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## ORIGINAL ARTICLE

# AGA practitioner challenges: A mixed-methods pilot survey

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## Abstract

**Background:** Androgenetic alopecia (AGA) practitioner care may be hampered by commercial biases and hair loss' omission from most medical curricula.

**Aim and Method:** Between November 2020 and September 2021, 34 AGA professionals (86% British; 62% trichologists), participated in a pilot, mixed-methods, survey. Practitioner views on: 1a–1j) AGA's commercial influences (e.g., participants were quantitatively assessed on their understanding of a popular, commercially-funded, AGA study) and 2a–2h) constraints on evidenced-based AGA responding (e.g., ethical dilemmas) were assessed. Quantitative responses are reported descriptively whilst qualitative responses are categorized alongside illustrative quotes.

**Results:** On average, (1a–1d) 42% of participants were misled by the popular AGA study and (1e) participants underestimated the extent of commercial biases in AGA research as 25%; (2a–2e). Participants also indicated that AGA treatment limitations and misinformation ethically challenged them (e.g., “[It's difficult to know when] to treat or not without being able to confirm the outcome”). (2c) Most (77%) indicated society played a powerful role in exacerbating AGA distress (e.g., “Society is hyper critical of appearance”) and 30% indicated greater “treatment” accessibility was needed: (e.g., “hair loss product [should] give clear indication of what the active ingredients are and how effective they are”).

**Conclusions:** Despite the limited sample size, these findings cohere with previous identified challenges of the AGA practitioner role. Evidence based guidance and research scrutiny tools would help practitioners overcome such challenges.

## KEYWORDS

AGA, challenges, hair loss, practitioner, psychology

## 1 | INTRODUCTION

Androgenetic alopecia (AGA) primarily occurs in men and is characterized by its genetic and hormonal links. Practitioners wishing to support evidence-based AGA responding may be challenged by a lack of AGA specific education and by the presence of commercial biases. This pilot study aims to assess practitioners' views and experiences of these challenges.

### 1.1 | The challenges of the AGA practitioner role

The role of the practitioner supporting men with AGA is challenging. For all medical practitioners, training and education is essential. But dermatological and AGA content is often absent in medical curricula.<sup>1,2</sup> The third edition of the popular medical text: “Dermatology: A Handbook for Medical Students and Junior Doctors”<sup>2</sup> mentions hair loss as a symptom of other skin conditions but does not include

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anything specific on hair loss itself. Commendable efforts to improve dermatological curricula have often been unsuccessful.<sup>1</sup>

Practitioner roles are further challenged by the widespread presence of AGA commercial influences. Approximately 70% of popular hair loss Facebook pages are funded, written or influenced by businesses<sup>3</sup> as is more than 60% of hair loss research.<sup>4,5</sup> For example, Alfonso et al.<sup>6</sup> conducted an international study on the psychosocial impact of AGA published in the journal *Current Medical Research and Opinion* (hereafter referred to as the Alfonso study). It has been cited 159 times according to Google Scholar (as of June 5, 2023) and is funded by Merck. According to Open Payments Data,<sup>7</sup> in 2019 alone, Merck made over 40000 payments, totaling almost \$345 million, to medical professionals for research. Such commercial influences matter. For example, research abstracts can include “spin” or selective and exaggerated reporting of findings that unduly influence how medical professionals interpret the benefits of different interventions.<sup>8</sup> Specifically, Alfonso et al. also indicate that finasteride had the highest success rate (62%) of any AGA intervention particularly compared to hair transplants (20%). However, on closer reading, the hair transplant success rate of 20% is based on a sample of just five men whereas finasteride's success rate is based on a larger sample of 29 men. This difference is not highlighted by the authors perhaps because, at the time, the study's funder, Merck sold finasteride.

Commercial biases increase the difficulty in ascertaining the most successful, safe and evidence-supported responses to AGA. Two reviews found that 27%<sup>9</sup> and 68%<sup>5</sup> of dermatological and AGA studies referenced interventions (e.g., drugs or transplants) without any meaningful discussion of their limitations. Comprehensive, evidence based guidance for AGA interventions may not be widely disseminated. As Manabe et al.<sup>10</sup> (pp. 1031–1032) note:

The fact remains that therapies with no scientific basis, and which, from the dermatological perspective, are entirely without effect, are still prevalent.

