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REVIEW

Taking a history in aesthetic surgery: SAGA — the surgeon's tool for patient selection☆

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Summary Most patient dissatisfaction in Aesthetic surgery is based on failures of communication and patient selection criteria, and not on technical faults [Ward CM. Consenting and consulting for cosmetic surgery. *Br J Plast Surg* 1998;**51**:547–50; Gorney M. (2004) Essentials of malpractice claims prevention for the plastic surgeon. *eMedicine*; Jan 5, 2004]. Litigation leaves the surgeon perplexed when the operation has been performed to his or her satisfaction. Taking a history of Aesthetic Distress is critical in understanding the patient's complaint and postoperative expectation. It is often overlooked. This valuable information influences patient selection for surgery and shapes the operation to be performed. If a carefully selected patient has a surgical result that addresses their complaint and meets their expectation, the rate of dissatisfaction is reduced and litigation is avoided or more easily defended.

An historical literature review of patient selection for aesthetic surgery is offered. It confirms that the need for establishing a rapport with the patient has been recognised and, indeed, stressed for many years. However, while we have found negative lists of the types of patient to avoid, and aspersions of psychiatric conditions in dissatisfied patients, we have been unable to find any structure or template for eliciting the required history, which is all important in determining patient selection.

SAGA is a simple template for questioning, during consultation. It provides the surgeon with a systematic tool for recording the history of the complaint of appearance, whilst establishing rapport with the patient. It gives insight into the patient's personality and complaint, thus aiding patient selection for surgery and shaping the operation performed.

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Finally it provides a record for ''rebuttal'' in the postoperative period, should this be necessary. It has served the senior author well for twenty-five years.

Part 1 — the history of NOT taking a history in aesthetic surgery

It is axiomatic that doctors take a 'history of the presenting complaint' from every patient. Taking a structured, systematic history in aesthetic surgery has been largely ignored, and there is a self-serving argument that those who become aesthetic surgeons are inherently not history takers. Those medical students who like to delve into patients' minds become psychiatrists, while those with a more technical bent, preferring to remedy an abnormal physical sign with a surgical procedure, become surgeons; and plastic/aesthetic surgeons would claim that they are the finest technicians of them all.

In most branches of medicine the 'history' is an investigative tool, used as an aid in making a diagnosis. It has very little, if anything, to do with treatment. The diagnosis determines the treatment, and the effectiveness of treatment is confirmed by the removal of abnormal physical signs. It could be argued, then, that a history in aesthetic surgery should be perfunctory. The surgeon can see the 'deformity of appearance', the abnormal physical sign, that is the complaint, and believes he has the solution through surgery.

For example, no great aesthetic history can be obtained in a case of Cleft Lip. The parents and the surgeon see the deformity and a surgical plan for repair is made. Litigation, if any, is rare in cleft repair. Perhaps another example is 'Micromastia'. If labelled as a disease, and the physical sign dictates the diagnosis, it has a surgical cure — breast augmentation. This operation became so common in the USA in the 1980s that it was performed with less and less attention to the preceding symptomatology — and it is probable that this phenomenon was a significant contributor to the explosion of litigation over silicone/silastic in the USA in the early 1990s.

The history of patient selection in aesthetic surgery

Techniques for avoidance of an unsatisfactory result, by patient selection, have evolved from being virtually absent to the crude and simplistic, and more recently, onto the much more sophisticated. There has been increasing awareness of the importance of addressing the patient's request and not just their physical deformity. The evolution of techniques for patient selection can be categorised as follows:

Stage 1 — the halcyon days

The patient complains of a feature of appearance. The surgeon sees and examines the feature of complaint, says 'leave it to me,' and then proceeds to surgery. The surgeon is pleased with the result — and, usually, so is the patient. Millard (1968),[1] states: *'Most plastic surgeons, by nature or experience, develop an artistic sense, but a surgeon without it and with a short memory of his aesthetic mishaps can become a menace.'* This is as close as he gets to patient selection for rhinoplasty, and is the only reference to patient selection in the first edition of 'Grabb and Smith' (1968).[2]

