hard to understand why parents would advocate fiercely for any treatment that could benefit their child. At what point, though, should clinicians decline such requests based on lack of benefit or disproportionate burden? And what role should institutional policies and public opinion have in determining the proper response to such requests?

Using the 2015 ATS/AACN/ACCP/ESICM/SCCM consensus statement on NBT as a framework, this interactive case-based session will examine requests for potentially non-beneficial treatment from clinical, historical, legal, and personal perspectives. After tracing the trajectory of medical decision-making from paternalism to radical autonomy, recent attempts at defining and actualizing the concept of medical futility will be reviewed. Competing notions of burden and benefit will be explored, with specific reference to physicians' well-documented tendency to underestimate quality of life compared to patients and their families. A multi-disciplinary panel will aid in presenting various perspectives, including that of the parents and families. Clinicians' engagement with public opinion will be specifically addressed by a palliative care physician who weighed in about the Charlie Gard case, and will explore the degree to which we assume responsibility in presenting these issues to the public evenly and accurately, as well as the potential pitfalls of modern media. Practical steps—including recommendations for specific language, institutional policies, and mediating measures—will be presented.

"My Family Would Be Better Off Without Me": Managing Suicidal Ideation and Risk in Palliative and Hospice Care (FR419)

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Objectives

- Recognize the high prevalence rate of suicidal ideation, attempts, and completed suicide in Veteran and non-Veteran patients receiving palliative care, and the widespread impact of suicide on survivors including family and professional caregivers.
- Describe validated assessment tools and evidence-based treatments to identify and manage patients at high risk of suicide in palliative care settings.
- Identify actionable strategies to integrate suicide risk assessment and management into clinical practice across various palliative care and hospice settings in Veteran and non-Veteran populations.

People facing serious medical illness often experience significant and debilitating psychological distress in addition to symptoms associated with the underlying disease. While many people are resilient, large epidemiologic studies suggest increased risk of suicide in serious medical illness. For example, in a study of suicide risk and precipitating circumstances in male Veterans >age 65 years, the adjusted odds ratio of suicide was 36-fold higher in those with physical health problems. Suicide in palliative care and hospice patients has not been widely studied, but known suicide risk factors include: older age, history of mental health problems, male gender, social isolation, recent medical hospitalization, poor physical functioning, and access to lethal means including opiates or firearms. Suicidal behavior is more lethal later in life, due to increased frailty, social isolation, greater resolve, and greater likelihood of firearm use.

Despite the high prevalence of these suicide risk factors in palliative care patients, few palliative or hospice programs have routine, standardized screening for suicide risk. Limited data guiding suicide assessment and prevention in palliative care are largely extrapolated from other patient populations. Multiple questions remain, including: should all palliative care and hospice patients be screened routinely for suicide risk? What assessment tools should be used? What warning signs signify especially high risk in this population? What words work best to evaluate risk without detracting from other goals of palliative care encounters? What interventions minimize suicide risk in palliative care patients?

In this concurrent session, our interdisciplinary panel will review current knowledge of suicide risk assessment and prevention across palliative care settings. We will present conceptual frameworks connecting suicidality, interpersonal risk factors, and biopsychosocial-spiritual domains. Then, based on evidence and clinical expertise, we will offer recommendations for assessing and stratifying suicide risk along with suicide risk-reduction strategies adaptable to palliative and hospice care settings.

Palliative Connect: Triggered Palliative Care Consultation Using an EHR Prediction Model (FR420A)

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