent agreement may represent genuine endorsement, adaptive compromise, constrained voluntariness, undue influence, or coercive leverage. The analysis focuses narrowly on financial dependence in treatment decision-making rather than family participation generally, cultural disclosure practices, fluctuating capacity, or surrogate authority. Its purpose is to identify when economic dependence merely narrows feasible choices and when another person's control over resources changes the moral character of agreement.

Financial dependence and the problem of apparent consent

Financial dependence is difficult to assess because burden is multidimensional. A systematic review of financial-toxicity screening found substantial variation in instruments and screening approaches [7]. Distress, material hardship, and coping consequences may therefore be detected differently, while dependence on a particular relative may escape standard measures altogether. Screening can show that finances matter; it cannot establish who controls the relevant resources or how that control affects voluntariness.

Hardship also reflects structural context. Dhir *et al.* found associations between cancer-related financial hardship and both individual- and community-level vulnerability [8]. This matters because a family member who helps pay for treatment may be expanding the patient's options against a background of insurance gaps, weak employment protection, or other structural disadvantage. The existence of dependency is therefore insufficient to locate the source of constraint inside the family.

Financial pressure also changes over time. Kircher *et al.* showed that burden evolved during the first year after colorectal-cancer diagnosis and did not follow the same course for all patients [9]. In a related longitudinal analysis, material hardship decreased while cost-related nonadherence did not significantly change [10]. These findings indicate that economic burden is not a single stable state. A patient's ability to refuse one option or sustain another may change as savings, employment, caregiving arrangements, and household obligations change.

Trajectory evidence in young adults with breast cancer similarly identified groups with little difficulty, improving difficulty, and persistent difficulty [11]. The implication is not that wealth determines autonomy. It is that the practical feasibility of a formally available option can vary over time. Treatment behavior can reflect this pressure. Among patients with pancreatic cancer, financial toxicity was associated with poorer quality of life and cost-related medication nonadherence [12]. These associations do not establish coercion or causality, but they demonstrate that financial conditions can become consequential for treatment conduct.

Shared decision-making and financial strain are also connected. In a nationwide Chinese study, Liu *et al.* found associations among shared decision-making, financial toxicity, and coping actions [13]. The cross-sectional design prevents causal ordering, but the findings support treating financial circumstances as part of deliberation rather than as an administrative issue that begins after consent. A patient can understand clinical risks and benefits while still lacking a realistic opportunity to discuss who will pay, what obligations accompany that support, and what happens if the patient rejects the preference of the person controlling the resources.

For this article, apparent consent means overt agreement whose external form is compatible with consent while voluntariness remains uncertain because feasible options are materially constrained. The term does not imply that

the agreement is invalid. Constrained voluntariness describes the narrower condition in which economic circumstances substantially limit feasible choice without sufficient evidence that another actor has coercively imposed that limitation. These concepts separate

structural scarcity, dependence, influence, and coercion rather than treating them as points on a single financial-toxicity scale.

The relevant configurations differ in ethically important ways, as summarized in **Table 1**.

Table 1. Financial configurations that can produce apparent agreement while differing in their implications for voluntariness

Financial configuration	Source of practical constraint	Control over relevant resources	What agreement may represent	Main voluntariness question	What cannot yet be inferred
System-generated scarcity	Prices, insurance exclusions, income loss, unavailable benefits	Payer, employer, market, or health system	Adaptation to a narrowed option set	Is any preferred alternative practically usable?	Family coercion
Patient-authorized family support	Reliance on relatives for payment, transport, housing, or care	Shared or family-held resources used with patient endorsement	Relationally supported choice	Does support remain aligned with the patient's priorities?	Dependence undermines autonomy
Reluctant financial compromise	Preferred option is economically unsustainable	Mixed structural and household resources	Constrained but potentially voluntary agreement	Can refusal or another option realistically be sustained?	Reluctance equals coercion
Unequal household bargaining	Treatment access depends heavily on another person's cooperation	Family or household decision-maker	Agreement shaped by bargaining asymmetry	Does disagreement predict serious material loss?	Unequal power is already coercive
Conditional or threatened support	Essential help is tied to accepting the resource-holder's preferred choice	Specific resource-holder	Agreement under possible economic leverage	Are consequences attached to refusal serious and practically unavoidable?	Coercion without examining context, legitimacy, and alternatives

The same observable endpoint—agreement with treatment—can therefore arise through different normative pathways. Financial-toxicity research is well suited to identifying burden and consequences. Determining whether a family relationship crosses into coercion requires a second analysis of how influence operates and what refusing it would cost.

