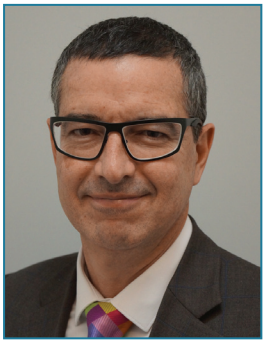

Medical and Professional Ethics

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Spotlight on Honesty with Patients

The second paragraph of the ISHRS Code of Ethics states: *"The member acknowledges that he or she is in a position of trust and will not betray that trust."* Patients put their trust in us as private practice doctors to do several things: to look after their health and well-being, to do no harm, to advise what is in their best interest both for the short term and for the long term, and to have the skills to do the procedure they are paying us to perform.

As hair transplant surgeons, patients trust us to be honest, to do what we have agreed pre-operatively to do, and to tell them what we have actually done. When we have not been able to achieve what we set out to do, or when there has been a complication, we ought to be truthful and tell them.

In the United Kingdom, this is referred to as the Duty of Candour and is spelled out in a document by the General Medical Council called Openness and honesty when things go wrong: the professional duty of candour (www.gmc-uk.org/-/media/documents/DoC_guidance_englsih.pdf_61618688.pdf) The principle within this guidance is that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must

- tell the patient when something has gone wrong;
- apologise to the patient;
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully to the patient the short- and long-term effects of what has happened.

How are these principles relevant to hair restoration surgery? There are some situations common to, and some unique to, the strip follicular unit transplant (strip FUT) and follicular unit excision (FUE) methods.

When planning a strip FUT procedure, the hair transplant surgeon makes a prediction of the number of grafts that will be harvested. What is the correct course of action if this number is not achieved? Should patients be given a refund for grafts not achieved? This will be partly dependent on how the patient has been counselled pre-operatively, what they are expecting, and the fee structure that has been agreed upon. It is important for patients to clearly understand the difference between "follicles" and "grafts," and that a graft is usually equivalent to a follicular unit not a follicle. Some hair transplant clinics charge per follicle, some per graft, and some per "session." If charging by graft then, if there is a shortfall, the planned number can be artificially manufactured by splitting grafts. Is this being honest since it does not in fact increase the number of hairs transplanted? What if too many grafts were harvested? If specific arrangements have not been made, should the patient be charged extra, should the grafts be discarded, or should they be "gifted" to the patient?

Reflective Question: Do I make it clear to my patients pre-operatively what the arrangements will be post-operatively if I have not achieved the graft numbers I was expecting to get or if I harvested too many grafts with the strip FUT method, and do I clearly record in the operation notes and tell patients exactly what has transpired especially with FUE surgery?

When performing FUE, there will be an inevitable partial graft transection rate, total graft transection rate, and follicle transection rate. Should patients be told these statistics since they might have implications for planning future FUE procedure graft numbers? They might also impact on the amount of scarring that has occurred in order to achieve the intended graft numbers and therefore limit further FUE graft harvesting. There is a greater expectation with FUE that the exact number of grafts paid for will be delivered since there is not the same mass harvesting of follicles as with the strip FUT method. So, if the surgeon is not able to harvest the required number of follicular units, should some be split in order to be able to tell the patient that the required number of grafts were achieved even though this doesn't change the actual numbers of follicles harvested or transplanted?

One of the idiosyncrasies of hair transplant surgery is that patients will never know exactly how many follicles/grafts were harvested and transplanted. Only the staff will know this and even then, only if there is strict quality control will this be accurately known.

The third paragraph of the ISHRS Code of Ethics states: *"The member will not take emotional or financial advantage of patients."* Hair transplantation in the private sector is, by definition, done for financial gain. However, there is a difference between patients being aware of the billing arrangements and agreeing to them, and patients thinking they have paid for something but not actually having this delivered because of dishonest behaviour.

I have been told by colleagues who worked for large commercial clinics that the non-clinical managers of these organisations expected that every patient who booked in for a consult would have surgery recommended to them. Making a judgment on what is the safe donor is a key element of the patient examination and the more experienced hair transplant surgeons will know that some patients are just not suitable for hair transplantation. Taking into account the current, and future, donor : recipient ratio and advising patients when a hair transplant is not in their best interest is a hallmark of an ethical consultation. Just because patients think they are suitable for a hair transplant procedure or request one, doesn't mean it should be recommended to them. Financial gain should never be put ahead of patient welfare. ■