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## Self-certification?

SIR,—Your leader on self-certification (24 October, p. 192) raises wider issues than the socioeconomic framework in which the subject is discussed.

The resentment felt by many general practitioners is not merely at the waste of time or at the workload entailed—1,600 to 2,000 statutory certificates per N.H.S. general practitioner per year, with roughly an equal number of non-N.H.S. (usually "non-medical") certificates. It is the distortion of relationships with patients, with hospital colleagues, and with the public which is also important—and which, no doubt, acts as a deterrent among young doctors who might otherwise consider general practice as a career. The patient who says "I've been off three days with diarrhoea, I need a line"; the hospital doctor who says to the patient "A line? Oh, you get that from your G.P."; the chamber of commerce which finally rebels at the "vague" certification from the general practitioner in their area and makes an issue of it with the L.M.C.; these are only some of the many examples of the ways in which the general practitioner is stressed.

(1) Can we not accept short-term absence for the management problem it so often is, rather than the medical problem it has been alleged to be?

(2) Should not personnel and works medical services assume greater responsibility in dealing with these problems?

(3) Should not the worker be entrusted with a greater degree of responsibility for his absence?

(4) Granted that the introduction of three-day self-certification has been shown to be feasible in one large works, is there not a case for a national scheme with the insured worker responsible for longer spells —more than three days, but less than, say, three weeks?

(5) Should not our highly skilled nursing sister, whether in the works or in the health centre, be granted the same authority in regard to certification as that entrusted to her counterpart in hospital?

Answers to these simple questions could go a long way towards decreasing clerical medicine, increasing clinical medicine, and raising standards of health care, without at the same time aggravating the situation regarding absence ascribed to sickness.—I am, etc.,

JAMES D. E. KNOX.

Department of General Practice,
University of Dundee.

## Phenacetin Nephropathy

SIR,—The interesting paper by Dr. K. G. Koutsaimanis and Professor H. E. de Wardener (17 October, p. 131) and your leading article on the subject (p. 125) draw attention once more to the vexed question of phenacetin. The fact that it is never prescribed alone is of some interest, and, as the authors note, most of it is purchased across the counter in preparations based on or identical with those in the *British Pharmacopoeia* and *British Pharmaceutical Codex*.

In 1955 at Westminster Hospital we removed phenacetin from the hospital compound codeine tablet and increased the aspirin content without any apparent loss in its popularity. We did this because it saved the pharmacy £100 a year, the new compound being less expensive, and because enterogenous cyanosis occurred not infrequently in arthritics taking large doses every day rather than because of the then recent reports from Switzerland[1] of renal toxicity caused by heavy daily consumption of compound analgesic tablets. There seemed, even in those days, no reason to retain phenacetin as an analgesic even in the absence of adequate proof that it was a nephrotoxic drug. Since then we have never regretted this move, and though the case against the drug as a nephrotoxic agent rests only on indirect evidence and could be considered non-proven we have felt for many years that its merits do not warrant its retention in analgesic tablets.

The case against paracetamol, however, we feel is different, and Dr. Koutsaimanis and Professor de Wardener have produced little evidence against the drug. It has been widely prescribed now for over ten years, its particular merit lying in its freedom from gatrointestinal irritation; in any busy rheumatism clinic this is a very considerable advantage. There is, to date, no good case against it, either in the literature or at the Ministry's Committee on Safety of Drugs. While we think there is a case for withdrawing phenacetin altogether or making it available only on prescription, we do not think, on present evidence, that paracetamol should be branded as a nephrotoxic agent or its prescribing restricted.—We are, etc.,

F. DUDLEY HART.
R. T. TAYLOR.
E. C. HUSKISSON.
GILLIAN M. SHENFIELD.

Westminster Hospital,
London S.W.1.

REFERENCE

1 Spühler, O., and Zollinger, H. U., *Zeitschrift für klinische Medizin*, 1953, **151**, 1.

SIR,—In their paper on phenacetin nephropathy (17 October, p. 131) Dr. K. G. Koutsaimanis and Professor H. E. de Wardener quote a personal communication from myself about two patients who have analgesic nephropathy following consumption of paracetamol. Since this quotation has caused