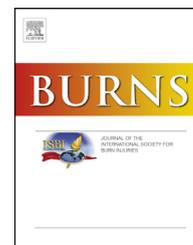


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Quantitative and thematic analysis of burns surgeons' attitudes, beliefs and surgical decision-making in self-harm burn injuries: The use of a questionnaire and hypothetical cases

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ARTICLE INFO

Article history:

Accepted 7 August 2018

Keywords:

Self-harm
Decision-making
Burns
Mental health
Surgery
Graft

ABSTRACT

Background: Self-harm injuries represent a significant minority of attendances within burns services. However, there is minimal research exploring burns surgeons' attitudes and beliefs about self-harm and how treatment decisions are made.

Method: Burns surgeons ($n=37$) completed a questionnaire which measured attitudes and beliefs about self-harm. Surgical decision-making was also explored by prompting surgeons to make treatment decisions for hypothetical case scenarios, and describe their rationale behind their decisions.

Results: The majority of surgeons reported positive attitudes about self-harm. However, around one in ten judged patients who self-harm more negatively, around a fifth offer surgery less frequently and almost a quarter believed that surgery should only be offered a limited number of times in repeated self-harm. Unhelpful or inaccurate beliefs (e.g. self-harm is 'attention seeking,' surgery would reinforce the self-harm, and that patients who self-harm tamper with skin grafts) were evident in some surgeons. Thematic analysis of qualitative data describing surgical decisions identified five themes: Equal Access to Care; Multidisciplinary Working; Old or Unhelpful Stories; Concerns about Tampering; and Repeated vs. First Time Self-Harm Episodes. More experienced surgeons were less judgmental, more likely to offer surgical interventions, and less likely to hold unhelpful or inaccurate beliefs compared to junior surgeons.

Conclusions: Some surgeons are not acting in line with UK guidance on the management of self-harm injuries. Education on the topic of self-harm is essential in burns services and this may be particularly important early on during surgical careers. Prospective research regarding surgical treatments and outcomes following self-harm is required.

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<https://doi.org/10.1016/j.burns.2018.08.003>

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1. Introduction

'Self-harm' refers to an intentional self-directed behaviour, which results in an injury [1]. In the UK, the prevalence of self-harm in the general population is reported to be between 4.6 and 6.6%, with preponderance among females and during adolescence and young adulthood [2]. Other factors associated with self-harm include: lower socioeconomic status; being single, divorced or living alone; poor social support; previous or ongoing adverse events (e.g. childhood abuse, domestic violence); mental health problems; and drug or alcohol problems [3–8]. Self-harm burn injuries are thought to account for 1.2%–1.7% of new attendances to UK burns services [9,10], with a prevalence of 4.9% [11]. Many patients have minor injuries that do not receive hospital admission, but some reports suggest that patients presenting with smaller self-harm burn injuries (0.5–1% total body surface area (%TBSA)) may be more likely to re-present with repeated self-harm burn injuries, than those presenting with more severe injuries [9,12].

Among healthcare professionals, attitudes towards patients who self-harm have been consistently found to be more negative than those regarding patients with other medical conditions [13,14]. It is possible that these negative attitudes may influence how self-injured patients are treated within burns services. The UK National Institute for Health and Care Excellence (NICE) guideline (2004) set out generic best practice for management of cases of self-harm, non-specific to burn injuries [7]. This guideline states that patients who have self-harmed should be treated with the same care, respect and privacy as other patients and that treatments offered for self-harm should be the same as those offered for injuries not caused by self-harm, irrespective of patients' willingness to accept psychosocial or psychiatric assessment or treatment. In cases of repeated self-harm, the guidance states that each episode should be treated independently, with patient-involvement in decision-making and fully-informed consent. The guideline also recommends that all healthcare professionals working with patients who self-harm should receive adequate, relevant training. The guideline further states that cases of self-harm in patients over 65 years should be particularly concerning, due to increased risks of later suicide in this age group.