## 1.2 | AGA practitioner views are understudied

Previous research about AGA practitioners' views and experiences is rare. Just three published surveys exist all conducted by market research companies.<sup>11–13</sup> In the first,<sup>11</sup> 466 doctors from a market database across the US, Germany, Spain, Japan, and Korea took part. The study was funded by Merck. The second study,<sup>12</sup> funded by GlaxoSmithKline, included 338 AGA practitioners (and 835 men who had recently undergone a hair transplant) from Latin America and Asia. Finally, a survey has been periodically conducted with members of the International Society of Hair Restoration Surgeons; most recently with 197 members in 2022.<sup>13</sup> Collectively, these surveys highlight differences in practices and knowledge across AGA practitioners. They emphasize the need for further education on AGA and the challenge for practitioners in providing good patient care. For example, Lulic et al.<sup>12</sup> highlighted: “[the] need for physicians to

spend sufficient time with patients discussing male AGA, treatment approaches and what patients wish to get out of treatment” (p. 901).

These surveys provide valuable insight into AGA practitioner's practices. Their strengths include their large sample sizes. However further research, that is not commercially funded and gathers practitioners' views in a more in-depth manner is needed. For example, it is unclear what influence commercial links have or what specific ethical dilemmas practitioners face. Thus, this pilot survey aims to identify practitioner's views on commercial biases (via ten questions: 1a–1j) and constraints on AGA evidenced-based responding (via eight questions: 2a–2h).

## 2 | MATERIALS

A wider survey assessed AGA practitioners' understanding and experiences. This study focuses on the survey responses relating to the following subtopics: (1) AGA commercial influences (questions 1a–1j), and (2) constraints around evidenced-based AGA responding (including diagnosis, general ethical dilemmas, the societal influence on AGA, AGA's psychological impact and informed consent; questions 2a–2h). These questions are presented in full in [Table 1](#). To aid readability, questions are also integrated below in the results, some responses are collapsed and percentages are calculated excluding blank responses ( $n=6$ ). The data that support the findings of this study are available from the osf: <https://osf.io/wyp46>. A fuller version of the results is available here: <https://osf.io/8s6va>.

## 3 | METHOD

### 3.1 | Procedure

Participants took part in an online survey from November 2020 to September 2021. Dermatological and AGA practitioner organizations or networks (largely US and UK based) were identified through a combination of internet searches and cross-referencing from key repositories (e.g., the British Association of Dermatologists lists organizations here: <https://www.bad.org.uk/derm-groups-charity/> and the ISHRS lists global council members here: <https://ishrs.org/about/global-council/>). Thirty-five organizations were approached up to three times (a full list of organizations is available upon request from the first author). Four indicated they would try to pass on the survey (these were The Institute of Trichologists, Registered Trichologists, British Association of Hair Restoration Surgeons and the International Society of Hair Surgeons). Additionally, two networks allowed direct posts to their members through their social media (World Scalp Micropigmentation Forum and Scalp Micropigmentation: Team Micro International Community). One indicated they could not pass on the survey as they did not pass on research requests generally. The remaining 28 organizations/ networks did not reply. As an incentive to participate, participants were offered a £10 UK e-voucher. Ethical approval from the lead author's institution (LREC 29-MAY-20) and informed consent for the survey were gained.

TABLE 1 Question details used in the study including response scales.

Question identifier	Question details/ wording	Response format	Response scale
1a-1d	Understanding of four Alfonso study's statements	Numerical	See Table 2
1e	View on Alfonso study's evidence	Numerical	See section 4.1.3
1f	View on Alfonso study's commercial funding	Qualitative	See section 4.1.4
1g	"What percentage (if any) of research on the psychosocial impact of AGA they thought was commercially funded?"	Numerical	Percentage estimation
1h	"Most or all research on AGA is independent and objective"	Numerical	Strongly disagree (5) to Strongly agree (1)
1i	"Most knowledge about AGA comes from medical sources"	Numerical	
1j	"AGA forums are largely independent spaces for those with AGA to discuss their AGA."	Numerical	
2a	"Male pattern AGA can be diagnosed with the Norwood-Hamilton scale."	Numerical	
2b	"What (if any) ethical dilemmas do they face in their work?"	Qualitative	Open-ended
2c	"What role do they think, if any, society (e.g., social media advertising) has on men's AGA experiences?"	Qualitative	
2d	"What role do they think, if any, society (e.g., social media advertising) has on men's AGA experiences?"	Qualitative	
2e	"Men need to fully understand the intervention approach before I will provide a AGA intervention"	Numerical	Strongly disagree (5) to Strongly agree (1)
2f	"I spend a lot of time explaining the reasons why I recommend/prescribe the AGA interventions to my patients"	Numerical	
2g	"Men consider the consequences of their AGA/ hair thinning to be very serious"	Numerical	
2h	"Male pattern AGA does affect male patients on a day-to-day basis"	Numerical	

