

# Plastic Surgery and Suicide: A Clinical Guide for Plastic Surgeons

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**Summary:** Several studies have identified an increased risk of suicide among patient populations which a plastic surgeon may have a high risk of encountering: women undergoing breast augmentation, cosmetic surgery patients, and breast cancer patients. No formal guidelines exist to assist a plastic surgeon when faced with such a patient, and not every plastic surgery team has mental health clinicians that are readily accessible for consultation or referral. The goal of this clinical guide is to offer plastic surgeons a set of practical approaches to manage potentially suicidal patients. In addition, the authors review a screening tool, which can assist surgeons when encountering high-risk patients. (*Plast Reconstr Surg Glob Open* 2016;4:e828; doi: 10.1097/GOX.0000000000000810; Published online 9 August 2016.)

Suicide is the 10th leading cause of death in the United States, with over 41,000 Americans dying from suicide in 2013 alone.<sup>1</sup> Among young adults, the statistics are even more staggering: for persons aged 15 to 34, suicide is the second leading killer—only accidents claim more lives than suicide.<sup>1</sup> For every person who dies by suicide, more than 30 others attempt suicide.<sup>2</sup> In addition, over 8 million adults report having serious thoughts of suicide in the past year.<sup>3</sup> The burden of suicide is devastating and far-reaching, and in 2014 the World Health Organization identified preventing suicide as “a global imperative.”<sup>4</sup>

Based on the sheer incidence alone, plastic surgeons may be likely to encounter patients who are suicidal. Plastic surgeons may have higher exposure to suicidal patients compared with their colleagues due to certain subsets of plastic surgery patients whom have a higher underlying risk of suicidality. A number of epidemiologic studies have identified an increased risk of suicide among women who have received breast implants.<sup>5–11</sup> Sarwer<sup>12</sup> reviewed the epidemiological studies and found that “the rate of suicide to be two to three times greater than what would be expected from estimates from the general population.”

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Received for publication January 22, 2016; accepted May 17, 2016.

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DOI: 10.1097/GOX.0000000000000810

Sarwer and other authors<sup>12–14</sup> have pointed out that the method of these epidemiological studies does not allow a causal relationship to be discerned between breast implants and suicidality. Additional studies have shown that women receiving breast augmentation may have relatively more risk factors for suicide, including a history of psychiatric hospitalization,<sup>7</sup> higher rates of alcohol and tobacco use,<sup>15–17</sup> higher rates of divorce,<sup>18,19</sup> and higher rates of receiving antidepressant medication.<sup>20</sup>

Beyond patients undergoing augmentation mammoplasty, cosmetic surgery patients as a whole have a higher incidence of body dysmorphic disorder, which carries with it a higher risk of suicide.<sup>21,22</sup> Moreover, patients with breast cancer have a higher risk of suicide compared with the general population.<sup>23–27</sup> Breast cancer patients also have a reported higher incidence of suicidality long after their diagnosis and treatment.<sup>23,28</sup> Women with breast cancer generally represent a very different patient population from women seeking elective cosmetic surgery, and the complex neuropsychiatric and psychosocial complexities of this patient population are rich and important topics that fall outside the scope of this more practical clinical guide.

Specific patient populations have a higher incidence of suicidality (breast augmentation patients, cosmetic patients, and breast cancer patients) and a plastic surgeon may encounter these patients more frequently depending on his or her practice. Although it is difficult to assess the potential number of suicidal patients a plastic surgeon may encounter, the authors hope to provide guidance for these situations. The following discussion focuses on practical approaches that plastic surgeons can follow, whether as part of a multidisciplinary team embedded in a large medical center or as an independent private surgeon. The

**Disclosure:** The authors have no financial interest to declare in relation to the content of this article. The Article Processing Charge was paid for by the authors.

authors also provide a preoperative screening tool for plastic surgeons to utilize.