Prior to this investigation, a PubMed search found no published articles which described the processes of surgical decision-making in self-harm burn injuries, or the frequency at which surgical, as opposed to conservative, management is offered to patients who have self-harmed. One UK study reported that some surveyed burns and plastic surgery healthcare professionals thought that surgery should only be offered to save life and around one in ten surgeons reported that patients should only be offered surgery once [15]. Furthermore, results from a recent UK audit of a burns and plastic surgery department suggested that patients who self-harm may be offered conservative management more often than patients with accidental injuries, with 9% of professionals explicitly reported that they advocated skin grafts less often to those with self-harm injuries [16]. Anecdotal reports suggested some burns surgeons may avoid operating on smaller self-

harm burn injuries, due to beliefs that patients may tamper with skin grafts or donor sites. However, the authors could find no published evidence detailing incidence or prevalence of tampering with surgical sites following self-harm injuries.

Further anecdotal evidence suggests that some surgeons may worry that offering surgical interventions reinforces self-harming behaviour. Similarly, no published evidence could be found to support or contradict this assumption. The commonly-held myth that self-harm is a form of 'attention-seeking' may be responsible for such beliefs. This myth continues to be pervasive despite a significant amount of published evidence which emphasises roles of cognitive processes, self- or emotion-regulation ability and social context, and which suggests that functions of self-harm include a coping mechanism, stress relief, regulating distressing emotions, self-punishment, managing unpleasant psychotic experiences, validating the self or influencing others, but that functions vary between individuals and within the same individual over time [17–21].

Improvements in understanding of surgical decision-making processes with regard to self-harm burn injuries are necessary, in order to ensure delivery of consistent best practice for patients who self-harm and in identifying additional educational opportunities for burn care professionals. This study aimed to investigate burn surgeons' beliefs and attitudes towards self-harm, as well as their surgical decision-making processes concerning self-harm burn injuries.

2. Method

2.1. Design

Data was collected between May and June 2017. A questionnaire was developed to assess burns surgeons' attitudes, beliefs and surgical decision-making concerning self-harm burn injuries. The study gained ethical approval from the Health Research Authority in the UK and informed consent was obtained prior to participation.

2.2. Participants

Thirty seven burns surgeons participated in the study. Fifty one percent (n=19) were male; 43% (n=16) were female and two participants did not state their gender. The modal age range of participants was 40–49 years (n=14; 38%), followed by 50–59 years (n=11; 30%); 30–39 years (n=6; 16%); 70+ years (n=2; 5%); 18–29 years (n=1; 3%) and 60–69 years (n=1; 3%). Two participants did not state their age. Seventy six percent (n=28) were of White ethnic background; 11% (n=4) were Asian/British Asian; one was of 'Mixed' ethnic background and 11% (n=4) did not state their ethnicity. Sixty eight percent (n=25) were Consultants; 14% (n=5) were Registrars; 3% (n=1) were Core Trainee grade and 16% (n=6) were 'Other' grades. Reported experience in burn care varied. Forty nine percent (n=18) reported more than 10 years' experience; 32% (n=12) reported five to 10 years' experience; 14% (n=5) reported two to five years' experience; one participant had less than one year's experience; one did not state their length of experience.

2.3. Measures

2.3.1. Questionnaire

An electronic questionnaire, specific to the study aims, was developed by the research team (see [Appendix A](#)). This took approximately 15–20 min to complete. Questions addressed demographic variables and burn care experience, followed by 18 Likert-scale items to prompt participants to state levels of agreement. Participants were then presented with two case scenarios. Both were hypothetical outpatient cases, presenting with small self-harm burn injuries. Participants were asked for their initial surgical decision from the following five options: ‘Graft as soon as practical as a day case’; ‘Graft as soon as practical and admit to the ward for two or three days’; ‘Wait for two weeks to get an indication of ongoing mental state’; ‘Treat conservatively’; or ‘None of the above’. Participants were prompted to describe what thought processes informed their decision-making and what previous experiences influenced their decision. If a participant selected ‘Treat conservatively’, they were also asked to describe what would have to be different for them to offer surgical intervention.

2.4. Procedure

Members of the British Burn Association were sent an email invitation to participate in the study. The invitation was open to surgeons currently working in burns services in England and Wales. Participants completed the questionnaire online via Survey Monkey[®].

