

on unwanted effects a judgment may be reached both in general and individual cases on whether its use is justified. Alzheimer's disease is after all a cruel and ultimately lethal disease, and, as with cancer, risky treatment may be acceptable if there are sound reasons to expect benefit from it. At present we have far too few hard facts either on the efficacy of tetrahydroaminoacridine or its dangers to justify its use other than as part of carefully regulated research.

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## Control of substances hazardous to health

### *Far reaching legislation or dead letter?*

Described by the Secretary of State for Employment as "the most far reaching health and safety legislation since the Health and Safety at Work Act 1974," the Control of Substances Hazardous to Health (COSHH) Regulations 1988 place specific obligations on employers (including the self employed) to control hazardous substances.<sup>1</sup> The regulations first define a hazardous substance broadly, as something that has the potential to harm health. (Because they are covered by separate legislation medicine for patients, asbestos, lead, radiation, and substances in mines are excluded.) They then require all employers to make, and usually to record, a comprehensive assessment of the risks of using such substances in the workplace. In many cases this must be followed by action to reduce the risk; in some instances monitoring of concentrations of the substance in the air and medical surveillance of the workforce are required. From 1 January 1990 any work with hazardous substances will be prohibited unless an assessment has been made.

The new regulations are well thought out and comprehensive. Furthermore, they have been framed after full consultation with the Confederation of British Industry and the Trades Union Congress. May we therefore expect a substantial improvement in the health record of industry? Unfortunately, there are grounds for pessimism. The Health and Safety at Work Act, in force now for nearly 15 years, was

also formed with the best of intentions. It has undoubtedly clarified a lot of obscure legislation and put the responsibility for health and safety at work firmly on employers and employees, and the Health and Safety Commission and the Health and Safety Executive have worked hard to educate and inform industry and to continue a programme of inspection and enforcement. But the fact remains that in those 15 years industry's accident record has not improved—each year still some two workers are killed and 95 are seriously injured among every 100 000 employed.

The Health and Safety Executive has commented on possible causes of this reversal in the downward trend of serious injuries in the workplace, pointing to the possible roles of decreased investment in new machinery, declining standards of maintenance, and reduced resources for safety.<sup>2</sup> To these might be added the unfamiliarity of senior management with the workplace and its hazards, the relative weakness of trades unions with respect to safety, and the need for industry to increase marginal profitability by reducing overhead costs, of which money spent on health and safety may be perceived as a component.

The new regulations come at a time when the public is more aware than ever of the hazards of industry. They provide a clear framework for preventive action. All that is necessary is enforcement. This requires that they are understood by all

employers and that the Health and Safety Executive can police their implementation. Examining the first criterion, a recent unpublished survey of 2000 companies by the Institute of Occupational Medicine and the National Occupational Hygiene Service has shown widespread ignorance of the new regulations and their implications among smaller concerns, many of which see a conflict between compliance with new regulations to protect their workers and the survival of their businesses. Enforcing the new regulations may be difficult: control of public spending has not spared the Health and Safety Executive—its total numbers of inspectors and doctors in the Employment Medical Advisory Service have been reduced as the complexity of industry and the number of small businesses have increased. Although there is ample evidence of increased efficiency and strong leadership within the executive, there is a limit to what can be expected of these hard pressed and underpaid men and women in terms of making the new regulations work.<sup>3</sup>

Britain has a good record of industrial health and safety legislation. But the first attempts, the Health and Morals of Apprentices Act 1802, the Factory Act 1819, and the Chimney Sweeps Act 1814, though well intentioned, were largely ineffective owing to the unwillingness of parliaments to give them the necessary teeth. Clearly, the effectiveness of the new regulations depends critically on the ability of the Health and Safety Executive to enforce them and the willingness of the government to support the executive.

In the mean time, we as doctors can do our bit. Firstly, we should ensure that our own houses are in order. General

practitioners should comply with the regulations to protect those they work with. Are any of them exposed to substances such as infected blood or fugitive anaesthetic gases? Hospital doctors should consider what hazards, chemical or microbiological, lurk in their laboratories. Are their employers taking steps to comply with the regulations? Doctors employed in part time occupational health practice should ensure that their employers know the regulations and take appropriate action.

Secondly, if doctors suspect work related illness they should contact their local Employment Medical Advisory Service doctor (listed in the telephone book under Health and Safety Executive), who can make the relevant investigations. Everything that can be done to prevent the new regulations becoming a dead letter will contribute to reducing the toll of ill health in the workplace.

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The following documents are available from the Health and Safety Executive, Library and Information Services, Baynard's House, 1 Chepstow Place, London W2 4TF: *Control of Substances Hazardous to Health Regulations 1988. Approved Code of Practice.* London: HMSO, 1989, price £4.00; *Control of Substances Hazardous to Health Assessments: A step by step Guide to Assessment and the Skills needed for it.* London: HMSO, 1989, price £2.00; and three free pamphlets: *Introducing Control of Substances Hazardous to Health, Hazard and Risk Explained,* and *Introducing Assessment.* London: Health and Safety Executive, 1989.

## Treating young men with hair loss

### *Encouraging them to come to terms with baldness is still the best response*

What do you advise a young man with thinning hair these days? In the past, provided that there were no underlying skin diseases such as tinea capitis, alopecia areata, eczema, psoriasis, lichen planus, or lupus erythematosus, there was no effective treatment. Male baldness was a fact of life, which the afflicted had either to accept or conceal with a wig. New treatments are available now, and the young man will want to know whether these are worth while.

The key question is whether treatment is a good idea, which applies just as well to other cosmetic complaints, such as unwanted hirsuties, naevi, and cysts. The available facilities and the training, personality, and philosophy of the doctor will influence the advice given. Nevertheless, most British dermatologists would explain the mechanism of male alopecia, pointing out that the degree of hair loss in near relatives is the best guide to prognosis, and persuade the young man to accept the natural course of events. Most take this advice, but some, especially those in public life or the entertainment industry, remain very concerned, even disturbed, by their hair loss and worry about further loss.

With mild hair loss and a family history suggesting a good prognosis it is wise to discuss the options for treatment and persuade the patient that they are unnecessary. He will find out about the treatments anyway so should receive advice first from his family doctor or a consultant dermatologist rather than a hair clinic with a strong commercial interest in treatment. With moderate hair loss and a poor prognosis the patient may wish to consider one of three available treat-

ments. All are costly, and none is available on the National Health Service.

Wigs are a well established remedy for concealing undesirable hair loss, but in men they are nearly always recognisable as such because the frontal margin usually looks unnatural. Wigs with woven fronts may be less obvious but are expensive. Extra hair can be woven into the natural hair, but this has to be rewoven at regular intervals as the natural hair grows. The wearing of wigs in some occupations—for example, outdoor workers and factory workers—might be undesirable because they could blow away or become too soiled and wear out quickly.

The second line of treatment is hair transplantation. Small punch grafts of the patient's scalp bearing hair, usually from the occiput, are transferred to the thinning areas.<sup>1</sup> This may be supplemented by scalp reduction: excising a triangle of bald scalp on the vertex and closing the defect by simple suture. It is essential that the procedures are undertaken by a qualified and experienced practitioner, and selection of suitable patients is crucial to success. The effect may be very gratifying, but treatment is expensive, and there are complications—failure of grafts, infection, scarring, keloid formation, and more hair loss that exposes the donor sites. The implantation of manmade fibres is not recommended because of the risk of the formation of necrotising granuloma.<sup>2</sup>

The third and most recent treatment is minoxidil lotion (Regaine). After about six months of twice daily applications one in 10 men are satisfied with the growth of hair, though