Family influence, voluntariness, and economic coercion

Relational autonomy provides a starting point because it does not equate autonomy with independence. Foo *et al.* distinguish competence, authenticity, and involvement of significant others in end-of-life decision-making [14]. Although developed in another context, that separation is useful here. A patient may understand the decision, authentically value family participation, and choose to rely on relatives. The relevant question is whether the resulting agreement continues to express the patient's priorities when those relatives also control resources needed for treatment.

Patients differ in how much family participation they want. In a multicenter Chinese study, Yan *et al.* found variation across stages of decision-making and discrepancies between expected and actual family involvement [15]. Family-led participation therefore cannot be classified as inherently autonomy-supporting or autonomy-reducing. The ethical concern arises when actual influence departs from the patient's preferred role distribution and the patient bears significant relational or economic costs for resisting that departure.

Relational autonomy itself is conceptually diverse. Gómez-Vírveda *et al.* found substantial variation in its meanings and uses in end-of-life ethics [16]. It should consequently serve as an interpretive lens rather than as permission for family control. Family involvement can sustain agency by providing care, information, and resources; the same relationship can become problematic when support is used to redirect a choice against the patient's priorities.

Caregiver roles are likewise heterogeneous. Dionne-Odom *et al.* identified observer, primary, shared, and delegated roles in cancer treatment decisions [17]. Advice, logistical support, shared deliberation, delegated assistance, and control over essential money are ethically different forms of participation. A relative may exert substantial influence without compromising voluntariness, particularly where the patient welcomes that role.

Coercion requires stronger grounds. Steel and Wendler argue, in research participation, that an unwelcome condition or restricted alternatives are not by themselves sufficient to establish coercion [18]. Treatment decisions differ from research participation, but the conceptual distinction is valuable: bad circumstances do not automatically reveal a coercing actor. A patient may face only unattractive options because every available treatment is expensive. That situation can be unjust and sharply constraining even when no relative has created or strategically exploited the constraint.

Buchbinder and Berens similarly challenge a simple autonomous-choice/coercion binary in medically assisted death, emphasizing competence, authenticity, relationship context, available options, financial considerations, and other features of influence [19]. Their analysis is context-specific, yet it highlights why economic pressure in families cannot be judged from the mere existence of dependence. The same person may be payer, caregiver, advocate, and emotional support, so the moral character of influence depends on how that position is used.

The distinction developed here is therefore between financial dependence as vulnerability and economic coercion as a relational use of leverage. Dependence becomes more ethically concerning when another actor controls resources that are practically indispensable, ties continued access to compliance with a preferred treatment decision, and makes refusal costly enough to compromise meaningful resistance. Context still matters. A relative who cannot afford an experimental intervention may be setting a painful but legitimate limit. A resource-holder who threatens to withdraw affordable and essential support solely to force treatment the patient rejects presents a different structure.

Between clearly voluntary support and presumptively coercive leverage lies a range of constrained and potentially undue influence. Some patients authentically choose among options narrowed by poverty, insurance rules, or household resources. Others face bargaining

pressure or manipulation while retaining meaningful room to refuse. The ethical task is to identify the mechanism linking dependence to agreement: who controls the resource, what condition is attached to it, what the patient prefers, what refusal would cost, whether the consequence is strategically imposed or structurally given, and whether realistic institutional alternatives could change the option set. Those questions provide the basis for distinguishing agreement from coercion without treating either family involvement or financial dependence as decisive on its own.

A framework for distinguishing agreement from coercion

The central problem is not whether money affects treatment choice; it plainly can. The harder question is when dependence on another person's resources alters the moral status of agreement. Cost conversations provide one practical entry point because they make financial constraints visible before they become fixed features of a treatment plan. Littman *et al.* describe such conversations as part of shared decision-making while emphasizing their persistent underuse and the limited prospective evidence concerning outcomes [20]. Cost disclosure therefore supports deliberation, but it cannot by itself determine whether a family arrangement is voluntary.