## 3.2 | Participants

Thirty-four practitioners (62% women, age years  $M=53$ ,  $SD=12$ ) providing or assisting with AGA interventions took part. The majority (86%) indicated they were British, 8% were American and 5% were Australian. Of those who disclosed their ethnicity ( $N=32$ ), 81% indicated they were White. Most self-defined their roles as trichologists ( $n=26$ , 68%), fewer as dermatologist-doctors ( $n=4$ ; 12%) or doctors ( $n=3$ ; 9%). The remainder were in other AGA intervention related roles ( $n=4$ ; 12%). All offered AGA diagnostics and/or interventions.

## 3.3 | Analytical strategy

Frequencies and percentages of the quantitative responses are reported below. Content analysis allowed for categorization of the qualitative responses alongside presentation of illustrative quotes by the first author. These categories were reviewed against raw responses and between both authors.

# 4 | RESULTS

## 4.1 | AGA' Commercial Influences

### 4.1.1 | (1a-1c 3) Alfonso study views

Participants were asked to read the abstract of the Alfonso study and were assessed on their understanding and views of it. This

included 1a-1d) how correctly they understood four key aspects of the study and their views regarding the study's 1e) evidence and 1f) commercial funding.

### 4.1.2 | (1a-1d) Understanding of the Alfonso study

Participants were quantitatively asked whether five, false, statements about the Alfonso study were true, false or whether they were unsure. Each statement was written by us (the authors). The statements were designed to explicate an implicit message we believed Alfonso et al. were promoting. For example, the first statement we assessed participants' understanding with was: (1a) "Most of the men with AGA indicated their self-esteem was impaired". We believed Alfonso et al. promoted this message based on their abstract sentence that: "62% agreed that AGA could affect self-esteem". However, each statement was false as close reading of the Alfonso study would reveal. Thirty-four participants responded. 42% on average, indicated at least one of the statements was true and 26%, on average, indicating they were unsure. Just 33%, on average, correctly identified at least one statement was false. The question statements (1a-1d), participants' responses and context from Alfonso study is reported in full in Table 2.

### 4.1.3 | (1e) View of evidence of the Alfonso study

Participants were quantitatively asked to indicate every strength or limitation of the Alfonso study that they believed influenced its

TABLE 2 Participants' (N=34) responses assessing (1a-1d) understanding of the Alfonso study.

False statement	Participants' responses			Reasons why statement was flawed	
	False (correct identification)	True	Unsure	Relevant abstract excerpt that participants read from the Alfonso study (2005)	Relevant data from the Alfonso study (2005) indicating why the statement was false
(1a) "Most of the men with AGA indicated their self-esteem was impaired"	18%	79%	3%	"62% agreed that AGA could affect self-esteem" (Alfonso et al., 2005: p. 1829).	Whether AGA may actually impact affect participant's own self-esteem was not assessed. Other study responses indicate a complex psychosocial impact on men. <sup>a</sup>
(1b) "Most men with AGA have interventions"	82%	6%	12%	"Less than 10% of men were currently pursuing treatment for AGA, and three out of four had never pursued treatment for AGA" (Alfonso et al., 2005: p. 1829)	Most men did not get interventions.
(1c) "Most of the men with AGA who had taken the interventions reported they were successful"	15%	35%	50%	"Those few men who pursued treatment and reported success (n=73)" (Alfonso et al., 2005: p. 1829).	41% reported success with the interventions.
(1d) "Most of the men with AGA benefited from the interventions"	15%	47%	38%	"[Participants] also reported psychosocial benefits as a result: from 43% to 59% experienced improvements in parameters of self-esteem and perception of personal attractiveness" (Alfonso et al., 2005: p. 1829)	Most men had never used interventions (76%), of these that did on average, 48% reported benefits.
Average	33%	42%	26%	-	-

<sup>a</sup>Some of the participants in Alfonso et al. (2005) indicated considerable distress but others indicated mild distress for example, just 7% reported they were "dissatisfied with their appearance", 58% disagreed that with "men with hair are much more sexy" and 43% agreed that AGA "makes men look more experienced" (p. 1832).

evidence quality. Most (61%; n=19) indicated the evidence quality was high/ convincing. Participants selected the following reasons/strengths to explain why: because "it took place in 5 different countries" (n=13), followed by because "it used a quantitative questionnaire" (n=11), because "it had a large sample" (n=10), because "it is published" (n=9) and because "there were many authors" (n=5).