Stage 2 — days of remorse and verbal retaliation

Barron (1980)[3] recognises that some *'patients are incapable of accepting a surgical result however satisfactory it may appear to the surgeon*'. Some of these unhappy patients become litigious. Rees (1984),[4] (1994)[5] states '*when challenged by a potential lawsuit…, feelings of rage and depression, as well as hostility directed at the patient, will be acknowledged.'* Barron continues: *'There is evidence to suggest that criminal behaviour can be initiated by the presence of some possibly minor 'blemish''*. Gillies (1958)[6] suggests that men presenting for rhinoplasty are expressing a prodromal symptom of schizophrenia (monosymptomatic hypochondriacal psychosis). Gipson (1975)[7] supports this.

However, by 1992, Slator[8] shows that schizophrenia is *not* more common in male rhinoplasty patients than would be expected in the normal population. She does note, though, that *'Male rhinoplasty patients could perhaps be described as having female sensitivities for quality of appearance*'. Harris (2001)[9] adds: *'Concern about appearance is widespread in the general population. More often than not, concern is about one feature only, which runs counter to the hypothesis that concern about appearance reflects a neurotic trait.'*

Stage 3 — counter-attack

Recognising that the unsuitable patient must be identified prior to surgery, many authors created negative lists of patient profiles. Rees (1984),[4] (1994),[5] Goldwyn (1984)[10] and Stark (1982)[11] advise on the types of patient to avoid, and their composite list of red flags is shown in Table 1. Daniel (1997)[12] adds *'never operate on a patient one does not like as an individual — the preop course is finite, but the post operative course is infinite*'. Goldwyn says *'You make your living by operating and your reputation by not.'* Stark finishes…. *'if in doubt…..heed the philosophy of Winston Churchill: When faced with a dilemma, do nothing*'. It is important to know when to say no.

While the strategies advocated are interesting, there is little satisfaction in learning the list of negative hoops that the potential patient's personality must jump through before being accepted and selected for surgery. However, the surgeon should bear Table 1 in mind, or ignore it at his peril.

Stage 4 — seek advice from a psychiatrist and learn about 'body image'

When in doubt on selecting a patient for surgery, a second opinion can be sought from a psychiatrist. Unfortunately plastic surgeons and most psychiatrists are far apart in their practice of medicine and the problems they face, and the

Table 1 Checklist of 'Red Flags' — Types of patient to avoid

Patient Assessment
Is the patient pushy and impatient? [4,5,10]
Is the patient solicitous or seductive or flattering?[4,5,10,11]
Does the patient have a minor defect and speak in a monotone?[4,5]
Does the patent have a maximal concern for minimal deformity?[10]
Did the patient help herself to my desk drawers?[4,5,10]
Did the patient bring photos of celebrities?[4,5]
Is the patient dishevelled and unkempt?[4,5,10]
Does the patient want surgery to please someone else?[4,5,10]
Does the patient ask lots of questions and not listen to replies?[4,5]
Is the patient overly talkative?[11]
Did the patient deprecate another surgeon?[4,5,10]
Is the patient a perfectionist?[4,5,10]
Was the patient rude to my office staff?[4,5]
Did the patient give off negative vibrations?[4,5]
Does the patient ignore pre-operative instructions?[4,5]
Is the patient realistic in regard to self-image?[11]
Does the patient expect surgery to achieve an entirely new identity?[11]
Has the patient just emerged from a personal tragedy?[11]
Did the patient write an excessively long letter to arrange consultation?[10]
Is the patient vague and indecisive, have poor self-esteem or appear depressed?[10]
Does the patient give a false history? (had previous surgery but denies it?)[10]
Does the patient refuse to cooperate? (refuses to undress, have photographs or lab tests?)[10]
Is the patient shopping around for the lowest price and a guaranteed result?[10]
Is the patient a Plasti-Surgiholic?[10]
Is the patient paranoid or depressed? Or in psychotherapy?[10]
Is the patient an older male requesting a Rhinoplasty?[10]
Is the patient a VIP?[10]
Do I like the patient?[10,12]
Does the patient have a pushy mother who is paying the bill? (*Blackburn V*)

cares they carry. Even when there is communication, mutual understanding can be difficult. Frances MacGregor (1984)[13] states that plastic surgeons should be cognisant of certain limitations in relying on the help of psychiatric colleagues, whose training is rooted in Freudian theory. *'Symptom removal has long been regarded by psychiatry with suspicion.'*

However, plastic surgeons studied 'the body image',[11] and the account given by John and Marcia Goin (1987)[14] is an important and very readable piece of psychiatry for plastic surgeons.

