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Areas of unethical behavior practiced today

William Rassman, MD *Los Angeles, California*

The following is an article by Dr. William Rassman, one of the most respected senior members of our profession. It should give all of us cause for concern and make us reflect on the damage—firstly to the patient, and secondly to us all—if we allow unethical practices to flourish. Unethical practices have always existed in medicine and cosmetic surgery is regarded as the "business end" of medicine where we are providing services for healthy patients (commonly called customers). If we apply this notion of customers (rather than patients), and argue that the customer is always right, we will allow unwise and unnecessary practice philosophies to develop.

I am disturbed that there is a rise in unethical practices in the hair transplant community. Although many of these practices have been around amongst a small handful of physicians, the recent recession has clearly increased their numbers. Each of us can see evidence of these practices as patients come into our offices and tell us about their experiences. When a patient comes to me and is clearly the victim of unethical behavior, I can only react by telling the patient the truth about what my fellow physician has done to them. We have no obligation to protect those doctors in our ranks who practice unethically, so maybe the way we respond is to become a patient advocate, one on one, for each patient so victimized. The following reflects a list of the practices I find so abhorrent:

We have no obligation to protect those doctors in our ranks who practice unethically, so maybe the way we respond is to become a patient advocate, one on one, for each patient so victimized.

1. **Selling hair transplants to patients who do not need it, just to make money.** I have met with an increasing number of very young patients getting hair transplants for changes in the frontal hairline that reflect a maturing hairline, not balding. Also, performing surgery on very young men (18-22) with early miniaturization is in my opinion outside the "Standard of Care." Treating these young men with a course of approved medications for a full year should be the Standard of Care for all of us.
2. **Selling and delivering more grafts than the patient needs.** Doctors are tapping the well of the patient's graft account by adding hundreds or thousands of grafts into areas of the scalp where the miniaturization is minimal and balding is not grossly evident. I have even seen patients who had grafts placed into areas of the scalp where there was no clinically significant miniaturization present. Can you imagine 3,000-4,000 grafts in an early Class III balding pattern? Unwise depletion of a patient's finite donor hair goes on far more frequently than I can say.
3. **Putting grafts into areas of normal hair under the guise of preventing hair loss.** There are many patients who have balding in the family and watch their own "hair fall" thinking that most of their hair will eventually fall out. A few doctors prey on these patients and actually offer hair transplantation on a *preventive* basis. This is far more common in women who may not be as familiar with what causes baldness and do not have targeted support systems like this forum. They become more and more desperate over time and are willing to do "anything" to get hair. They are a set-up for physicians with predatory practice styles.
4. **Pushing the number of grafts that are not within the skill set of the surgeon and/or staff.**

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President's Message

Edwin S. Epstein, MD *Virginia Beach, Virginia*

It is an honor and a privilege to serve the members of the ISHRS as your president during the next year. I wish to take a moment to reflect on the Amsterdam meeting, which was a successful event in so many ways. Amsterdam is a unique city with its canals, parks, cyclists, and museums, and I hope everyone had an opportunity to explore and enjoy its culture and beauty. The international diversity of the meeting was apparent from the opening ceremony during which members from various countries recited in their native language excerpts from the modern Hippocratic and Physician Oaths.

The average attendee shows up to learn, but has relatively little knowledge as to the enormous undertaking by the Scientific Committee and ISHRS staff. I want to congratulate Dr. Ken Washenik for organizing this conference, despite such distractions as the birth of his first child, Ava Grace, and all his other hair-related commitments. Kudos to Drs. Paul McAndrews and Tommy Hwang (Chairs, Advanced Review Course); Dr. Jean Devroye (Live Patient Viewing); and Tina Lardner (Chair, Surgical Assistants Program). The efforts of the ISHRS staff are invaluable to the success of this meeting, and I applaud Victoria, Kimberly, Jule, Liz, and Amy for all their hard work and dedication.