### MANAGING THE POTENTIALLY SUICIDAL PATIENT

Once a patient is identified as being at an increased risk for suicide, the general approach in a busy office practice should be to establish immediate safety and then transfer the patient to the next most appropriate care setting.<sup>29,30</sup> Just as a plastic surgeon is confident in performing a rapid but careful triage assessment of a patient complaining of chest pain, so too should he or she have a facility with suicide risk assessment. Neither the surgeon’s time nor expertise affords the opportunity to do much more in a clinically safe and effective way. The World Health Organization’s Mental Health Gap Program’s (mhGAP) Intervention Guide provides a useful and straightforward approach (Table 1).<sup>29</sup>

The first step to establish the patient’s immediate safety while in the clinic is to assess whether the patient has just attempted a medically serious act of self-harm. Look for signs of bleeding, poisoning or intoxication, and reduced level of arousal. Ask the patient about recent ingestions, drug use, or self-injurious behavior. Treat any acute injury as indicated.

If the patient has not just attempted a medically serious act of self-harm, then the surgeon should next assess for any imminent risk of suicide or self-harm. The patient should not be returned to the waiting area unsupervised. Instead, the patient should be placed in a safe, secure, and supportive environment. Any object that could be used in a suicide attempt, such as medications, weapons, or sharp objects, should be removed. A named staff member or family member should be assigned to remain with the patient. Introduce the staff person by name, and explain why additional personnel are needed. Let the patient know what is happening and reassure the patient that he or she is safe.

In an empathetic way, the plastic surgeon should ask the patient about any access to means of self-harm, especially firearms. Inquire about any history of suicidal thoughts or behavior and any recent alcohol or drug use. Assess the patient for warning signs of suicide (Table 2).<sup>31</sup> Next, the surgeon should offer and activate social support—articulate suicide risk as a medical condition that you want to help the patient manage just as you would any

other medical condition. Encourage the patient to contact a friend or family member, or to let you do so. While being sensitive to the patient’s privacy and confidentiality, consider letting him or her know that you value his or her safety just as much—if not more—than his or her privacy. For more assistance at any time, the surgeon and/or the patient can call the U.S. National Suicide Prevention Lifeline at 800-273-TALK/8255. The Lifeline is a recommendation from the National Strategy for Suicide Prevention and is available 24 hours a day nationwide,<sup>30</sup> which may be especially valuable in areas where local mental health first aid resources may be limited.

Again, the goal of this brief intervention is to inform the surgeon’s decision of how best to refer the patient to a behavioral health specialist. In some cases, the nearest emergency department may be the only place where a more thorough psychiatric evaluation can take place with 911 services being utilized if the patient does not have family to transport the patient. If the surgeon’s assessment is that the patient does not need an immediate evaluation by a behavioral health specialist and, thus, can be safely discharged home before receiving that evaluation, then it is important for the surgeon to take steps to reduce the patient’s access at home to any potential lethal means of self-injury, such as firearms, other weapons, and pill bottles. At our institution we insist that the patient identify and contact (while in the clinic office) a support person to assist in carrying out this important safety step.

Once the patient leaves the clinic, the encounter should be documented clearly and completely in the medical record. A particularly helpful structure format to use when documenting the assessment of a suicidal patient is shown in Table 3. It is important to articulate clinical decision-making, to acknowledge the patient’s risk factors for suicide, and to describe the interventions taken to reduce the patient’s immediate risk of self-harm.

Practice guidelines or protocols for these scenarios can be helpful as they can be developed collaboratively in advance and rehearsed with some regular frequency (ie, akin to running a code). At our institution, ambulatory providers manage a suicidal patient by following a practice guideline that delivers same-day access for that patient to a behavioral health specialist who is competent and comfortable performing a comprehensive suicide risk assessment. This process obviates the need to send a patient by ambulance to the emergency department, a process that is costly, time-consuming, and distressing for

**Table 1. Key Steps to Managing a Suicidal Patient in a Plastic Surgery Office Setting**

Question	Steps to Take to Answer the Question
1. Has the person attempted a medically serious act of self-harm? 2. Is there an imminent risk of self-harm or suicide?	1. Look for signs of bleeding, poisoning or intoxication, and reduced level of arousal. Ask about recent ingestions or self-injury. 2. Place the person in a safe, secure, and monitored environment. Activate social support. Provide reassurance that the person is safe. Assess for warning signs of suicide. Inquire about easy access to potentially lethal means of self-harm. Call the Suicide Prevention Lifeline at 800-273-TALK/8255.
3. Does the person have signs or symptoms of a mental, neurological, or substance use disorder, or chronic pain?	3. Provide an appropriate referral to a mental health specialist. Document the encounter, including a suicide risk assessment.