Institutional context also affects what dependence means. Wheeler *et al.* identified heterogeneous interventions intended to reduce cancer-related financial hardship, including navigation, assistance, education, and other supports [21]. Their diversity matters conceptually: a patient who appears wholly dependent on a relative may have different practical options once benefits, charity programs, transport, or payment arrangements are identified. Conversely, the absence of accessible alternatives may intensify dependence without proving that the relative is coercing the patient.

The proposed distinction begins with patient-authored preference. The question is whether the treatment choice and the desired role of family members remain recognizably connected to values the patient endorses. Authentic family involvement can include substantial reliance on shared money and practical support. Concern increases when the patient's stated preference differs from the family-preferred option and the patient's ability to act on that preference depends on resources controlled by the same person exerting pressure. Authenticity is therefore relevant without becoming a demand for independence.

A second dimension is the form of influence. Advice, persuasion, negotiation, refusal to fund unaffordable care, strategic conditionality, and threats are not interchangeable. Family members may reasonably disclose what they can contribute or decline costs they cannot sustain. Economic leverage becomes more serious when continued access to indispensable resources is intentionally attached to compliance with a treatment preference and the threatened loss exceeds an ordinary disagreement over shared spending.

Third, the analysis asks what the resource-holder actually controls. Financial dependence may concern the treatment itself, insurance premiums, accommodation near a specialist center, transportation, caregiving, food, or the patient's broader household security. Control becomes ethically weightier as the resource becomes more indispensable and less replaceable. Yet resource control remains only one component. A relative may control an essential resource while using it entirely in accordance with the patient's wishes.

Fourth, formal permission to refuse must be separated from practical refusal. A patient can legally say no while facing consequences that make refusal barely usable in practice. The relevant inquiry is whether rejecting the resource-holder's preferred option would leave a realistic pathway to treatment, basic living needs, or continued care. This does not generate a numerical threshold. Practical feasibility is context-dependent and must be judged with attention to severity, immediacy, substitutability, and the patient's own priorities.

Fifth, institutional remediability helps locate responsibility. If a financial counselor, benefits program, insurer appeal, transport service, social worker, or other institutional intervention can materially widen the patient's option set, the patient's dependence may be partly avoidable. Failure to provide such support can sustain ethically troubling constraint even where no family member is coercive. Structural and interpersonal pressures can also coexist: a health system may create scarcity that gives a relative unusually powerful leverage over the decision.

A further distinction concerns whether the adverse consequence is strategically imposed or independently

unavoidable. A relative who says that the household cannot finance a treatment may be describing a real limit; a relative who can provide agreed support but threatens to withdraw it only if the patient refuses the relative's preferred option is using the resource differently. The content of the consequence may look similar—loss of money—but its relation to the decision is not. Clinicians therefore need to ask whether the consequence would occur regardless of the patient's choice, whether it is selectively activated by disagreement, and whether the person controlling the resource has legitimate competing obligations. This prevents the analysis from treating every painful household trade-off as coercive while still recognizing that apparently ordinary financial conditions can be used strategically. It also keeps the framework attentive to reciprocal duties within families without allowing those duties to erase the patient's treatment preference.

Taken together, these dimensions support four interpretive states without turning them into a score. Voluntary family agreement exists when the patient endorses both the treatment and the family's role, and support is not conditioned on abandoning the patient's own priorities. Financially constrained but voluntary agreement exists when options are materially narrowed yet the decisive limitation arises from background scarcity, legitimate resource limits, or patient-endorsed compromise. Undue economic influence becomes plausible when asymmetrical control over resources distorts deliberation or burdens resistance despite some meaningful room for refusal. Presumptively coercive economic leverage arises when an actor strategically conditions indispensable support on compliance and the consequences of refusal are serious, difficult to avoid, and inconsistent with the patient's authentic treatment preference.

The moral classification can change as resources, preferences, or alternatives change. **Figure 1** therefore treats voluntariness as a relational and revisable assessment rather than as a linear progression from dependence to coercion.