The Gala was highlighted by the Follicle Award presentations, our highest recognition. The Golden Follicle recipient was Dr. Robert Haber. Bob has been a huge contributor to the ISHRS as a *Forum* editor, past president, and numerous committee involvements. He coauthors a textbook with Dr. Dow Stough, and is most deserving of this recognition. Dr. Bernard Cohen was the Platinum Follicle Award winner. Bernie has not only been a visionary, but has the unique ability to make the transition from imagination to reality as an inventor of surgical devices, most notably for tissue extension and hair mass measurement, and a mapping classification for hair loss. In addition, the Distinguished Assistant Award was awarded to Dr. Patrick Tafoya. Patrick has been involved in hair restoration for over 20 years. In addition to teaching many surgical assistants, he has developed technical and ergonomic solutions to assist them. My congratulations to our Follicle Award winners, as well as to the recipients of research grants.

At the Business Meeting we had some changes in the Board of Governors. Dr. Damkerng Pathomvanich (Thailand) retired after 3 years of service, of which I would like to thank him for his contributions. Congratulations to Dr. Jerry Cooley (USA) who was elected vice-president; Dr. Carlos Puig (USA), treasurer; and our newest Board Members, Drs. Alex Ginzburg (Israel) and Arthur Tykocinski (Brazil).

We introduced an Audience Response System that enabled the moderator and panels to query the audience. This allowed for impromptu surveys by the audience after topics were presented and debated. This was not only fun and maintained audience interest, but also provided valuable information, insights, and opinions. We are looking into purchasing a system for use in future meetings. One person came up to me and observed that "there was nothing new this year." Well for those new to hair restoration, there is a vast amount of new knowledge. For those more advanced, there may only be one or two "new" things learned, but this can have a major impact on your practice and results. So I challenge you all to begin now the process of thinking up new abstracts and evidenced based studies for next year's meeting.

At the Amsterdam meeting, we initiated our first Newcomer Program, which was a huge success with over 120 attending. It afforded the opportunity for the ISHRS leadership, past presidents, and involved members to express their passion and enthusiasm for the ISHRS, and to provide a buddy system throughout the meeting to share ideas and answer questions. We plan to continue this program in Boston, and I encourage all members to participate.

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Co-editors' Messages

Paco Jimenez, MD *Las Palmas, Spain*

This issue begins with Dr. William Rassman's article on unethical behavior related to HRS, such as selling hair transplants to patients who do not need them or selling more grafts than the patient needs, for the sole purpose of making more money. These wise reflections are even more significant when coming from this well-respected colleague who in the early 1990s was one of the first to introduce the concept of megasession in HRS, although at that time a megasession was equivalent to a hair transplant session of 1,000 or more grafts, a "small" session by today's standards.

In my opinion, there are a handful of unethical doctors and HT centers or franchises that inflate the number of grafts just to make money, but there are many others who simply believe that HT is a procedure in which one has to make as many hair grafts as possible, in other words, "the more the better," as simple as that. Basic traditional concepts, such as creating a high mature hairline, being conservative in dealing with young patients, etc., are discarded. Dr. Rassman asks: How is it possible for someone to transplant 3,000 grafts in a class III balding patient? Simply, either by lowering the hairline to unacceptable limits (which increases the area of the recipient zone to an area similar in size to a Norwood type IV-V) or by transplanting more FUs per cm^2 than needed. (Dr. Sharon Keene reported in the March/April 2009 *Forum* that 40-50 FUs/cm^2 is the normal FU density in frontal hairline of normal individuals and there is no need for more.) Therefore, besides intentional unethical behavior, there may well be some doctors who simply follow erroneous principles in basic HT concepts due to inadequate training.

There used to be a workshop at the ISHRS meetings called "Back to the Basics" led by Drs. Dow Stough and Russell Knudsen. This was a superb workshop, which should be

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Bernard Nusbaum, MD *Coral Gables, Florida*

As we settle down to our daily routine we can reflect upon the Amsterdam meeting and, of the variety of topics discussed, some that stand out in my mind are: trichophytic closure, follicular unit extraction (FUE), and low level laser therapy (LLLT).