She defines: *'Body image is the mental representation of one's body at any given moment..... the picture one has of oneself as seen through one's own mind's eye.'... 'This mental picture is not necessarily static. The body image may go from lean to fat during a Christmas dinner while there is no change in the actual body perceptible to fellow revellers'*. The writer then discusses body image distortion. Millard recommends that Marcia Goin should be compulsory reading for all trainee plastic surgeons and, certainly, she is outstanding in that, as a psychiatrist, she understands the effects of surgery for appearance sake, and tries to shed some light on the causes and avoidance of problems. However, she recognises the difference between psychiatrists and plastic surgeons when she says: *'Most surgeons are surgeons because they like to operate.....if surgeons had wanted to spend their lives talking to people, they would have become psychiatrists or internists or hairdressers'*.

Barsky (1950),[15] is extraordinary in that, nearly 60 years ago, he seems to have had some brilliant insight of the problem well ahead of his time. He gives a surgical version of psychiatry and points out a quintessential difference: *'The patient undergoing plastic surgery differs from the ordinary patient, for the former comes to the surgeon in the hope that he will be subjected to an operation, whereas the patient comes to the general surgeon in the hope that he will be told that no surgery is necessary.'*

Stage 5 — recognise the patient — talk and listen

In his paper *Consenting and consulting for plastic surgery*, Ward (1998)[16] touches the core: *'The precipitating factor in initiating a complaint is not necessarily a technical error but often a failure on the part of the surgeon to establish any reasonable rapport from the outset'*. Barron and Saad (1980)[3] encourage the surgeon: *'The reconstructive surgeon must be able to fathom the depths of his patient's mind'.... 'It thus emerges that the reconstructive surgeon should establish a rapport with his patient before surgery'*. However, no instruction is given and no template for questioning suggested.

Goldwyn (1984)[10] advocates that the surgeon *'be a good listener'*, while Millard (1986)[17] defines consultation: *'The purpose of consultation is to find out what the patient really wants — not what the family wants, not what you want but what the patient desires. When he or she is telling you, listen.'* Even though he does not give a flexible template (like the flexibility of his technique for lip repair) he succinctly defines the purpose and essential outcome of the consultation. Daniel (1997)[12] devotes a long paragraph of his chapter on rhinoplasty to consultation and gives sound advice on history taking, examination and patient selection. At last the need for a history is recognised but no general structure for this has been suggested.

Stage 6 — the age of the Internet

The last ten years have produced an explosion of scientific information and specialisation. Ready access to the literature has been made possible by the Internet. Psychiatrists and psychologists have specialised in the study and treatment of all facets of appearance and how they impact on the quality of human life. Dr. David Sarwer, a psychologist at the 'Center for Human Appearance' at the University of Pennsylvania, has published extensively on the subject and specialised in body image dissatisfaction in obese people. In 1996, Katherine Phillips,[18,19] a psychiatrist, published her pioneering work *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder*. She followed this with

the multi-authored book *Disorders of Body Image* in 2002. Thus cosmetic surgery and body image pathology has been researched, expanded and publicised, refining but confirming the work of earlier authors such as Barsky, MacGregor, Goin and Harris: recognising Alfred Adler's theory of the Inferiority Complex caused by self perceived ugliness. The need for 'normalcy of appearance' to allow membership of the tribe has been confirmed, and retrospective studies have shown that cosmetic surgery generally improves quality of life and relieves depressive symptoms.