2.5. Data analysis

Descriptive and statistical analyses were used. Differences in between-subjects variables were assessed, using a Mann Whitney-U test. Differences in within-group variables were assessed using a McNemar test. Qualitative data underwent thematic analysis, using a six-step semantic inductive approach [22]. Themes were second-rated by an independent practitioner to ensure reliability.

3. Results

The levels of agreement in response to the Likert-scale items, measuring attitudes, beliefs and surgical decisions, are shown ([Table 1](#)). Responses generally suggested non-judgmental and compassionate attitudes towards patients who self-harm. However, 11% ($n=4$) admitted that they judged patients who self-harm more negatively than patients who have accidental injuries. Nineteen percent ($n=7$) stated that they offer surgery less frequently to self-harmed patients and 24% ($n=9$) believed that surgery should only be offered a limited number of times in cases of repeated self-harm. Nineteen percent ($n=7$) of surgeons believed that self-harm is used to gain attention, 14% ($n=5$) believed that surgery would reinforce self-harm behaviour, 27% ($n=10$) believed that patients who self-harm would be more likely to tamper with skin grafts, 27% ($n=10$) believed that patients would be less motivated to heal their wounds, 24% ($n=9$) reported that surgery should only be offered if patients were willing to accept psychosocial assessment or treatment,

and 43% ($n=16$) believed that it was safer practice to offer conservative management more frequently for self-harm injuries.

Several statistically significant differences were observed between the attitudes and beliefs of experienced versus less-experienced burns surgeons. Those of more than 10 years’ burn care experience more frequently agreed with the items: ‘I view patients who have self-harmed in the same way as I view other patients ($U=80.0$, $P<0.01$)’; ‘Patients who have self-harmed should be offered the same physical and surgical treatments for their burn injuries as patients whose injuries have been caused accidentally ($U=96.0$, $P<0.05$)’; ‘I offer the same surgical intervention for chronic burn scars, irrespective of whether the injuries were caused through self-harm or an accident ($U=82.0$, $P=0.01$)’; ‘I believe that patients who have self-harmed have the same degree of motivation for healing their burn wound in general as people who sustained the burns accidentally ($U=100.5$, $P=0.05$)’; ‘Patients should always be offered surgery, where indicated, no matter how many times they have presented with self-harm burns ($U=93.0$, $P<0.05$)’. In addition, surgeons with more than 10 years’ experience disagreed more frequently with the items: ‘Patients should only be offered surgical interventions for their self-harm burns if they are willing to accept psychosocial assessment or treatment ($U=92.5$, $P<0.05$)’; ‘Carrying out surgery for self-harm burns will reinforce future self-harm behaviour ($U=78.0$, $P<0.01$)’; and ‘I think it is safer practice to offer conservative management more frequently for self-harm burn injuries, compared with accidental burn injuries ($U=93.0$, $p<0.05$)’.

3.1. Case scenarios

Surgeons’ hypothetical decisions are shown ([Table 2](#)). In Case 1, which involved: a 0.5%TBSA full-thickness burn in a patient who had not burnt themselves before; minimal self-harm and psychiatric history; a delay in seeking help; and declined mental health service input, 59% ($n=17$) opted for surgical management, whereas 14% ($n=4$) chose conservative management. In Case 2, which involved: a 1%TBSA full-thickness burn; significant previous self-harm through burning and other methods; two previous skin grafts; medical help sought promptly; and a mental health team in place, 28% ($n=8$) of burns surgeons chose surgical management; 46% ($n=13$) stated they would await mental state assessment and 18% ($n=5$) chose conservative management. Statistically, significantly fewer surgeons opted for surgical management in Case 2 ($P<0.05$). Instead, significantly more surgeons opted to wait for mental state assessment in Case 2 than in Case 1 ($P<0.01$). There was no statistically significant difference between the numbers of surgeons opting for conservative management in these cases ($P>0.05$).

3.2. Thematic analysis of surgical decision-making

Thematic analysis led to the emergence of five different themes: Equal Access to Care; Multidisciplinary Working; Old or Unhelpful Stories; Concerns about Tampering; and First Time vs. Repeat Episodes of Self-harm. These themes are discussed in more detail below, with example quotes from participants.

Table 1 – Surgeons' attitudes, beliefs and surgical decision-making in self-harm injuries.