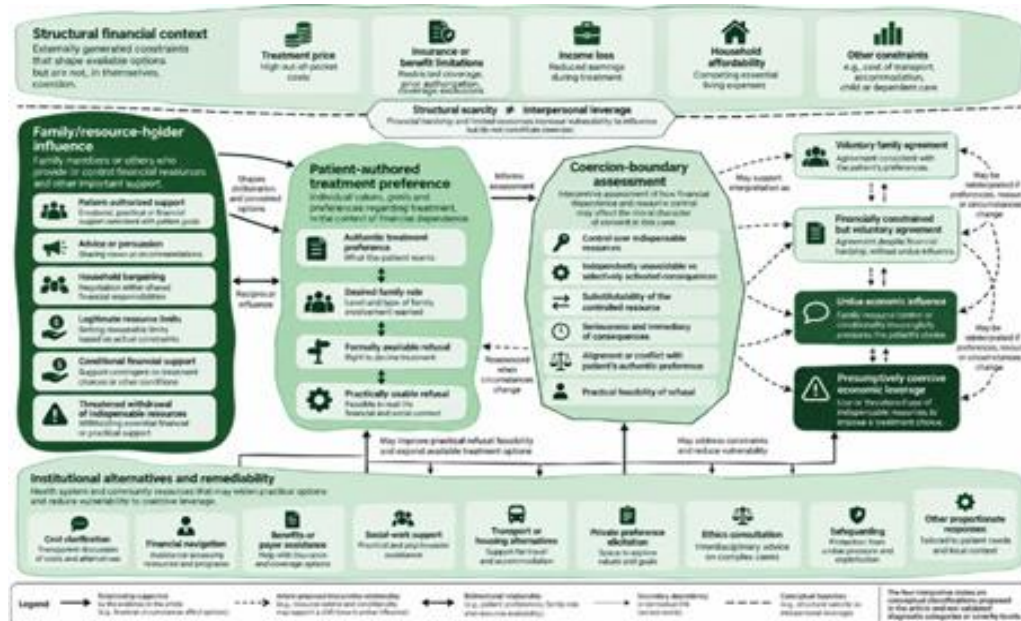


Figure 1. Agreement under financial dependence: where resource control and conditionality change the moral character of consent

Clinical and institutional implications

Clinical response should begin by identifying the mechanism of constraint rather than by treating financial dependence as evidence of family misconduct. Financial navigation can connect patients with insurance assistance, copayment programs, and nonmedical resources [22]. Multidisciplinary approaches similarly locate financial toxicity across patient, provider, payer, and policy levels [23]. These sources support a broader responsibility model in which clinicians need not solve household finances themselves but should recognize when the practical conditions of consent warrant additional support.

Resource referral should not be represented as a guaranteed remedy. In a randomized trial, Henrikson *et al.* found that proactive brief or extended financial navigation did not improve the primary financial-hardship or quality-of-life outcomes over enhanced usual care at 12 months [24]. The implication is not that navigation lacks value; it is that institutional response must be evaluated against the specific constraint faced by the patient. A benefits problem, transportation dependency, housing insecurity, and coercive control over family money require different responses.

Early cost communication is nevertheless important because discussion after a treatment commitment may occur after dependency arrangements have hardened. Rai *et al.* found that only about one quarter of surveyed US

cancer survivors reported out-of-pocket cost discussions with providers [25]. Cost information should therefore be elicited before clinicians interpret acceptance as stable preference, particularly when the patient indicates that relatives will determine whether treatment is financially possible.

Cost also belongs within preference-sensitive shared decision-making [26]. For the present framework, that means asking, with the patient's authorization, not only whether a treatment is affordable but how it will be financed, whether financial help carries conditions, and whether the patient can privately express disagreement. These questions should not become routine interrogation of families. Their purpose is to distinguish support from leverage when the clinical context gives reason for concern.

Patients themselves may assign high importance to out-of-pocket costs and other quality-of-life priorities that are not consistently discussed before plans are finalized [27]. A private opportunity for the patient to state preferences can therefore be ethically useful when financial support and family authority overlap. If the patient endorses the family's role and the proposed treatment, further escalation may be unnecessary. If the patient describes threatened loss of indispensable support, clinicians should assess feasible alternatives and involve appropriate financial, social-work, ethics, safeguarding,

or legal resources according to the nature and seriousness of the concern.