However, it does not appear that all this information has been translated into a method of taking a history from the prospective patient for cosmetic surgery. Gorney (2004)[3] repeats that *'well over half of malpractice claims are preventable. Most are based on failures of communication and patient selection criteria and not technical faults.'*..... *'The ability to communicate clearly and well is probably the most outstanding characteristic of the claims free surgeon.'* Communication requires mutual understanding between patient and surgeon but Gorney, while his review is excellent, gives no advice on interview technique to establish a rapport with the patient. He lists the types of patient to avoid, echoing Goldwyn and Rees.

Part 2 — taking a history of the presenting complaint in aesthetic surgery

The succinct template or mnemonic SAGA is used to elicit the 'history of the presenting complaint' from the patient, but it will be of no use if the surgeon has no understanding of the possible level of distress a complaint of appearance can produce, and cannot appreciate that the patient's aesthetic sensibilities may be very different to his own.

Goin[14] states *'Aesthetic plastic surgeons must develop skills in patient selection that are less important to surgeons in other fields'*. We propose that these skills should be similar to history taking and decision making in other branches of surgery, and not require the aesthetic surgeon to become a psychiatrist.

The 'skill' of taking a history is not new to a surgeon, but, for that history to be effective, the aesthetic surgeon must understand the motivation of a patient wishing to change an aspect of appearance. The surgeon needs to adopt a sympathetic focus to discover the body image misidentification perceived by the patient. Abnormalities of body image can cause misidentification by the peer group.[20] For example, the large breasted woman may feel identified as a sexual object, the small breasted as unfeminine, the scarred face as threatening or criminal, the wrinkled face as tired or old, etc.

To this end, judgemental concepts such as 'vanity' are not only unhelpful but are counterproductive. We accept the need to style our hair, wash our bodies and wear clothes of a certain colour and cut in order to conform to our peer group (confirm our tribal membership), and also to make a personal statement of our identities. All this is normal but yet it is 'vanity'. A large nose, however, can not be changed as easily as a pair of unfashionable shoes, and may cause considerable discomfort to its owner, who may feel ethnically (mis)identified.

SAGA attempts to address this issue. It is strongly based on, and loosely adapted from, Harris' papers.[21–23]

First understand aestheticality

Harris, supported by Millard,[17] recommends that the aesthetic surgeon should have an idea of the concept of 'Aestheticality', for it is the patients' distress with their own aesthetic assessment of their complaint which motivates them to seek surgical help. 'Aestheticality' can be explained by considering a series of twenty pictures — the first a monkey and the last a beautiful woman, with each picture slightly different to its predecessor so that, over the twenty pictures, the metamorphosis is complete.

The choice of where, in the series of pictures, 'monkey' ends and 'human' begins, gives an indication of an individual's Aestheticality. Those with a low level of Aestheticality will accept various monkey faces as looking human, and those with a high sense of Aestheticality will not accept 'human' until all the traces of monkey have disappeared. Harris likens 'Aestheticality' to 'Musicality' — there are those who notice and are distressed by the slightest disharmony or flat note in a piece of music, while there are those who would never notice a poorly tuned violin.

Aestheticality is a simple concept, but it can be difficult to digest and incorporate into practice, for this requires an individual to re-evaluate his preconception of 'vanity', which may be a firmly fixed prejudice.

Aestheticality, then, is the quality or character of a person's aesthetic sense. By understanding his own Aestheticality and understanding the patient's Aestheticality, the surgeon gains insight into the patient's mind and complaint. He can appreciate more easily the level of distress the complaint produces and assess the surgical outcome necessary to achieve a happy and satisfied patient. Understanding Aestheticality and using it in taking a history for aesthetic surgery, addresses and underpins many of the issues and alarms or 'red flags' listed earlier.

However, it also gainsays or debunks some of the cautions. Harris[21] puts it well: *'....One person may be only slightly distressed by an extensive port wine stain of the face whilst another may be severely distressed by a relatively insignificant hump on the nasal bridge.....the application of cosmetic surgery should be judged, not on the grossness of the abnormality, but on the degree of emotional distress that the abnormality of appearance produces. Cosmetic surgery is psychotherapeutic.'*

This concept and our experience is at odds with Mark Gorney's 'Gorneygram',[24] which compares disfigurement (as, presumably, assessed by the surgeon) with the patient's level of distress. He advises the surgeon to beware of the patient with minimal disfigurement and maximal distress. We have found that many patients with minimal pre operative disfigurement have realistic expectations of the surgical result but concede that the surgeon should be wary of the perfectionist who has an unrealistic expectation of surgical outcome and may have body dysmorphic disorder.