Item	Strongly agree % (n)	Agree % (n)	Unsure % (n)	Disagree % (n)	Strongly disagree % (n)
1. I view patients who have self-harmed in the same way as I view other patients	35% (n=13)	32% (n=12)	8% (n=3)	22% (n=8)	3% (n=1)
2. In my experience, patients who have self-harmed are treated with compassion by the burns team	35% (n=13)	57% (n=21)	5% (n=2)	0	3% (n=1)
3. I think that patients who self-harm usually do it to gain attention	0	19% (n=7)	30% (n=11)	38% (n=14)	14% (n=5)
4. I feel more frustrated when caring for patients whose injuries have been caused by self-harm	3% (n=1)	27% (n=10)	19% (n=7)	27% (n=10)	24% (n=9)
5. I believe that there is a feeling within the burns team that patients who self-harm are less deserving of burn care	5% (n=2)	5% (n=2)	24% (n=9)	30% (n=11)	35% (n=13)
6. I judge patients who self-harm more negatively compared with other patients	0	11% (n=4)	14% (n=5)	30% (n=11)	46% (n=17)
7. Patients who have self-harmed should be offered the same physical and surgical treatments for their burn injuries as patients whose injuries have been caused accidentally	51% (n=19)	14% (n=5)	22% (n=8)	8% (n=3)	5% (n=2)
8. Patients should only be offered surgical interventions for their self-harm burns if they are willing to accept psychosocial assessment or treatment	5% (n=2)	19% (n=7)	16% (n=6)	46% (n=17)	14% (n=5)
9. I offer the same surgical interventions for acute burns, irrespective of whether the injuries were caused through self-harm or an accident	38% (n=14)	32% (n=12)	11% (n=4)	19% (n=7)	0
10. I offer the same surgical intervention for chronic burn scars, irrespective of whether the injuries were caused through self-harm or an accident	41% (n=15)	30% (n=11)	16% (n=6)	14% (n=5)	0
11. I think that patients who self-harm by burning are no more likely to tamper with or damage skin grafts after surgery, compared to patients whose injuries were caused accidentally	11% (n=4)	24% (n=9)	38% (n=14)	24% (n=9)	3% (n=1)
12. I believe that patients who have self-harmed have the same degree of motivation for healing their burn wound in general as people who sustained the burns accidentally	11% (n=4)	19% (n=7)	43% (n=16)	22% (n=8)	5% (n=2)
13. There should be a limit to the number of times surgery is offered/carried out in individuals who repeatedly self-harm by burning	5% (n=2)	19% (n=7)	19% (n=7)	32% (n=12)	24% (n=9)
14. Surgery should only be offered to treat self-harm burns in order to save life	8% (n=3)	3% (n=1)	5% (n=2)	38% (n=14)	46% (n=17)
15. Carrying out surgery for self-harm burns will reinforce future self-harm behaviour	0	14% (n=5)	30% (n=11)	38% (n=14)	19% (n=7)
16. Patients should always be offered surgery, where indicated, no matter how many times they have presented with self-harm burns	19% (n=7)	32% (n=12)	24% (n=9)	16% (n=6)	8% (n=3)
17. Patients with scarring from previous self-harm injuries should be able to have corrective surgery for their scars on the NHS	32% (n=12)	43% (n=16)	19% (n=7)	5% (n=2)	0
18. I think it is safer practice to offer conservative management more frequently for self-harm burn injuries, compared with accidental burn injuries	11% (n=4)	32% (n=12)	27% (n=10)	19% (n=7)	11% (n=4)

Table 2 – Surgical decisions when presented with two hypothetical case scenarios.

Hypothetical surgical decision	Case 1 % (n)	Case 2 % (n)
Graft as soon as practical as a day case	31% (n=9)	14% (n=4)
Graft as soon as practical and admit to the ward for two or three days	28% (n=8)	14% (n=4)
Wait for two weeks to get an indication of ongoing mental state	10% (n=3)	46% (n=13)
Manage conservatively	14% (n=4)	18% (n=5)
None of the above	17% (n=5)	7% (n=2)

3.3. Equal access to care

A prominent theme in participants' responses was the need for Equal Access To Care for all patients, irrespective of whether the injury was accidental or caused by self-harm. Surgeons described the desire to deliver compassionate care, involve patients in decision-making and treating according to surgical need, in order to ensure patients who self-harm receive equal care to other patients, in line with UK guidance [7].