This mechanism-sensitive allocation of response is summarized in **Table 2**.

Table 2. Matching institutional response to the mechanism that makes financial dependence ethically significant

Observed treatment-decision condition	Question that should be resolved	Immediate clinical task	Institutional resource most relevant	Escalation condition	Interpretive caution
Patient endorses family financing and treatment	Is family involvement consistent with the patient's preferred role?	Confirm preferences and preserve ordinary shared decision-making	Usual clinical team; financial information if desired	Patient later expresses conflict or loss of choice	Dependence alone does not justify protective intervention
Patient prefers another option but cannot afford it	Is the constraint primarily structural rather than interpersonal?	Clarify feasible alternatives and costs	Financial counselor, social worker, benefits or payer support	No realistic alternative despite serious unmet need	Structural injustice should not be mislabeled as family coercion
Family contribution has explicit spending limits	Are limits genuine resource boundaries or conditions imposed to redirect treatment?	Clarify what support is actually available	Financial navigation and private patient discussion	Limits are selectively tied to abandoning the patient's preference	Inability to pay is not equivalent to a threat
Patient fears loss of housing, care, transport, or essential support after disagreement	Who controls the resource and how avoidable is the threatened consequence?	Provide private assessment and identify substitute supports	Social work, financial services, safeguarding or ethics as indicated	Serious, strategically imposed consequences make refusal practically unusable	Avoid requiring the patient to prove coercion before support is offered
Conditional support appears to override an authentic treatment preference	Can institutional alternatives restore meaningful refusal?	Separate immediate safety/resource needs from treatment authorization	Multidisciplinary escalation proportionate to the risk	Indispensable support remains contingent on compliance and alternatives are absent	Classification remains contextual; no numerical threshold applies

Results and Discussion

The framework developed here rejects two shortcuts. The first treats financially dependent choice as intrinsically nonvoluntary. That position ignores the relational structure of autonomy and the legitimate role that chosen family support can play in sustaining agency [1]. The second assumes that family participation is benign whenever it occurs within a caring relationship. Evidence on patient preferences and caregiver roles shows substantial heterogeneity, while relational-autonomy scholarship cautions against equating relationship itself with authorization [16].

Structural scarcity is the strongest rival explanation for many cases of apparent consent. High treatment prices, insurance design, unemployment, and geographically uneven services can make a preferred option unusable without any interpersonal coercer. Financial-toxicity evidence supports taking these constraints seriously while also showing wide heterogeneity across settings [5]. Calling every constrained choice coercive would collapse injustice, scarcity, dependence, and wrongful

leverage into one category and obscure who is responsible for changing the patient's circumstances.

Cultural or family-centered decision preferences present a second boundary condition. Patients may authentically prefer shared or family-involved decisions, including arrangements in which relatives control pooled household resources. The multicenter evidence on family involvement illustrates that expected roles vary between patients and across decisional stages [15]. A coercion analysis should therefore begin with the patient's preferred relational arrangement rather than an assumption that individual financial independence is the benchmark of valid consent.

The account also has evidentiary limits. The coercion literature used here comes partly from research ethics and medically assisted death, where the institutional stakes and available alternatives differ from high-cost treatment [18]. The proposed categories consequently should not be treated as validated clinical instruments. They are conceptual distinctions intended to improve case analysis. Empirical work would be needed to determine whether clinicians and patients can reliably distinguish the proposed states, whether the distinctions identify

otherwise hidden threats to voluntariness, and whether interventions based on them improve patient experience. Institutional mitigation is another area requiring caution. The intervention literature is heterogeneous [21], and the randomized navigation trial included in this analysis produced null primary outcomes [24]. An institutional duty to recognize and address avoidable constraint therefore cannot rest on assumptions that any single service reliably removes financial hardship. Its ethical basis is narrower: where preventable lack of information, benefits, or support makes refusal practically unavailable, institutions should examine whether they can widen the patient's option set before interpreting agreement as settled.