The patient interview — the consultation

Those who write about the consultation usually start with the surgeon and patient talking for a few moments to be at ease with each other and the surroundings. Condolences are often shared about the state of the weather. Certainly,

greetings should be exchanged with a handshake and Goin[14] says the surgeon should look at the patient — not at a feature and guess the complaint. One may open with: 'What brought you here to see me?' In response, the complaint is heard and the proper history can be taken.

The title of the mnemonic, 'SAGA', suggests that the patient has a tale to tell. This history can be elicited by enquiry mirroring the chronological development of the patient's symptoms: first the episode of *S*ensitisation, then *A*esthetic self assessment (with the Patient's Expectations), followed by peer *G*roup comparison and, finally, patterns of *A*voidance behaviour.

Sensitisation may be intrinsic or extrinsic — it may be self induced or the result of extraneous remarks or teasing. Or the patient may *not* be sensitised and may be requesting surgery to please someone else (a red flag symptom).

Aesthetic self assessment is the patient's own private evaluation of the feature of complaint. This is often done in a bathroom with several mirrors. Patients are pleasantly surprised that their surgeon knows that this was done, that it is normal and predictable. Such empathy helps to establish trust and rapport.

After this self-assessment, the patient should have a clear idea of the improvements that are desired in the feature of complaint. This gives the surgeon an idea of the patient's expectations of surgical outcome (realistic or unrealistic). When the patient's expectations are unrealistic, i.e. they are expecting a result that the surgeon feels he cannot deliver, surgery should be refused.

Peer Group comparison is both an index of sensitisation and another insight into the patient's behaviour, which further establishes rapport. A patient sensitised about a feature will scrutinise this feature on everyone else — always comparing or contrasting — looking for a nose/ears/breasts/abdomen/etc which is better, the same or worse than theirs. (Denial of peer group comparison is a minor red flag symptom).

Avoidance behaviour patterns describe strategies employed by patients to camouflage or avoid exposure of their feature of complaint. These may involve, for example, choice of clothing, hairstyles, make-up, avoiding undressing with the lights on, sporting activities, positioning in front of a camera and even weight gain. These diversionary tactics are recorded as they should resolve with appropriate surgery. They are a useful positive reminder and rebuttal to the patient in the post-operative period, when, say, there is a complaint of the appearance of the scar.

SAGA is both simple and concise. It is a positive and proactive tool for establishing rapport with the patient. It should be used as part of every aesthetic consultation to elicit the symptoms (if present) described by Harris. When used in conjunction with the Red Flag personality traits (Table 1) it provides the surgeon with an invaluable insight as to whether or not the patient should be accepted or rejected for surgery. If there is any doubt, a psychiatric opinion can still be sought.

If the patient seems reasonably and properly motivated, and the surgeon feels he can help, a general medical history is taken, a pertinent examination is made and photographs are taken. Then the specifics of the feature of complaint are discussed together with the options for treatment, with the help of a brochure. The chosen operation is discussed in detail including its nature (anaesthetic, bruising, scar) limitations (perfection is impossible) and all potential complications (including their management). The patient leaves the consultation with the brochure to reinforce this information.

If the patient decides to have surgery, she is seen at a review visit, when photographs are available. The operative details are discussed again along with the expected outcome and potential complications. Informed consent for surgery is then obtained (Table 2).

Examples of typical complaint profiles

Prominent ears/abnormal ears

There are three variations in the presentation of the complaint of prominent ears.