Indeed, surgeons typically agreed that all patients should receive the same care and be treated with dignity and compassion and one explicitly expressed the desire “. . . not to be prejudiced in my treatment.” Having honest conversations with patients and offering fair, non-judgmental advice regarding treatment options and establishing a trusting patient-doctor relationship featured strongly in responses. Example quotes include:

“In my experience, treating patients with compassion and understanding helps them to recover mentally as well as physically.”

“It is not my place to pass judgment on an individual and how they have harmed themselves. My job is to protect them from further harm and to treat their injury in the best way possible and according to their wishes.”

Responses indicated that patients who self-harm should be fully informed about treatment options and involved in clinical decision-making. Participants felt that establishing a good rapport permits honest conversations regarding patient expectations and achievable outcomes. For example:

“The wound requires surgery so the patient should be treated to enable the best possible outcome, in line with her own wishes.”

Burns surgeons described the consideration of multiple factors in relation to surgical need and outcome (e.g. expedited healing, improved scarring and reduced medical complications). Most surgeons used the same decision-making criteria in self-harm burn injuries, as would be used in accidental injuries (e.g. burn depth, size and wound age). Many believed that unhealed wounds affect patients' ability to recover mentally, as well as physically. For example:

“[The] patient needs surgery. Her wound is likely to get infected if left alone and also she'll have a worse scar. This delay and ongoing issues are not going to help her mental health issue . . .”

3.4. Multidisciplinary working

Many burns surgeons reported feelings of powerlessness and helplessness in cases of self-harm burn injury. However, input from clinical psychologists and psychiatrists appeared to provide emotional containment and reassurance. Surgeons seemed to seek these in relation to burn management, patient support and prevention of future episodes of self-harm. The high value of psychological discussions within multidisciplinary team meetings and the influence of these discussions in shaping clinical decision-making, were also described. For example:

“With his past history I would want the assistance of the psychiatrist and the patient to come to a treatment decision.”

“This patient exemplifies the need for coordinated psychiatric and surgical management. I would say a case conference would be essential in the decision making around the management of this burn and the strategy for avoiding self-harm and treatment of future injuries.”

“Contact with our burns MDT staff may persuade her to discuss her problems and we may be able to help her and direct her towards a suitable therapist.”

From a holistic perspective, some surgeons described how patients' psychological care and support should be prioritised over physical health needs. One participant stated that “Mental health issues [are] as important as physical ones.” Input from clinical psychology colleagues within the burns team was recommended, to assess a patient's risk and safety, and to help facilitate access to community-based psychological treatment. There was a clear consensus that patients benefit from satisfactory mental health support to aid recovery and ensure good outcomes, exemplified by the quotes below:

“As long as this patient is having mental health support, I'm hopeful that with the right help, his mental condition would improve. His burn is due to these mental health issues, which is being addressed . . .”

“I would offer her surgery as soon as practical, but perform a direct questioning assessment myself ‘Are you thinking of further harm?’ and ‘Have you been thinking about taking your own life?’”

3.5. Old or unhelpful stories

Stories, in the sense of labels, judgements and stereotyping, were evident within some participants, and these may be deemed barriers in adhering to guidance [7]. Some surgeons felt that the case scenarios provided examples of ‘attention-seeking’ behaviour, perhaps demonstrating a lack of awareness and understanding of the functions of self-harm behaviour for individuals. In Case Scenario 2, some surgeons suggested that the patient’s wound would be better managed conservatively than surgically. A belief that surgery would reinforce future self-harm behaviour was evident. For example:

“The extra attention to the act/injured part fuels the impulse to try again.”

“ . . . We are at risk of him seeking operations, treatment and encouraging this attention seeking behaviour.”

“I don’t think that re-attendance and re-operating should be encouraged in these patients - but only where there is unlikely to be any resulting functional deficit. These wounds are often on flat (not flexural) surfaces where movement and function is unlikely to be affected and the result of scarring is predominantly cosmetic.”