The remainder (39%) found the evidence unconvincing. Participants selected the following weakness(es) as reasons/weaknesses to explain why: because "it does not appear to use validated measures" (n=9), followed by because "most of the men never had treatment" (n=7), because "other (unspecified)" (n=7) and because "it is funded by a pharmaceutical company" (n=6).

#### 4.1.4 | (1f) View on commercial funding of the Alfonso study

Participants were qualitatively asked their views on Merck's funding of the Alfonso study. Half (51%; n=17) indicated that the funding did not change their view of the study. Participants explained they believed/ assumed the study was not biased as commercial

influences are common, as the conclusions seem reasonable, as the interventions are regulatorily approved or as the findings correlated with their own professional experience (e.g., "i assume the rese[a]rchers were independant" and "most studies have some Pharma input").

Slightly less than half (48%; n=16) indicated that Merck's funding of the study did change their view of the study. Participants explained this was because funders' vested interest in the AGA intervention, finasteride, may bias the study (e.g., "Questions etc. may be framed to produce the answers the investigators want"; "they [may] have a vested interest in pursuing the most favorable results for their business and may not be impartial in their selecting criteria" and "These companies have a vested interest").

#### 4.1.5 | (1g-1j) Independence of AGA information

Participants were quantitatively asked to estimate 1g) "What percentage (if any) of research on the psychosocial impact of AGA they thought was commercially funded?" Participants were next quantitatively asked to indicate their agreement with the following

statements: (1h) "Most or all research on AGA is independent and objective"; (1i) "Most knowledge about AGA comes from medical sources" and (1j) "AGA forums are largely independent spaces for those with AGA to discuss their AGA".

(1g) Twenty-one participants estimated a percentage of commercially funded research ranging from 0 to 95%. The average estimated was 25% (SD=32). Furthermore, (1h) 61% of participants disagreed that "most or all research on AGA is independent and objective", (1i) 36% disagreed that "Most knowledge about AGA comes from medical sources" and (1j) 11% disagreed that "AGA forums are largely independent spaces".

## 4.2 | Constraints on AGA evidence-based Responding

### 4.2.1 | (2a) Norwood Hamilton scale

Participants were asked to quantitatively indicate their agreement with the following statement: "Male pattern AGA can be diagnosed with the Norwood-Hamilton scale". Of the 28 that responded, 71% indicated they strongly or somewhat agreed, 14% indicated neutrally and 14% indicated they strongly or somewhat disagreed.

### 4.2.2 | (2b) Ethical dilemmas

Participants were qualitatively asked: "What (if any) ethical dilemmas do they face in their work?". Twenty responded including three that indicated they experienced no ethical dilemmas and 1 which indicated unclearly. Among the remaining 16, five wrote treatment limitations, inefficacy or cost were dilemmas (e.g., "Sometimes a patient can present in a distressed state pleading for a cure for hair loss, when one knows that any treatment is unlikely to be successful"). A further four revealed pressure to unnecessarily or inappropriately treat worried them (e.g., "when to say no, if I do not think the patient will benefit or what they are asking for is unreasonable"). Two more indicated the lack of treatment evidence was an ethical concern (e.g., "Most research around treating AGA is very limited and the field is full of anecdotal or non-human based studies"). An additional, two indicated that being mistaken for a medical professional concerned them (e.g., "As a trichologist people think that I am medically qualified so I have to be clear about the limits of my responsibility in treatments"). Finally, a further two highlighted the practices of other unethical practitioners presented dilemmas (e.g., "Only the ability to whistleblow and expose wrongdoing to the patient within theatre").