The first is the pre-school child, brought to consultation by concerned parents. The child is *not Sensitised*. A surgical operation, inflicting pain and bandages, on this child will

Table 2 SAGA template for taking a history

History
Complains of.....
Episode(s) of **S**ensitization .....
Aesthetic self-assessment
(and Patient Expectation) .....
Peer **G**roup comparison?.....
Avoidance behaviour/defence
mechanisms .....
Can patient define physical problems with complaint?
Can patient describe what corrective surgery should achieve to correct complaint?
Is request for surgery self-motivated?
Examination
Can I see/appreciate the complaint?
Can I offer surgery to correct this abnormality?
(Proceed to discussion of specifics of surgery, including all complications: operative risks, scars, change in sensation, possible asymmetry, secondary surgery, perfection is impossible — improvement is expected.
Give patient procedure information leaflet to take away and read)
Conclusions
Like/dislike patient — rapport established?
Patient understands and requests proposed surgical procedure?
Will this procedure (including scars etc) satisfy patient and improve quality of life?
Any negatives/warnings/'red flags' detected?
Finale
Select or Reject patient for surgery

achieve little more than a distrust, dislike and, possibly, terror of doctors. Surgical correction should be refused, pending sensitisation when older. The explanation is readily accepted by the parents.

The second presentation is the child who, after leaving the security of family, has been exposed to body image comparisons in the wider world of primary school. He/she has been subject to adverse comments and teasing by the school peer group and has become *sensitised*. This sensitisation has produced a change in personality or behaviour of the child (*Avoidance behaviour*). *O*ften the child becomes withdrawn and reluctant to return to school. The child eventually requests help and surgery has a successful outcome.

The third presentation is the young adult. A clear history can usually be obtained of episodes of classroom teasing: ears being flicked, 'can you fly jumbo?' *Avoidance behaviour* patterns of wearing the hair long to cover the ears and avoidance of swimming and high winds — any situation which will expose the ears is avoided. One patient even applied super glue to his ears to keep them stuck to the side of his head. Once again, surgery is usually successful — after first determining, from the patient, how much correction is desired. Often these patients want their ears positioned very close to the side of the head.

Abdominoplasty

The typical patient for abdominoplasty is 38 years old. She has finished the childbearing phase of her life and would like to improve the appearance of her abdomen. *Sensitisation* is usually self-induced. 'My husband says he doesn't mind, but I can't stand it when he touches my tummy'. After the ravages of pregnancy, the patient has gone to great lengths, with diet and exercise, to restore her figure; but when she leans forward to put on socks, the loose skin of her abdomen hangs down in front of her. When she wears jeans, a roll of loose skin hangs over the belt line. Wearing a bikini at the beach is impossible. (*Avoidance behaviour*) In bed she lies on her back. 'If I lie on my side, my tummy lies next to me.' 'When I see other women or look through magazines, I always look at tummies, and feel distressed.' (*Peer Group comparison*).

Surgical correction, by abdominoplasty, produces a great improvement in this distress. 'I am thrilled with the result'; but though the complaints produced by loose abdominal skin have been corrected, in exchange for a long scar and change in skin sensation, the patient rarely feels 'restored'. Perhaps this is due to the general loss of elasticity in the abdominal skin of these patients.

Breast reduction

There are two distinct groups for breast reduction: the 19 year old and the 50 year old — and the mixture of symptomatology for those in between.

The 19 year old group is emotionally/aesthetically assaulted by the sudden (physiological) development of overlarge breasts. *Sensitisation* is self induced, spurred on by peer group teasing. Sensitisation may have taken place at an early age: 'when I was eleven, I was playing at my friend's house and I was aware that my friend's father treated me 'differently' — because I had these breasts. I felt strange and uncomfortable.'

(*Avoidance behaviour*) The patient often puts on weight to disguise the disproportion between breast and body size. She wears a 'reducer' brassiere and large frilly tops, and often hunches her shoulders forward. She complains that men talk to her breasts not to her face, and whistle at her when she walks past. She stops athletic activities: horse-back riding, running, — indeed she may walk for shelter when caught out in the rain.

Her personality and behaviour may change and she may become withdrawn — going straight to her room after school and leaving the group of friends she once had.

Intimate sensitisation is also strong. 'I always undress with the lights off.' 'My husband/boyfriend loves my breasts, but I can't stand him touching them.' 'I would feel much more self confident and 'sexier' if my breasts were smaller.'