Adapted from the mhGAP Intervention Guide for Self-harm and Suicide.

**Table 2. Warning Signs of Suicide**

I	Ideation (ie, thoughts of suicide or self-harm)
S	Substance abuse
P	Purposelessness
A	Anxiety
T	Feeling trapped
H	Hopelessness
W	Social withdrawal
A	Anger
R	Recklessness
M	Mood change

Adapted from the American Academy of Suicidology.

the patient. Without such practice guidelines, the safest recourse may be to transfer the patient to the nearest emergency department.

### Preoperative Screening for Suicide

Safe and effective management of the suicidal patient begins with identifying those patients at risk before they identify themselves. Some experts recommend that plastic surgeons perform preoperative assessments of all patients that include an evaluation of “patient motivations and expectations, body image dissatisfaction and body dysmorphic disorder, and general psychiatric status and history.”<sup>12</sup> Outside of a multidisciplinary team, such assessments would be time-consuming and, as such, not likely to be sustainable in a busy plastic surgery practice. A simpler and more efficient approach involves preoperative screening for common forms of psychiatric illness and, when indicated, a referral for expert consultation.

At our institution, one approach used for suicide screening in general medical settings is to screen for highly prevalent psychiatric conditions that increase a person’s risk of suicide, rather than screening for suicide itself. To perform this screening, we use a tool known as the depression, anxiety, polysubstance, and suicide (DAPS) screen (Table 4).<sup>32</sup> The DAPS screen consists of 7 questions coming from 5 individual evidence-based screening measures: the PHQ-2 for depression, the GAD-2 for anxiety, question item 9 from the PHQ-9 for suicidal ideation, the SASQ for problem alcohol use, and the single drug use question for substance abuse. Each of these questionnaires has been

validated as a sensitive screening measure for the psychiatric condition of interest (eg, major depression, generalized anxiety). Some of them have been validated specifically in general medical settings or among general medical patient populations. Moreover, each questionnaire is valid whether clinician-administered or self-completed. Some have been validated in languages other than English.

The DAPS screen bundles together these separate screening measures into one easy and efficient tool. As a bundle, the DAPS tool offers 3 major advantages over dedicated suicide risk–screening tools. First, the tool takes a broader approach to suicide risk with the aim of increasing sensitivity. Rather than screening specifically for suicidality alone (eg, thoughts, plans, behaviors), the DAPS tool screens for psychiatric conditions associated with an increased risk of suicide that are common in general medical settings. We refer to these conditions as “the big 3”—major depression, generalized anxiety, and substance abuse disorders. This approach to suicide screening is novel and facilitates the recognition of more people who may benefit from behavioral health interventions.

The second advantage of the DAPS tool is that the information it obtains is actionable. Suicide-screening tools, whether brief or comprehensive, are not predictive and generally arrive at some variation of the same conclusion—an individual falls along some risk stratification (eg, high, medium, low risk; acute vs nonacute risk). In general medical settings, the responses to these stratifications are limited (eg, sending the patient to the ED) and not specific to the level of risk. Furthermore, persons with psychiatric disorders are at increased risk of suicide even if they are not acutely or “actively” suicidal at the moment. The DAPS tool allows for the recognition of these persons, thus identifying opportunities for intervention even if no crisis is present. For example, a person who screens positive on the PHQ-2 portion of the DAPS but who is not acutely suicidal may not benefit from an immediate safety measure (eg, sending the patient to the ED) but may benefit from an evaluation for depression (eg, referring the patient to a mental health specialist). Treating that person’s depression, if indicated, may decrease the longitudinal risk of suicide.