The framework's main contribution is thus diagnostic rather than predictive. It specifies what must be distinguished before apparent agreement is classified: background scarcity from interpersonal conditionality, wanted support from imposed leverage, resource dependence from strategic control, and formal refusal from practically usable refusal. Future research should test these distinctions qualitatively before attempting numerical instruments. Premature scoring would create false precision around a judgment whose meaning depends on relationships, timing, institutional alternatives, and the patient's own account.

Conclusion

Financial dependence can make treatment agreement ethically fragile without making it coercive. Its significance depends on how resources, relationships, and refusal options interact. Family financial support can enlarge autonomy when it reflects the patient's preferences, and severe financial hardship can constrain choice even when no person is coercing the patient. Concern rises when another actor controls indispensable resources, conditions access on compliance, and makes disagreement carry serious consequences that the patient cannot realistically avoid. Clinical and institutional responsibility therefore lies in identifying the source of constraint, protecting a private opportunity for preference expression, and widening practical alternatives where possible. The defensible boundary is conditional: financial dependence supports a finding of coercive economic leverage only when dependence is used in a way that meaningfully subordinates an authentic treatment preference by making refusal practically untenable.

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References

1. Wilkinson D, Levy N. Scaffolding informed consent. *J Med Ethics*. 2024. doi:10.1136/jme-2024-110105
2. Kuehlmeier K, Jansky B, Mertz M, Marckmann G. Transformative medical ethics: A framework for changing practice according to normative-ethical requirements. *Bioethics*. 2024;38(3):241-51. doi:10.1111/bioe.13185
3. Lentz R, Benson AB III, Kircher S. Financial toxicity in cancer care: Prevalence, causes, consequences, and reduction strategies. *J Surg Oncol*. 2019;120(1):85-92. doi:10.1002/jso.25374
4. Fiala MA. Financial toxicity and willingness-to-pay for cancer treatment among people with multiple myeloma. *JCO Oncol Pract*. 2024;20(9):1263-71. doi:10.1200/OP.24.00016
5. Kitaw TA, Tilahun BD, Zemariam AB, Getie A, Bizuayehu MA, Haile RN. The financial toxicity of cancer: Unveiling global burden and risk factors—a systematic review and meta-analysis. *BMJ Glob Health*. 2025;10(2):e017133. doi:10.1136/bmjgh-2024-017133
6. Carrera PM, Curigliano G, Santini D, Sharp L, Chan RJ, Pisu M, et al. ESMO expert consensus statements on the screening and management of financial toxicity in patients with cancer. *ESMO Open*. 2024;9(5):102992. doi:10.1016/j.esmoop.2024.102992
7. Samaha NL, Mady LJ, Armache M, Hearn M, Stemme R, Jagsi R, et al. Screening for financial toxicity among patients with cancer: A systematic review. *J Am Coll Radiol*. 2024;21(9):1380-97. doi:10.1016/j.jacr.2024.04.024
8. Dhir A, Stensland KD, Herrel LA, Sekar RR. Individual- and community-level risk factors of cancer-related financial hardship among cancer survivors. *JAMA Netw Open*. 2024;7(8):e2429286. doi:10.1001/jamanetworkopen.2024.29286