Trychophytic closure, in my opinion, has stood the test of time and most of us who perform the technique can attest to the fact that it has significantly improved the appearance of our strip excision scars. When it works well, it is difficult to locate the scar upon casual observation when backcombing through the donor zone. I would like to commend Dr. Paco Jimenez for his presentation identifying the depth at which the "bulge" regenerative cells may be damaged and possibly result in permanent loss of donor follicles. In this regard, I have always felt that the trichophytic excision should be as superficial as possible, as all that should be necessary to remove is simply the epidermal layer. There are no "miracles" or scarless surgery, however, and this technique is not a panacea as results are less than optimal in areas of wound tension and subsequent scar spread. On another note, FUE, as expected, has progressed toward automated instrumentation such as the mechanical rotary instruments that have appeared on the scene and should improve the efficiency of this technique. FUE appears to be "here to stay" and, without question, the noninvasive nature of the technique is quite appealing to prospective patients. Since the San Diego meeting, live patient results have been presented that look quite good. One always hears the mutterings in the crowd among skeptics who feel that results are not as dense as those accomplished with equal numbers of FUT strip grafts. As with any surgical technique, FUT results must be technique and patient dependent. Further studies to evaluate survival rates and close monitoring of transection

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Editorial Guidelines for Submission and Acceptance of Articles for the *Forum* Publication:

1. Articles should be written with the intent of sharing scientific information with the purpose of progressing the art and science of hair restoration and benefiting patient outcomes.
2. If results are presented, the medical regimen or surgical techniques that were used to obtain the results should be disclosed in detail.
3. Articles submitted with the sole purpose of promotion or marketing will not be accepted.
4. Authors should acknowledge all funding sources that supported their work as well as any relevant corporate affiliation.
5. Trademarked names should not be used to refer to devices or techniques, when possible.
6. Although we encourage submission of articles that may only contain the author's opinion for the purpose of stimulating thought, the editors may present such articles to colleagues who are experts in the particular area in question, for the purpose of obtaining rebuttal opinions to be published alongside the original article. Occasionally, a manuscript might be sent to an external reviewer, who will judge the manuscript in a blinded fashion to make recommendations about its acceptance, further revision, or rejection.
7. Once the manuscript is accepted, it will be published as soon as possible, depending on space availability.
8. All manuscripts should be submitted to both drnusbaum@yahoo.com and jimenezeditor@clinicadelpelo.com
9. A completed Author Authorization and Release form—sent as a Word document (not a fax)—must accompany your submission. The form can be obtained in the Members Only section of the Society website at www.ishrs.org.
10. All photos and figures referred to in your article should be sent as separate attachments in JPEG or TIFF format. Be sure to attach your files to the email. Do ***NOT*** embed your files in the email or in the document itself (other than to show placement within the article).

Submission deadlines:
October 5 for November/December 2009 issue
December 5 for January/February 2010 issue
February 5 for March/April 2010

President's Message

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The next annual meeting will be in Boston in October 2010. Dr. Paul McAndrews has accepted the position of Program Chair. His support cast will include Drs. Robert Niedbalski and Ricardo Mejia (Basics Course Chair and Co-chair); Tommy Hwang and Glenn Charles (Board Review Chair and Co-chair); Ivan Cohen (Workshop Chair); Mark Di Stefano (Live Patient Viewing Chair); and Bob Leonard (Newcomer Chair).

This meeting truly demonstrated the international flavor of our membership. The majority of attendees were non-North American, and we had excellent attendance from many countries that either have difficulty with U.S. visas, or found it easier not to travel to the U.S. We recognize the need for more "off-shore meetings," and while we have contracts signed for our annual meetings through 2013, we plan to increase our workshop programs outside North America.

We have all been affected by the changes in the global economy. Membership dues will remain unchanged, and we will continue to streamline programs designed to increase the value of your membership. We have a task force to look into increasing our membership. I welcome and encourage your ideas as to this task, and will be contacting many of you personally especially about allied medical societies in which you are associated, and colleagues who may already do hair surgery but are not current members. The more we teach and share ideas, the better the quality of our results, and the more potential patients we can generate.

U.S. President John Kennedy challenged us: "Ask not what your country can do for you, ask what you can do for your country." I wish to make a similar challenge to all ISHRS members: to get more involved in committees, to offer to give lectures during our basic and advance courses, to submit abstracts and posters, and to get involved in OPERATION RESTORE. While our next meeting in Boston in October 2010 sounds far away, now is the time to plant the seeds (and follicles) for next year. I want to be available for your thoughts, suggestions, and yes, even complaints, by a dedicated email address: ed.ishrs@gmail.com.