One surgeon described a rigid process for managing self-harm burn injuries, seemingly resulting from the above belief:

“Our policy not to graft repeat small (deliberate self-harm) burns . . . is based on years of experience/evidence & all senior surgeons are in agreement on this matter.”

3.6. Concerns about tampering

The possibility of patients tampering with wounds and grafts should surgery be offered was a commonly reported concern. Most surgeons did not appear to base their concerns on previous experiences, although one did. In Case Scenario 2, some surgeons particularly felt that the patient may not comply with the indicated dressings care and may create additional wounds and surgeons felt reluctant to graft the burn injury without assurance from psychology or psychiatry colleagues that the patient would not tamper with their wounds or donor sites. Some illustrative quotes include:

“ . . . if we opted for surgery if he tampered then he would not get a further operation . . . ”

“I have seen multiple previous burners who have re-burn the healed skin grafted area within weeks of the original injury”

“Reassurances from psych team that they believe he would not tamper with wounds.”

3.7. Repeated vs. first time self-harm episodes

Current guidance [7] recommends that each episode of self-harm should be treated independently regardless of any history of self-harm. However, against this, a common thread in both case scenarios was consideration of whether a self-harm injury was a one-off incident, or part of a pattern of repeated episodes. This variable appeared strongly to influence decisions about whether to treat surgically or conservatively. Responses fell into one of two categories. For patients who self-harmed for the first time and in whom the risk of further episodes was low, surgeons tended to opt for surgical management. When patients repeatedly self-harmed, labelled by one surgeon as an “Established DSH,” surgeons tended to offer conservative management. For example:

“Will treat as a regular burn as it’s a first time.”

“If this was the first time I would give benefit of doubt and graft but a non-healing 2 month old graft is a warning.”

4. Discussion

This study evaluated burn surgeons’ attitudes and beliefs and surgical decision-making processes in relation to self-harm burn injuries. Currently, no published literature describes how burn surgeons arrive at decisions on: management choices; frequency; or consistency of offers of surgical or conservative management. It is important to understand these aspects of clinical management, in order to assure fairness of healthcare provision, with respect to this vulnerable patient subgroup.

Whilst most participants reported positive attitudes towards patients who self-harm, a significant minority did not and some surgeons reported offering conservative management more often than surgery for patients who have self-harmed. Thematic analysis identified five themes: Equal Access to Care; Multidisciplinary Working; Old or Unhelpful Stories; Concerns about Tampering; and Repeated vs. First Time Self-Harm Episodes. Most surgeons agreed that patients who have self-harmed should be treated with compassion, respect and dignity. Most surgeons wished to involve patients in the decision-making process and to discuss their wishes and expectations. However, some surgeons held unhelpful and/or inaccurate labels, judgements or stereotypes about self-harm. For example, that patients self-harm to gain attention or that surgery would reinforce future self-harm. A belief about patients tampering with post-operative wounds, or beliefs about lack of motivation towards wound healing was evident in some surgeons. Furthermore, some surgeons were reluctant to operate when injuries were not a first presentation. Negative attitudes, treating wounds differently because they are caused by self-harm, and not treating each new wound independently (in the case of repeated self-harm) are all in contrast to guidance [7].

The results may be conceptualised as rigid versus flexible clinical decision-making processes. Some surgeons held rigid rules about treating self-harm wounds surgically, at times with the offer of care conditional upon: an individual’s

acceptance of psychological or psychiatric support; the surgeon's confidence that a patient will not tamper with wounds; and a first episode of self-harm. Other surgeons displayed more flexible decision-making, considering each case or wound in isolation, believing that self-harm patients should be managed with compassion and that surgical intervention should be offered if the injuries would benefit from it. These surgeons still encouraged engagement with mental health services, but regarded unhealed wounds as sources of additional distress and therefore as indications for surgery.

Patients who attend specialist centres expect to receive assessment and treatment appropriate to the level of specialisation of the centre and the complexity of their own healthcare needs. Therefore, it is incumbent upon burn care experts to provide the level of diagnostic and management expertise of which their status declares them capable [23]. The guideline [7] states that healthcare professionals should receive adequate training and support. However, a previous UK audit reported that education around self-harm was lacking but desired [16]. The results of this study indeed demonstrate that there is a need for education on self-harm, particularly for non-consultant grade doctors early in their careers, since these individuals' beliefs are most likely not based upon experience.