**Table 3. Documenting a Suicide Risk Assessment**

1. State clearly that a suicide risk assessment was performed.  
*Eg, Together with the patient, her husband (by phone), and the clinic RN, I performed a comprehensive suicide risk assessment.*
2. List the patient’s demographic/nonmodifiable risk factors for suicide or self-harm.  
*Eg, The patient’s nonmodifiable risk factors for suicide include a history of one previous suicide attempt and a family history of suicide.*
3. List the patient’s acute/modifiable risk factors for suicide or self-harm.  
*Eg, The patient’s modifiable risk factors for suicide include current symptoms of depression, recent increase in alcohol use, and easy access to her husband’s hunting rifle at home.*
4. List the patient’s protective factors for suicide or self-harm.  
*Eg, The patient’s protective factors against suicide include the facts that she is married and has strong social support, that she has easy access to effective clinical care, and that her religion considers suicide a sin.*
5. Describe the interventions carried out to reduce the patient’s immediate risk of suicide.  
*Eg, During her clinic visit today, we reduced her immediate risk of suicide by collaborating with her husband to remove his hunting rifle from their home until her clinical condition improves, helping the patient to contact the Suicide Prevention Lifeline, and providing her with a referral to a mental health specialist for managing her depression and alcohol use.*
6. Articulate the clinical decision-making clearly and completely.  
*Eg, Based on this information, all parties agreed that although her depression and alcohol use place her at an ongoing increased risk of suicide, her excellent social support and easy access to mental health care services outweigh the risk of immediate self-harm. Her husband feels comfortable monitoring her safety at home, and she was reminded to call the Suicide Prevention Lifeline or 911 at any time should thoughts of suicide recur.*

**Table 4. The DAPS Screen for Pre-/Postoperative Suicide Risk**

	Never (0)	More than 12 mo ago (1)	3–12 mo ago (2)	Within the last 3 mo (3)
1. When was the last time you had 4 or more drinks in 1 day?	Never (0)	More than 12 mo ago (1)	3–12 mo ago (2)	Within the last 3 mo (3)
2. How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?	Never (0)	Once (1)	Twice (2)	More than twice (3)
3. Over the last 2 weeks, how often have you been bothered by any of these problems?	Not at all (0)	Several days (1)	More days than not (2)	Nearly every day (3)
a. Feeling nervous, anxious, or on edge .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Not being able to stop or control your worrying .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Feeling down, depressed, or hopeless .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Having little interest or pleasure in doing things .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Having thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(0)	(1)	(2)	(3)

The screening tool is *positive* when any of the following criteria are met:

- The response to Item 1 (SASQ) is “within the last 3 months.”
- The response to Item 2 (SQST) is ≥1.
- The total score of Items 3a–d (PHQ-4) is ≥6.
- The score of Item 3e is ≥1.

The third advantage of the DAPS tool is its ease of use. There are a limited number of psychiatrists and other mental healthcare workers, and that number is not sufficient to have all psychiatric screens and assessments in general medical settings performed by a specialist.<sup>33</sup> The DAPS tool consists of scripted questions that any healthcare provider can read and follow. This type of instruction may be especially beneficial to healthcare providers who are unsure or uncomfortable about how to screen patients for suicide or psychiatric disorders. The DAPS tool provides these clinicians with language they can use when talking with patients. Alternatively, patients themselves can complete the DAPS questions, which frees up valuable time for providers to deliver other types of care.

It is important that the decision to implement preoperative screening comes with the attendant requirement to act on a positive screen with an appropriate referral to a behavioral health specialist. Plastic surgeons are not psychiatrists and cannot be expected to provide the same level of care. Nonetheless, plastic surgeons ought to be able to demonstrate basic assessment skills and sound judgment. Suicide is extremely difficult to predict, even for mental health specialists, and legal negligence is very difficult to allege in cases where clinicians from any specialty document their decision-making.<sup>34</sup> Conversely, “Physicians can be held liable, however, where the patient’s suicide was foreseeable, and the physician’s negligence in preventing the suicide was the actual and proximate cause of the patient’s suicide (ie, there were no intervening events).”<sup>34</sup> Having a standardized approach to suicide risk assessment, as described here, can guide such documentation and is very likely to support clinicians in these rare legal situations.

**SUMMARY**

By the very nature of their clinical work, plastic surgeons will care for patients who may be at an increased risk of suicide. To manage these complex patients safely and effectively, plastic surgeons can follow the relatively simple, practical steps that the authors have outlined above. The DAPS screen and the WHO mhGAP guide-

lines are helpful tools that plastic surgeons might want to utilize to manage these challenging patients.

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