Difficulty with clothing is a strong complaint in all patients for breast reduction. 'I can't find bras which are comfortable and fit — and, when I do, they are so expensive.' 'I am a size 8 below the waist and a size 16 on top. I can never find clothes to fit. I can never wear anything fashionable.'

The 50 year old group, for breast reduction, has a more 'functional', or 'general surgical', list of complaints. After years of enjoying her large breasts, she may have put on weight in middle age and achieved even larger breasts. She now finds them a nuisance — 'they get in the way all the time'. She complains of the weight on her chest, back pain, shoulder indentation and shoulder pain — sometimes going down her arms. She may also complain of sweating and rashes under her breasts. Nipple sensation may be very important to this patient.

Most patients for breast reduction have a mixture of complaints between the 'aesthetic sensitisation' and the 'functional'. It is interesting that the American College of Surgeons only recommends insurance coverage for those with 'functional' complaints. The improvement in quality of life, by breast reduction, is often greater when the 'aesthetic sensitisation' is corrected.[25]

Post-operative management

By using SAGA and taking a record of the specifics of a 'complaint of appearance', it is rewarding to review those complaints in the post-operative period and assess the degree of improvement in the quality of life. ('I no longer scrutinise the feature on other people — I can wear a swimsuit again — I enjoy shopping for clothes — I can now wear my hair in different styles — I don't mind, indeed enjoy, my husband seeing and touching — etc.')

This record is particularly useful when the post-operative patient has a complaint. For example, when a breast reduction patient complains that the scars are taking an inordinately long time to settle, sympathy and treatment can be offered; but she will often be cheered by pointing out the silver lining to the black cloud which is obscuring her pleasure with her surgical result. She can now wear fashionable clothes, she can go without a bra, she rides horses again, her general appearance is improved — she

looks slimmer, younger, more elegant and she has greater self-confidence. Often the patient has forgotten the encumbrances of her pre-operative condition and she may be placated by recognising the improvements in the complaints she had before surgery. These records are most useful in avoiding or defending litigation — particularly if it is understood, from the beginning, that improvement is expected but perfection is impossible.

SAGA is also useful for dealing with a patient who is seeking a second opinion after unfavourable surgery elsewhere. The SAGA history can be recorded retrospectively and improvements, if any, to the original complaint are recorded. This is useful in defusing a potentially hostile situation as it focuses the discussion on the patient and her problem, and away from the perceived errant surgeon. Based on the patient's expectations, it also allows the surgeon to assess whether or not any revisional surgery should be offered.

Discussion

The message is clear: Take a history of the presenting complaint. A technique, SAGA, is offered which enables the surgeon to understand the complaint and establish a rapport with the patient.

The surgeon must listen to his patient — assess her level of aestheticality — assess and score her level of aesthetic distress with her complaint — consider carefully whether or not he can deliver a surgical result, scars included, which will address and correct the complaint and so improve her quality of life. Afterwards he should listen to his patient again, record the increase in self-confidence and the happiness created, and try to score the improvement. Aesthetic surgery is (psycho)therapeutic. Taking a history is an important aid to patient selection — to establish a rapport with the patient, to do the right operation on the right patient, to recognise when it is wrong to operate and, by so doing, to avoid litigation.

Many surgeons already do this, but there are others, some great technical surgeons, who did not, do not, and possibly cannot bring themselves to sympathetically discuss a complaint of appearance with the patient. Perhaps these surgeons are type 'Super A' personalities and can only follow their own aesthetic sense.[26,27] They operate, usually successfully, on the deformity they see without regard for the patient's complaint. After all that training they know what is best — 'what could the patient possibly contribute to the operation?' By allowing the patient input into the surgical plan, the surgeon has to relinquish control, and this may be the sticking point. However, by listening to the patient, the surgeon can select a patient with a difficult problem when any improvement will be gratefully received, and reject a patient with a simple problem when only perfection will be accepted.

SAGA provides the surgeon with an easily remembered format for establishing rapport, obtaining a history of the complaint and recording aesthetic distress. It is a simple key for opening dialogue and understanding with the patient and, with experience, will be modified by each surgeon that uses it, and elaborated on to suit each individual patient.

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