Edwin S. Epstein, MD

Jimenez Message

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included in the meeting program every year, and which I would recommend be of obligatory attendance for every new ISHRS member. We need to emphasize these basic concepts and put less emphasis on "numbers" and "giga-supermegasessions," etc. As Dr. Rassman indicates, only a "limited number of doctors can safely perform these large sessions," and, in my opinion, only a limited number of patients need them.

Paco Jimenez, MD

Nusbaum Message

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rates should settle some of the questions still surrounding this technique. Finally, the general consensus continues to mount on this side favoring the fact that LLLT has some positive effect on hair growth. We long for more data quantifying this effect within a targeted zone with scientific evaluation of optimal dosage and frequency of application.

The Amsterdam meeting was a tremendous accomplishment at the highest academic level and I extend well-deserved congratulations to Dr. Ken Washenik, the Scientific Committee, and Victoria Ceh and the ISHRS staff.

Bernard Nusbaum, MD

2009–10 Chairs of Committees

Note: Committees are in the process of being assigned.

2010 Annual Scientific Meeting Committee: Paul J. McAndrews, MD
American Medical Association (AMA) Specialty & Service Society (SSS) Representative: Paul T. Rose, MD, JD (until 12/31/09) & Carlos J. Puig, DO
Annual Giving Fund Chair: Matt L. Leavitt, DO
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Bylaws and Ethics Committee: Robert T. Leonard, Jr., DO
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Pro Bono Committee: David Perez-Meza MD
Scientific Research, Grants, & Awards Committee: Michael L. Beehner, MD
Surgical Assistants Executive Committee: Laureen Gorham, RN
Surgical Assistants Awards Committee: Cheryl J. Pomerantz, RN
Task Force on Hair Transplant CPT Codes: Robert S. Haber, MD
Website Committee: Ivan S. Cohen, MD
Ad Hoc Committee on Database of Transplantation Results on Patients with Cicatricial Alopecia: Nina Otberg, MD
Ad Hoc Committee on Feasibility of Product Endorsement: Jennifer H. Martinick, MBBS
Ad Hoc Committee on Regulatory Issues: Paul T. Rose, MD, JD
Evidence Based Medicine (EBM) Task Force: Sharon A. Keene, MD

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INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

Unethical behavior

from front page

The push to large megasessions and gigasessions are driven by a limited number of doctors who can safely perform these large sessions. Competitive forces in the marketplace make doctors feel that they must offer the large sessions, even if they cannot do them effectively. A small set of doctors promote large sessions of hair transplants, but really do not deliver them, fraudulently collecting fees for services not received by the patient. Fraud is a criminal offense and when we see these patients in consultation, I ask you to consider your obligation under our oaths and our respective state medical board license agencies to report these doctors.

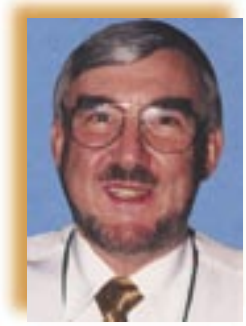
5. **Some doctors are coloring the truth with regard to their results, using inflated graft counts, misleading photos, or inaccurate balding classifications.** False representation occurs not only to patients while the doctor is selling his skills, but also to professionals in the field when the doctor presents his results. Rigging patient results and testimonials are not uncommon. Lifestyle Lift, a cosmetic surgery company, settled a claim by the State of New York over its attempts to produce positive consumer reviews publishing statements on Web sites faking the voices of satisfied customers. Employees of this company reportedly produced substantial content for the web.

The hair transplant physician community has developed wonderful technology that could never have been imagined 20 years ago. The results of modern hair transplantation have produced many satisfied patients and the connection between what we represent to our patient and what we can realistically do is impressive today. Unfortunately, a small handful of physicians have developed predatory behavior that is negatively impacting all of us and each of us sees this almost daily in our practices. Writing an opinion piece like this is not a pleasant process, but what I have said here needs to be said. According to the American Medical Association Opinion 9.031: "Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requires in each state…."✧

Knudsen's Note: Ironically, we used to complain about "low-balling" where the patient is under-quoted the necessary number of grafts to achieve his or her goals, thereby requiring them to return for extra sessions. Now we have the more frequent problem of "high-balling" where the patient is being quoted more grafts than necessary to achieve the patient's goal. Whether the physician is doing the quoting, or a paid consultant, it is the physician's responsibility for what happens afterwards. If you know the physician involved when you see a patient with a strange quote, you may feel comfortable having a conversation with them about the situation. We are, however, responsible primarily to the patient, and Dr. Rassman urges us to swallow our discomfort about reporting colleagues when seeing fraudulent behavior, and act in the patient's best interests. I wholeheartedly agree.