### 4.2.3 | (2c, 2d) Society's influence

2c) Participants were qualitatively asked: "What role do they think, if any, society (e.g., social media advertising) has on men's AGA experiences?". 30 responded. Some responses were multiply categorized

forming 42 responses. The majority (86%;  $n=36$ ) indicated society played a significant and detrimental role, especially through advertising, celebrity culture, reality TV and social media (e.g., "Social media exacerbates insecurity across the board", "Open to abuse, advertising standards are low to non-existent"). Some of these responses noted that society particularly impacted younger men (e.g., "There is a feeling of 'loss' for many young men who lose their hair") or that indicated snake oil remedies and treatment advertising was specifically harmful ( $n=4$ ; e.g., "lots of 'miracle' products are advertised that are a waste of money").

Of the remaining responses, three (7%) were positive about society, arguing it promoted solutions (i.e., interventions) or facilitated discussion of AGA distress ("Social media advertising is helpful in promoting treatments as well"). Finally, three (7%) responses were unclear.

(2d) Participants were qualitatively asked: "What, if anything, do you think can be done to positively influence society (e.g., social media advertising) so that it might benefit men's AGA experiences?". Twenty-seven responded with some responses multiply categorized, forming 33 (100%) responses. These were coded into the following: 10 (30%) responses indicated AGA interventions needed to be made more transparent, accessible and normalized so distressed men could access them (e.g., "Encouraging those celebrities etc. who have had e.g. hair transplant to be open about it"). Another 10 (30%) responses indicated society needed better representation of men who had AGA (e.g., "More visible role models who are AGA and don't feel the need to seek treatment"). Seven (21%) indicated some interventions could be harmful and required regulation (e.g., "Stop shaming for financial gain" and "Less influence by expensive AGA clinic advertising"). Five (15%) responses indicated they were unsure or that they felt there was nothing that could be done (e.g., "Nothing. Cannot close down internet and commercial influences preying on men"). Finally, 1 (3%) response indicated "education" was required.

### 4.2.4 | (2e-2h) Importance of informed consent and AGA's psychosocial distress

Participants were quantitatively asked to indicate their agreement with four questions (2e-2h) about informed consent and psychological distress relating to AGA. These questions were used previously by Lulic et al.<sup>12</sup> Most responses indicated informed consent was important (93%) and psychological distress significant (77%; akin to participants in Lulic et al.<sup>12</sup>). Full details are presented in Table 3.

## 5 | DISCUSSION

### 5.1 | AGA' commercial influences summary

Our analysis found evidence of misinformation arising from commercial biases. An average of 42% of participants were misled by four false statements about the Alfonso study.<sup>6</sup> A further 26% indicated



**TABLE 3** Participant responses to importance of informed consent and AGA's psychological distress questions (2e–2h) in comparison with Lulic et al.<sup>12</sup> participant responses.

Question statement	Lulic et al. <sup>12</sup> responses					
	Current survey (N = 34) <sup>a</sup>		AGA practitioners (N = 338)		AGA men (N = 835) <sup>b</sup>	
	Agree	Disagree	Agree	Disagree	Agree	Disagree
(2e) AGA interventions require full understanding	96%	4%	95%	2%	75%	6%
(2f) AGA interventions require considerable explanation	89%	4%	78%	8%	54%	6%
(2g) AGA has serious consequences	79%	4%	86%	4%	71%	12%
(2h) AGA has a day-to-day impact	75%	14%	68%	18%	44%	32%

<sup>a</sup>Strongly and somewhat (dis)agree responses were collapsed. Percentages in the table do not total 100 as neutral responses (n = 6; 18%) are not included.

<sup>b</sup>Participants answered modified statements that pertained to them personally.

they were unsure. This was, at least, in part because Alfonso et al.<sup>6</sup> wrote misleading statements in the abstract (that the study results sometimes contradicted). Less than half of participants were critical about the Alfonso study,<sup>6</sup> for example, believing the evidence was unconvincing (35%) or the commercial funding was a bias (47%). This reflects the Alfonso study's influence generally; where it has been cited over 150 times and has been used to inform dermatological guidance.<sup>14</sup> The Alfonso<sup>6</sup> study had substantial limitations. For example, it used non-validated measures, lacked a control group and had a skewed framing (that presented AGA as only negative). Participants were only shown the Alfonso abstract, within a survey and thus may not have had time to read it thoroughly. Nonetheless, this brevity reflects practitioners' reality of having little time to read research in the context of a busy practice. It is concerning that the Alfonso study's commercial influence and limitations may not be recognized.

