Notes from the Editor Emeritus

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The pursuit of perfection

Many innovations in our field of hair restoration surgery have been influenced by patient preference. An early example was the temporary consumer popularity of synthetic single-"hair" (fiber) implantation that seemed to have better cosmesis than standard plug grafts. I believe this helped influence the development of smaller grafts resulting eventually in the development of follicular unit transplantation. A more recent example is patient concern regarding donor scarring influencing the development and popularity of follicular unit extraction (FUE) and the later development of trichophytic donor closures in response.

Any temptation for complacency on our behalf, by believing that we have reached our end-point of the refinement of our grafting techniques, should note that we now have patients asking us to provide their surgery on the condition that there is no visible scarring anywhere on the scalp—*even when the scalp is shaved clean!*

I was reminded of the ever increasing patient demands for perfection in our results by a comment a well-renowned colleague made to me in Montréal. He stated that "densely packed single hairs just look better than even FU grafts." Is this really going to be the next "gold standard"? Is this implying that we can create a result superior to nature? Or, rather, is it acknowledging that almost all FUT cases are performed at considerably less-than-normal density with resulting minor irregularities in reduced density that fails to meet the goal of "perfection"?

So, where does this all stop? The continued innovation and refinement of techniques seek to "raise the bar" on our results with the implication that, generally, patients will then be happier. But, is this a true paradigm?

Surgeons who are serious about their work do continually seek to improve techniques even when the cost of doing so is much higher. The current popularity of maxi-session, single-pass surgery that requires maxi-staffing is a case in point. Consider also the development of FUE and the impending push toward robotics for FUE.

But, is perfection an appropriate goal? After all, isn't hair transplantation the art of cosmetic illusion whereby remaining hair is partially redistributed to "fool the eye" into believing greater coverage exists than in reality?

The pursuit of perfection conceivably assumes that most patients want perfect results, which discounts the reality, learned over many years, that patients are generally quite happy with what has been achieved with our current techniques. As well, most patients want a result they can justify financially (which is not necessarily the same thing as what they can afford). How many patients tell us they don't care about the cost, just the result?

There is nothing wrong with attempting to improve our results. Improving our average outcomes (i.e., reproducibility) is the single most important improvement we should seek. Increasingly, our results depend almost entirely upon the skills and technique of our surgical teams, coupled to the surgeon's design. It is hard to blame the patient for poor outcomes. They cannot reject their own tissue after all. Disappointing growth rates are almost always our fault. I specifically take responsibility for this at the consult to reassure the patient that the post-operative phase is quite simple and predictable.

It is also my contention that failure to meet patient expectations (creating disappointment) is also partially our fault as we allow unrealistic expectations to survive the consultation, the operation, and the 6 months' post-operative period.

Who are the patients that demand perfection? In my experience, they include the following:

1. *Body Dysmorphic Syndrome patients.* These people should be excluded from our surgical lists and offered psychological evaluation.
2. *Obsessive-personality patients.* These patients often arrive from other surgeons with good to excellent results but are very unhappy with the result.
3. People with the least amount of hair loss/balding (of any age).
4. *The very young* (e.g., less than 23 years old).

Why should we try to meet these expectations? Perhaps with the eventual nirvana of stem cell/cell culture techniques, we might only be limited by the patient's budget and the pursuit of perfection in these individuals might become practicable.

However, the ability to achieve what has been termed the "esthetic durability" of the perfect result demands either no progression of balding or sufficient donor hair for all future needs. Is this realistic? Of course not, despite advances made in this regard by finasteride and dutasteride.

Single-pass transplants and "normal density" FUT are potentially dangerous and illusory concepts that over-simplify a complex evolving problem—Male Pattern Baldness (MPB)—and promise over-optimistic solutions to patient desires for "instant gratification." How many times have we heard patients tell us they don't want to keep taking medication, they just want a permanent solution achieved with a single surgery? This naïve belief stems from patients mistaking our *treatments* for *a cure*.

Surely it remains safer to continually lower patient expectations regarding "perfection" or esthetic durability. The exception regarding durability might be the older patient with extensive baldness who may almost be "stable." My solution has been to use the analogy of the "leaking bucket." I explain that MPB is like a leaking bucket, but that you are leaking hair. Medication is designed to partially or, hopefully, totally, "fix the leak." Surgery is designed to "top up the bucket." I tell them that topping up the bucket without fixing the leak produces only a temporary benefit. They then may need further top-ups (if donor hair is available).

The "perfect" result and reality are usually two quite different things. An alternative strategy is one I call "minimum comfort level." When a patient asks me, "How much hair do

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I need?" I define the "finish line" or goal as one that is unique to each patient. I tell them we may not be able to exactly describe or define the goal, but most patients will "know it when they see it." I then say that my goal is to achieve it using the *least* amount of grafted hair. This leaves some hair in the "donor bank" for future needs.

Thus, in a world where, ironically, the result of our ever increasing quality of result has been the attraction of ever-more-demanding patients, could it perhaps be that the "best clinics" are those that best set and meet patient expectations regarding outcomes?✧

Call for Nominations

2009 Follicle Awards

GOLDEN FOLLICLE AWARD — Presented for outstanding and significant clinical contributions related to hair restoration surgery.

PLATINUM FOLLICLE AWARD — Presented for outstanding achievement in basic scientific or clinically-related research in hair pathophysiology or anatomy as it relates to hair restoration.

DISTINGUISHED ASSISTANT AWARD — Presented to a surgical assistant for exemplary service and outstanding accomplishments in the field of hair restoration surgery.

How to Submit a Nomination:
Include the following information in an e-mail to: info@ishrs.org

- **Your name,**
- **The person you are nominating,**
- **The award you are nominating the person for, and**
- **An explanation of why the person is deserving; include specific information and accomplishments.**

Nominating deadline: April 16, 2009

See the Member home page on the ISHRS website at www.ishrs.org for further nomination criteria. All awards will be presented during the Gala at the ISHRS 17th Annual Scientific Meeting, July 22-26, in Amsterdam, The Netherlands.

2009 Research Grant Application Deadline: March 16

Research Grants Available

1. The annual ISHRS research grants with amounts of up to US$1,200 per grant.
2. In addition, one grant is being offered for US$10,000 via a joint program between the ISHRS and the International Hair Research Foundation (IHRF).

The deadline for all grant applications is

Monday, March 16, 2009

Further information and a full application can be obtained on the ISHRS website at
http://www.ishrs.org/member-grants.htm