Notes from the Editor Emeritus

Richard C. Shiell, MBBS *Melbourne, Australia*



Some hair transplant surgeons I have known

There are some really memorable, and at times odd, characters in the HT profession. The problem is that some of the guys are still alive, although none ever joined the ISHRS. To prevent possible embarrassment, I have concealed the names of some of the living.

London Plastic Surgeon Philip Lebon was an early starter in the Hair Transplant field and published his first paper on HT in the British Journal of Dermatology in April 1963 (75; 170). He was pretty vague about dates and as his first cases were done in a hospital setting he had no personal records of the precise date. It was in 1962 or 1961 when he was a Surgical Registrar at Highlands General Hospital in London, England. I knew him pretty well during my years in Britain in the 1970s but have lost touch with him since that time.

He was a Cockney (central Londoner) and a very flamboyant character, and was the first medico I ever heard using the "F" word in front of his patients. He used it frequently and with great effect like the Scotsman Billy Connelly does on TV today, but this was back in 1969. Hair transplantation was never a big part of his cosmetic surgery. I introduced him to the motorized punch in 1975, although I had been using it myself since 1969. Entering into Juri flaps in a big way when they were introduced in the mid-1970's, he soon struck some legal troubles, but shrugged it off and bounced back like a true Cockney

My main memory of his Weymouth St. consulting rooms is of his tiny 2-man elevator and of an enormously long and aged greyhound dog, lying full length over three cushions on an antique settee. The docile animal would open an eye as each new patient entered the room and then, failing to recognize a member of the staff, promptly go back to sleep. Meanwhile the lady patient (they were mostly females) would try to find somewhere else to sit in the small waiting room while keeping a wary eye on the extraordinarily large animal.

Myles Wislang of New Zealand had a brilliant mind and was not only the Gold Medalist in Anatomy on the way to his medical degree at the University of Otago, but a violinist of rare talent. He was also a photographer of such excellence that an exhibition of his enlarged photographs of the New Zealand Alps was given in the Auckland Art Gallery before going on world tour, sponsored by one of the big international drug companies.

He was also decidedly eccentric. Married a couple of times, and with numerous children, he was careless about matters like parking fines, payment of the rent on his professional rooms, and more seriously his annual Medical Registration. When I first met him in the early 1970s, he was heavily into natural medicine, yoga, and the alternate lifestyle. Patients reported ringing the doorbell, hearing the command "come in," and being confronted by the sight of a man in a kaftan, standing on his head in the corner of the office. They had not been entered in the appointment book and had arrived in the middle of Myles' Yoga session.

He sold his practice in the early 1980s to go to Ireland and then Israel to perform Emergency Surgery, which had become his latest passion. I knew the doctor who bought his practice and he assured me that nearly every former patient of Myles who required further surgery had already been done and he had to rely entirely on new patients. Myles returned a few years later and "squatted" in Auckland and recommenced HT practice in his former territory. He never became a member of the ISHRS and never moved from the 4mm plug technique.

Ian Morrison of Birmingham was not your typical stay-at-home British doctor. To start with he had worked in the West Indies after graduation and had married a very lovely registered nurse who ran his home and office very competently and bore him two delightful children. He would come to a wine bar with us after work occasionally but did not drink. He claimed, probably correctly, that the only point in drinking was to change your state of mind, thus unless you intended to get drunk there was no point in drinking. He was a highly intelligent man and we did not attempt to argue with his impeccable logic as we ordered another glass or two of red wine for ourselves.