More broadly, participants underestimated the prevalence of commercial influences on AGA information sources. For example, participants estimated 25% of AGA research was commercially biased when evidence has found at least 66% is.<sup>4,5</sup> Commercial influences abound in the AGA 'information landscape' generally. For example, 68% of 600 popular hair loss intervention Facebook pages<sup>3</sup>; 54% of 90 hair loss intervention YouTube videos<sup>15</sup>; and 46% of 73 alopecia intervention YouTube videos<sup>16</sup> analyzed were found to have commercial biases. Collectively this research and our results highlight the limits of AGA information; in particular, that commercial influences on AGA research may mislead busy practitioners.

## 5.2 | Constraints on AGA's evidence-based responding summary

### 5.2.1 | Ethical dilemmas, society's influence and diagnosing AGA

Most practitioners believed in the accuracy of the Norwood–Hamilton scale despite the recommendation of alternative AGA diagnostic tools (e.g., the BASP).<sup>17</sup> Intervention limitations, including

side effects or inefficacy and misinformation, presented ethical dilemmas to practitioners wishing to responsibly support AGA men. Such ethical dilemmas were compounded by the unclear evidence base behind such interventions and the expectations and hopes placed on practitioners (including to operate beyond their expertise). These challenges have been recognized by others.<sup>10</sup> Additionally, the detrimental role of society in engendering AGA distress, recognized by 80% of participants, added to the pressure on practitioners to support AGA men. Participants suggested better AGA representations and intervention normalization could combat this societal influence.

### 5.2.2 | Importance of informed consent and AGA's psychological impact

Most practitioners valued informed consent and extensive discussion of intervention approaches. Lulic et al.'s<sup>12</sup> Latin American practitioners and AGA men echoed this. These findings are encouraging and cohere with official recommendations for AGA practice.<sup>18,19</sup> They also emphasize the importance of a pressure-free, timely and informed discussion between practitioners and AGA men.

Additionally, practitioners in this study and in Lulic et al.<sup>12</sup> believed AGA to be distressing for men including on a day-to-day basis. However, systematic reviews<sup>20,21</sup> have found that biased samples of overly distressed AGA men (e.g., attending clinics) and other methodological issues meant the psychosocial impact was somewhat exaggerated and more likely to be mild to moderate. Indeed, this may explain why substantially fewer of Lulic et al.'s<sup>12</sup> 835 AGA men (58%) indicated the psychosocial impact was severe compared to the study's practitioners (77% see Table 1).

## 5.3 | Recommendations

The results from this survey show there is a need to carefully scrutinize research including its framing, funding and design (e.g., sample sizes). The free research tools Pubpeer (<https://pubpe>

er.com/) and Retraction Watch (<http://retractiondatabase.org/>) can help do this. Shared-decision making guidance that supports practitioners to gain full understanding and informed consent<sup>22</sup> may help allow practitioners to meet the ethical dilemmas they contend with.

## 5.4 | Limitations

We made extensive recruitment efforts. We contacted a wide number of relevant organizations, we provided incentives and we designed the survey sections to be easily skipped to reduce participant burden. We also sent reminder emails and used snowball sampling techniques. Despite this our final sample was small ( $N=34$ ). The response rate of the other comparable studies<sup>11,13</sup> were also relatively low (15% and 24%, respectively) but likely much greater than ours (we are unable to determine our response rate as it is unclear which organizations passed on their surveys or not and how big each membership was). Ultimately, recruiting this population of busy professionals into research is likely to be an ongoing challenge and can help explain why market research companies are traditionally approached.<sup>6,11,12</sup> Additionally, there are likely to be important differences between practitioners who took part in the survey in training, experience and views on AGA (e.g., trichologists in the UK cannot prescribe pharmaceutical drugs whereas dermatologists can) that were not considered due to the small sample size. Clearly more research, whilst challenging to conduct, is needed.

## 6 | CONCLUSION

Thirty-four AGA practitioners completed our mixed-methods, pilot, survey. Our results indicated some practitioners underestimated the prevalence and impact of commercial biases. Some practitioners also reported ethical dilemmas such as wanting to support AGA men without unduly offering those interventions with limited or unclear efficacy. Research scrutiny tools and shared-decision making resources may be valuable to lessen practitioner constraints and improve AGA care.

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### CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to declare.

### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in OSF at <https://osf.io/wyp46>, reference number doi.org/10.17605/OSF.IO/RZP47.

### ETHICS STATEMENT

Ethical approval from the lead author's institution (LREC 29-MAY-20) and informed consent for the survey were gained.

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