9. Kircher S, Duan F, An N, Gareen IF, Sicks JD, Sadigh G, et al. Patient-reported financial burden of treatment for colon or rectal cancer. *JAMA Netw Open*. 2024;7(1):e2350844. doi:10.1001/jamanetworkopen.2023.50844
10. Sadigh G, Duan F, An N, Gareen ID, Sicks J, Suga JM, et al. Financial hardship among patients with early-stage colorectal cancer. *JAMA Netw Open*. 2024;7(9):e2431967. doi:10.1001/jamanetworkopen.2024.31967
11. Myers SP, Zheng Y, Dibble K, Mittendorf EA, King TA, Ruddy KJ, et al. Financial difficulty over time in young adults with breast cancer. *JAMA Netw Open*. 2024;7(11):e2446091. doi:10.1001/jamanetworkopen.2024.46091
12. Schleimer LE, Aviki E, Kalvin HL, Magnin J, Sokolowski SS, Kingham TP, et al. Impact of financial toxicity on treatment adherence and quality of life in pancreatic cancer. *JCO Oncol Pract*. 2025;21(9):1325-34. doi:10.1200/OP-24-00528
13. Liu M, Huang D, Ma J, Wei W, Liu Y. Association of shared decision-making with financial toxicity and coping actions in adult patients with cancer: A nationwide study in China. *Oncologist*. 2024;29(8):e1031-40. doi:10.1093/oncolo/oyae065
14. Foo KF, Lin YP, Lin CP, Chen YC. Fostering relational autonomy in end-of-life care: A procedural approach and three-dimensional decision-making model. *J Med Ethics*. 2026;52(6):400-7. doi:10.1136/jme-2023-109818
15. Yan S, Wang D, Huang Q, Wang Y, Fan M, Xue H, et al. Examining cancer patient preferences during three stages of decision making and family involvement: A multicenter survey study in China. *BMC Med Inform Decis Mak*. 2025;25(1):9. doi:10.1186/s12911-024-02846-z
16. Gómez-Vírseda C, de Maeseneer Y, Gastmans C. Relational autonomy: What does it mean and how is it used in end-of-life care? A systematic review of argument-based ethics literature. *BMC Med Ethics*. 2019;20(1):76. doi:10.1186/s12910-019-0417-3
17. Dionne-Odom JN, Kent EE, Rocque GB, Azuero A, Harrell ER, Gazaway S, et al. Family caregiver roles and challenges in assisting patients with cancer treatment decision-making: Analysis of data from a national survey. *Health Expect*. 2023;26(5):1965-76. doi:10.1111/hex.13805
18. Steel R, Wendler D. Distinguishing appropriate from inappropriate conditions on research participation. *Bioethics*. 2023;37(2):135-45. doi:10.1111/bioe.13092
19. Buchbinder M, Berens N. Beyond coercion: Reframing the influencing other in medically assisted death. *J Med Ethics*. 2024;50(12):841-5. doi:10.1136/jme-2023-109554
20. Littman D, Lam AB, Chino F. Cost conversations to mitigate the effects of financial toxicity in oncology: Current state, opportunities, and barriers. *JCO Oncol Pract*. 2025;21(1):23-8. doi:10.1200/OP-24-00454
21. Wheeler SB, Thom B, Waters AR, Shankaran V. Interventions to address cancer-related financial hardship: A scoping review and call to action. *JCO Oncol Pract*. 2025;21(1):29-40. doi:10.1200/OP.24.00375
22. Offodile AC II, Gallagher K, Angove R, Tucker-Seeley RD, Balch A, Shankaran V. Financial navigation in cancer care delivery: State of the evidence, opportunities for research, and future directions. *J Clin Oncol*. 2022;40(21):2291-4. doi:10.1200/JCO.21.02184
23. Smith GL, Banegas MP, Acquati C, Chang S, Chino F, Conti RM, et al. Navigating financial toxicity in patients with cancer: A multidisciplinary management approach. *CA Cancer J Clin*. 2022;72(5):437-53. doi:10.3322/caac.21730
24. Henrikson NB, Anderson ML, Dickerson J, Petrik AF, Figueroa Gray M, Ewing JJ, et al. Financial navigation for people newly diagnosed with cancer: Primary outcomes from the Cancer Financial Experience randomized trial. *JCO Oncol Pract*. 2025;21(12):1817-29. doi:10.1200/OP-25-00874
25. Rai A, Zheng Z, Zhao J, de Moor JS, Ekwueme DU, Yabroff KR. Patient-provider discussions about out-of-pocket costs of cancer care in the U.S. *Am J Prev Med*. 2020;59(2):228-36. doi:10.1016/j.amepre.2020.02.017
26. Szumigalski KD, Tan ASL, Sinaiko AD. Let's talk costs: Out-of-pocket cost discussions and shared decision making. *Patient Educ Couns*. 2020;103(11):2388-90. doi:10.1016/j.pec.2020.04.022
27. Williams CP, Miller-Sonet E, Nipp RD, Kamal AH, Love S, Rocque GB. Importance of quality-of-life priorities and preferences surrounding treatment decision making in patients with cancer and oncology clinicians. *Cancer*. 2020;126(15):3534-41. doi:10.1002/cncr.32961