ment option for suffering at the end of life, then it would be undertaken in inappropriate circumstances. Importantly, if VSED is not part of standard of care, then physicians do not have an obligation to inform or educate their patients about it, contrary to the claims of many who recommend this practice.

There are different cases to consider, of course. A patient who refuses food and fluids may resemble a patient who refuses artificial nutrition and hydration, judging that the burdens outweigh the benefits and that continued nutrition and hydration would be extraordinary and disproportionate treatment. Such a decision is not patient suicide. In contrast, patients who engage in VSED as a response to existential suffering or a sense of powerlessness or social isolation can be accurately described as killing themselves as a means to end suffering. Admittedly, the distinction between these different cases is not always sharp, and judgment is needed to make the relevant distinction, but its existence explains why PAS and VSED are linked. A number of the ethical objections to PAS apply to VSED, at least when it is recommended as an alternative route to the same end.

Advocates for PAS often present VSED as an alternative treatment option for end of life suffering that avoids moral controversy. But, in reality, VSED raises challenging moral questions about the permissibility of physician collaboration in patient decisions to end their lives as a means to ending their suffering.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/content/13/5/410.

Submitted July 26, 2015; submitted, revised, July 26, 2015; accepted July 26, 2015.

References

1. Bernat JL, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition: an alternative to physician-assisted suicide or voluntary active euthanasia. *Arch Int Med. 1993;*153(24): 2723-2731.
2. Savulescu J. A simple solution to the puzzles of end of life? Voluntary palliated starvation. *J Med Ethics.* 2014;40(2):110-113.
3. Jansen LA. No safe harbor: the principle of complicity and the practice of voluntary stopping of eating and drinking. *J Med Phil.* 2004;29(1): 61-74.1791.

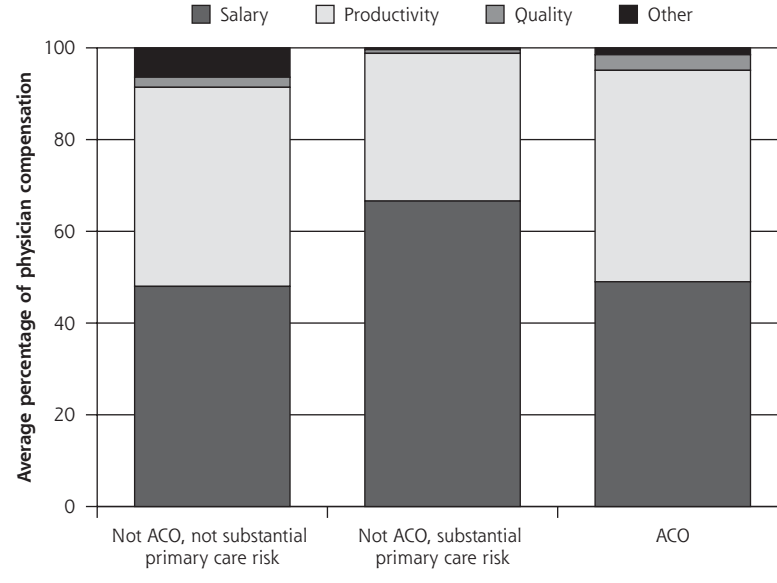
CORRECTION

Ann Fam Med 2015;13:411. doi: 10.1370/afm.1791.

Ryan AM, Shortell SM, Ramsay PP, Casalino LP. Salary and quality compensation for physician practices participating in accountable care organizations. *Ann Fam Med.* 2015;13(4):321-324.

In Figure 2 of this paper, it should have reflected that primary care physicians in ACO practices on average received 49.0% of their compensation from salary, 46.1% from productivity, 3.4% from quality, and 1.5% from other factors, but the figure was incorrect. The correct Figure 2 appears here and has been corrected in the online version of the paper. The online version therefore differs from the print journal. The author regrets the error.

Figure 2. Primary care physician compensation across financial risk and ACO participation.



ACO = accountable care organization

Note: Substantial risk denotes that a practice bears at least some financial risk for primary care costs for all of its health maintenance organization or point-of-service patients.