POLICY:

High Peaks Hospice & Palliative Care, Inc. (HPHPC) must be in solidarity with those who suffer, affirming the sacredness of each life, serving as a reassuring and consoling presence and a trusted guardian of the patient’s deepest values.

HPHPC believes that mercy should lie at the heart of how we care for the dying and that a central ingredient for that mercy is compassion for suffering with the patient. A decision of physician assisted suicide is abandonment of that mercy, is dehumanizing, and is incompatible with the healing role of physicians and with the accepted code of medical ethics.

A plea for physician assisted suicide is a plea for better care, compassion, meaning of one’s life, and alleviation of fear at the end-of-life. The appropriate response to that plea is to intensify care and intensify the assessment of sources of physical, emotional, psychosocial and spiritual distress. It is through such an integrated approach to end-of-life care that fears and suffering are eased, personal growth and preparation for death can occur, and desire for a hastened death can be minimized.

DEFINITIONS

Suicidal ideation is a common medical term for thoughts about suicide that may be as detailed as a formulated plan. Although most people who undergo suicidal ideation do not commit suicide, some do go on to make a suicide attempt or take their own life.

Euthanasia is an act that intentionally and directly causes a patient’s death. This definition of euthanasia encompasses active euthanasia, voluntary euthanasia, and in some settings physician assisted suicide. The term “assisted suicide” is most commonly used to represent an act in which a patient is given the means and specific instructions to take his or her own life. Withholding or withdrawing life sustaining therapies or unintentionally affecting the dying process through treatments aimed at controlling symptoms does not constitute either euthanasia or assisted suicide. The purpose of these acts is comfort of the patient, not ending the patient’s life. Thus, neither is an act that intentionally and indirectly causes a patient’s death.

PROCEDURE

1. IDENTIFICATION OF SUICIDAL IDEATION:
   Valid ideation which requires further intervention is the active consideration of suicide as an option for a patient or family member (i.e., not just the thought of
suicide). Phrases like “I would never do it” or “I would be afraid to attempt it” do not indicate ideation requiring intervention beyond routine clinical exploration.

2. REPORTING OF SUICIDAL IDEATION:
The HPHPC team member who identifies the suicidal ideation will immediately notify the Hospice Nurse Coordinator (HNC) who will contact the HPHPC Social Worker (SW). The suicidal ideation and the notification will be documented in the patient’s medical record by the reporting team member.

3. ASSESSMENT OF SUICIDAL RISK:
The SW will conduct an assessment of the suicidal ideation as soon as possible. The suicidal assessment requires assessing the risk of actual suicide.

   a. There are five factors to assess first:
      i. Is there a viable plan including time, place and action?
      ii. Are there means at hand (with special attention given to the presence of firearms in the house)?
      iii. Is there intent?
      iv. Is there a history of attempts?
      v. Is the individual abusing alcohol or drugs?

   b. Factors to be included in the assessment are:
      i. Is the family a viable resource and can they intervene?
      ii. Is there a history of suicide in the family?
      iii. Is there a diagnosable mental illness? If so, is it being treated?
      iv. Demographic risk factors include being male, over 65 and living alone
      v. Is the individual experiencing chronic pain?
      vi. What is their life expectancy without a possible successful suicide attempt?

   c. The SW will document this assessment in the patient's medical record.

4. ACTION BASED ON LEVEL OF RISK:

   a. Low Risk: The HPHPC team members will further assess the underlying reasons for the suicidal ideation and initiate a plan of care to address them appropriately. The following steps will be taken and team members, including on-call providers, will be notified:
      i. A referral will be made to the individual’s spiritual mentor if there is a spiritual connection identified
      ii. Medications will be monitored or secured

   b. High Risk: After implementing the low risk strategies the following steps will be taken and HPHPC team members, including on-call providers, will be notified:
i. A request will be made to remove guns from the home if present. This request will be documented in the patient’s medical record.

ii. The SW may consult with a mental health consultant and other HPHPC Social Workers

iii. The SW or HPHPC RN Case Manager will notify the individual’s attending physician.

iv. The SW will explore voluntary interventions. These may include transferring the individual to the hospital, 24 hour care, using support of family to protect the individual, removing the means, etc.

v. If no contract or voluntary interventions are accepted and there is risk for physical harm to self or others in the home, aggressive intervention will be initiated by contacting the appropriate responder in the community such as the mental health hotline mobile crisis team, police, etc. to explore possible hospitalization or 24 hour care in the home to prevent suicide attempt. The HPHPC team member assessing the immediate risk will contact the mental health hotline and/or police.

1. Franklin County (Crisis Hotline) 24 hrs./day
   a. Southern Franklin County – 518-891-5535
   b. Northern Franklin County – 518-483-3261

2. Essex County (Crisis Hotline)
   a. 8 a.m. - 5 p.m. (walk in hours) – 518-873-3670
   b. Other than walk in hours – 1-888-854-3773

3. Warren County
   a. Glens Falls Hospital (24 hrs./day) 518-926-3265
   b. Samaritans Suicide Prevention Center 518 689-4673
   c. Crisis Department of Samaritan Hospital 518-274-4345

4. Washington County
   a. Samaritans Suicide Prevention Center 518-689-4673
   b. Crisis Department of Samaritan Hospital 518-274-4345

vi. Notify HNC who will notify the Executive Director

5. ACTION IF SUICIDE OCCURS, THE FOLLOWING STEPS WILL BE TAKEN:

   a. The first staff person who is aware of the suicide will call the police

   b. An HPHPC RN and/or SW will make a visit to the family. If the family is out of the area, the HPHPC RN and/or SW will contract them as soon as possible.

   c. Notify the attending physician

   d. Notify the HNC who will notify the Executive Director and the specific HPHPC team members involved

   e. Notify NYS Department of Health - 518-408-5413

   f. The SW in coordination with the HNC will arrange for debriefing/processing with HPHPC team members
g. The HNC will conduct a Performance Improvement Review in conjunction with the other HNCs and the Executive Director

h. Identify bereavement high risk contacts

i. Notify the HPHPC Board of Directors’ Clinical Committee members

6. EDUCATION FOR STAFF AND VOLUNTEERS:
   In-service education for all staff and volunteers will be provided by HPHPC. This will include:
   
a. Educational class for all current staff and volunteers
   
b. Follow-up support meeting availability
   
c. Orientation for all new staff and volunteers

7. EDUCATION FOR PATIENTS AND FAMILY MEMBERS:
   A copy of the Statement on Physician Assisted Suicide will be included in the packet that HPHPC gives to patients and family members at the time of the referral assessment for HPHPC services. The HPHPC representative will review the Statement at that time.

LAST REVIEW DATE:  SWs 04/2014, Clinical Committee, 5/6/14

LAST UPDATED:  May 6, 2014

BOARD APPROVAL: May 29, 2014