The limitations of this study method may include: a UK-only surgeon population; use of hypothetical scenarios in the questionnaire; and social desirability bias affecting responses. Furthermore, surgeons were not asked about the frequency with which they encounter self-inflicted burn injuries and a future avenue for research could be the exploration of whether experience and opinions or behaviour are related, and whether there is a difference in attitudes and surgical decision-making between surgeons who have had more and less exposure to self-inflicted burns. Whilst all participants in the study had experience with handling self-harm burns, individuals' degree of involvement will have likely varied with occupation profile and level. The authors therefore acknowledge that variation in depth of involvement may influence individuals' values and beliefs about patients, although to what degree is unknown without research directed at this question. Despite these limitations, this study highlights a need to improve education about self-harm in burns surgeons. Prospective research is also required.

Conflict of interest

The authors have no conflict of interest to declare.

Appendix A.

Surgeons' beliefs and surgical decision-making in self-harm burns

Thank you for taking the time to complete this questionnaire. It should take you around 15 minutes in total. Your responses will be kept entirely confidential. Please answer honestly – there are no right or wrong answers.

Part 1: About you

1. What is your gender? Please tick one of the following options:

- (a) Male (b) Female (c) Prefer not to say

2. How old are you? Please tick one of the following options:

- (a) 18-29 years (b) 30-39 years (c) 40-49 years (d) 50-59 years
(e) 60-69 years (f) 70+ years (g) Prefer not to say

3. What is your ethnic background? Please tick one the following options:

- (a) White (b) Asian/British Asian (c) Black/British Black
(d) Other, including Chinese (e) Mixed background (f) Prefer not to say

4. What is your surgical grade? Please tick one of the following options:

- (a) Junior doctor (b) Registrar (c) Consultant (d) Other

5. For how long have you worked in a burns service? Please tick one of the following options:

- (a) Less than 1 year (b) 1-2 years (c) 2-5 years (d) 5-10 years
(e) More than 10 years (f) Prefer not to say

Part 2: Your opinions and experiences

The following statements refer to your opinions and experiences in managing self-harm burn injuries. Please indicate the extent to which you agree or disagree with the following statements by using the following scale. Please write a number (1-5) in the appropriate box.

1. What would be your initial surgical decision? Please select one of the following:

1. What would be your initial surgical decision? Please select one of the following:

- (a) Graft as soon as practical as a day case?
- (b) Graft as soon as practical and admit to the ward for two to three days?
- (c) Wait for two weeks to get indication of ongoing mental state?
- (d) Treat conservatively?
- (e) None of the above

2. What thought processes were going through your mind when making your decision? Please explain as fully as possible:

3. What previous experiences of yours or others influenced your decision? Please explain as fully as possible:

4. If you opted for conservative management (option d), what would have to be different for you to change your mind and offer surgical intervention? Please explain as fully as possible:

Case 2: The patient is a 35 year old male. He has a long history of self-harm including overdosing, cutting, burning and ingestion of harmful objects. He has had several psychiatric admissions in the past and is currently an inpatient in a specialist mental health unit (under section). He self-harmed three days ago using an aerosol to his leg and has a 1% TBSA full thickness burn. He has multiple historic scars from different self-harm episodes and has two skin grafts in the past, one which successfully healed graft and one which is still healing from a self-harm chemical burn two months ago. On this occasion, he sought help within minutes. His mental health team are reserving to make any opinions about his medical management.

1. What would be your initial surgical decision? Please tick one of the following:

1. What would be your initial surgical decision? Please tick one of the following:

- (a) Graft as soon as practical as a day case?
- (b) Graft as soon as practical and admit to the ward for two to three days?
- (c) Wait for two weeks to get indication of ongoing mental state?
- (d) Treat conservatively?
- (e) None of the above

2. What thought processes were going through your mind when making your decision? Please explain as fully as possible:

3. What previous experiences of yours or others influenced your decision? Please explain as fully as possible:

4. If you opted for conservative management (option d), what would have to be different for you to change your mind and offer surgical intervention? Please explain as fully as possible:

Thank you!

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