He had worked in the VD lab of the Pathology Department in Barbados and was absolutely paranoid about "germs and things." I worked with him in England in the days before AIDS made its appearance in the Western world. He was, nevertheless, very aware of the dangers of Hepatitis B and his performance after pricking his finger one day in the operating room is indelibly etched on my mind. First he swore very loudly and profanely while ripping off his two pairs of latex gloves, frightening the life out of the poor patient and nursing assistants who were in the O.R. with him. After frantically washing the blood off his punctured finger, he proceeded to suck it with the vigor of a poddy calf attacking a feeding bottle in a farmyard. He then proceeded to question the patient in detail about his recent and distant sex life and lifestyle in general, before gradually settling down to re-glove and resume the operation. It was a performance worthy of an Academy Award.

So scared of blood borne viruses was he, that this extended also to the blood in his meat. While most of us liked our steak rare or medium he always demanded his steak be "very well done" as a matter of course. These are pretty vague terms and one accepts some leeway depending on whether the chef is French, Italian, or British. Alf was the

only man I have ever known to send a steak back THREE times for further abuse on the griddle. On the final occasion the chef emerged personally with the poor little lump of tortured protein and placed it before Alf with a grunt of obvious disapproval. No doubt he had been curious to see the cut of this culinary "nut" who would eat a lump of hot charcoal and pretend to like it. With the advent of AIDS and the recognition that it was blood-borne, Alf quickly dropped out of the hazardous profession of Hair Transplantation and returned to full-time General Practice.

Wayne Bradshaw, the wild man from West Australia, should enter the history books as the man who finally convinced the doubting and conservative hair transplant profession of the value of small grafts. He certainly did not invent the process as small grafts and even single-hair grafts had been around for decades. In fact they dated back to the Japanese in the late 1930s. It was a small case of mine that he saw in the late 1970s that prompted him to completely abandon 4mm punch grafting and switch to "quarter grafts" for more extensive cases of baldness.

He did many cases in Australia and had his assistants do a lot on his own scalp in the early 1980s. He turned up at the New York HT meeting in 1984 with his very impressive transplant contrasting greatly with the traditional "plug jobs" sported by many other physicians at the meeting. He was an exceedingly extroverted character but had not been scheduled to speak at the meeting. O'Tar Norwood generously gave him half of his 30 minute spot scheduled for 9 am on the Saturday morning (those were the days when favored speakers had up to half an hour at the podium).

Wayne gave his address in the morning. Followed by an invitation for audience members to inspect his transplants, the talk went 15 minutes over time and upset the schedule of the entire day. It was, nevertheless, the highlight of the meeting. Despite the fact that many surgeons, such as Pierre Poutoux of Paris, had been quietly using small grafts for years, quarter grafts were now "kick-started" into history. Wayne never received any recognition for his pioneering efforts but in 2000 we gave Dr.Carlos Uebel a Platinum Follicle Award in belated recognition of his quiet contribution to both minigrafting and megasessions. Carlos had presented both of these concepts to unsympathetic audiences in America as far back as 1982, well before Wayne appeared in New York.

Wayne was also the initiator of the Large Bilateral Alopecia Reductions that held favor for a while in the late 1980s and early 1990s. Dr. Mario Marzola quickly realized the perils of the bilateral approach and left the field to Bradshaw who knew no fear.

Wayne set up a branch practice in New Zealand in 1990s and flew in and out of Auckland on surgical forays from time to time. By this time he had added liposculpture to his bag of tricks.

Wayne could dance all night and yet still turn up "bright eyed and bushy tailed" at the start of the next morning's program. He was a high achiever, and in addition to running a busy general and cosmetic surgery practice in the city of Wannaroo in the outer suburbs of Perth, he found time to act as City Mayor for several terms.

He is now back working as a GP in a county seaside township in West Australia. I dined with him five years ago and he was still full of energy and vitality. His wife and seven children have stuck with him and I keep waiting for his "next trick."

Anthony Pignataro of the USA first came to my attention at the Chicago meeting of the American Academy of Facial, Plastic and Reconstructive Surgery at the Drake Hotel in June 1995 (see ISHRS *Forum,* Vol. 5, No. 4, p. 7). While lecturing to the gathering on the joys of hair he reached up and snapped off his own unit, which was attached to titanium implants embedded in his cranium. I had been forewarned by someone who had seen his party trick previously and I captured it on film for the Forum. Nothing came of this novel "Osteo-integrated" method of attachment, however, and it faded into history.✧