is a welcome addition to the literature on women's knowledge of emergency contraception (October *Journal,* p.451). Among those who use contraception, those choosing barrier methods are the most likely to have reason to resort to secondary methods,[1] hence it is sensible to target these individuals during consultations. Were accurate knowledge of the availability of emergency methods more widespread, sex which has not been planned (a characteristic of much early sexual activity[2]) might less often result in unwanted pregnancy.

During the summer of 1994 a random sample of 30 general practices in the London district health authority of Camden and Islington were visited to address the following question: Would a member of the public, walking into the waiting room, encounter anything to suggest that emergency contraception is available here? Although a number of general contraception leaflets have a small section on emergency methods, only two sorts of leaflets which deal exclusively with emergency contraception were found in 10 of the practices. The most common was the Family Planning Association 1992 leaflet which was found in eight practices. Another two practices had copies of a 1984 Family Planning Association leaflet entitled the 'morning after pill'.

Practices were visited rather than invited to respond to a postal survey, allowing us to consider the impact of the material as well as simply recording its presence or absence. Where material was available this impact varied considerably, from prominently displayed posters to out-of-date leaflets positioned at the back of a rack.

In an attempt to locate innovative materials, a postal survey was conducted of all young peoples' advice centres and clinics throughout the United Kingdom, listed in a directory compiled by the Department of Education at the University of Aberdeen. Among the 79 responses received it was found that 30% of advice centres were still using the 1984 'morning after pill' leaflet, despite longstanding concerns about the misleading nature of this term.[3] There were isolated examples of well designed posters and credit-card sized reminders, which had been developed for specific clinics.

The potential benefits of increasing knowledge of emergency contraception are enormous. As well as providing individual advice to users of barrier methods, general practitioners can help to increase public knowledge of emergency contraception through judicious display of well designed, informative and accurate publicity, including the conspicuous positioning of posters in their waiting rooms.

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Managing violence in the practice

Sir,

Hobbs' study of general practitioners' fear of aggression at work, reports findings from 611 respondents who 'completed at least some of the questions on their levels of intimidation at work' (September *Journal,* p.390). This represents only 22.7% of the original sample of 2694 doctors. No details of the non-respondents are reported and this severely limits the conclusions which can be drawn from the paper. Such an unrepresentative sample can carry little weight in the argument for a change of practice.

Hobbs' previously published findings from this survey[1] reported on the prevalence of assaults on general practitioners. The problem of violence in the community is not confined to doctors, however, and we disagree with the assertion that training in the management of aggression has long been available to other professional groups. Nursing, social work and education department staff have much in common with general practitioners and are plagued by similar problems of lack of resources, inadequate training and poor organizational support.[2] Although also hampered by a low response rate, a recent Royal College of Nursing survey found that 88% of practice nurses reported having been the subject of verbal abuse in the previous year.[3] Despite this, only 12% reported any training in dealing with violence while 7% were aware of a practice policy on violence. Clearly the problem of violence in primary care is not borne solely by doctors.

There is an urgent need for continuing research into occupational violence, and into the effectiveness of competing strategies for prevention and management. General practitioners can do much to lead this process of turning research findings into practice by carrying out risk assessments of their premises, reviewing their policies on violence and seeking appropriate training for themselves and the staff with whom they work.

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Alzheimers Disease Society

Sir,

It is a shame that a paper mentioning the Alzheimers Disease Society (September *Journal,* p.405) gave no details of the society's address. For those who are interested, and every general practitioner should be, the address is: Alzheimers Disease Society, Gordon House, 10 Greencoat Place, London SW1P 1PH. Tel: 0171-306 0606. The national society can give details of any local branches and activities.

My wife was the chief carer for my sister for 12 years when my sister suffered from the disease, and we know from personal experience how helpful the advice and information from the society was at that time. Unfortunately, one of the chief grievances expressed at carers' meetings is the lack of information and help given by general practitioners. If a general practitioner puts a carer in touch with the society, he or she will have done the carer a great service.

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Communication in the year 2000

Sir,

I welcome the editorial on communication in the year 2000 by Robert Walton and Tony Randall (October *Journal,* p.434). The information super-highway is here: it is called the Internet and is currently accessed by 16.5 million people worldwide.[1] The Internet is a global network of computers that includes huge machines at

universities, businesses, military bases and government locations as well as small personal computers in medical schools, hospitals, health centres and homes. Most of the information available on the Internet is free. No one 'owns' the Internet and no one is 'in charge' of it.

A wide range of information and services is available for general practitioners on the Internet. Anyone with a personal computer, modem, communications software and a subscription to an Internet service provider can use this information super-highway. Perhaps the most widely used service initially will be the ability to have electronic mail (email) facilities. This allows ease of communication between general practitioners in different countries and also allows access to email mailing lists such as the Fam-Med list (an Internet resource and discussion group on computers in family medicine).[2]

MedLine can be accessed by Telnet through the Internet from the National Library of Medicine or through commercial hosts such as CD Plus. Other information such as consensus statements from the National Institutes of Health in the United States of America and cancer information from the National Cancer Institute's CancerNet, also in the USA, is easily available on the Internet. Access to many of these data banks is made easier by a programme called *MOSAIC* on a system called 'the world wide web' that gives users a graphical magazine-style interface to the Internet.

I have recently come across two excellent sources of information concerning what is available for physicians on the Internet. These are the *Medical list,* a guide to on-line medical resources by Gary Malet and Lee Hancock, and *Internet/Bitnet health sciences resources* by Lee Hancock. These documents are available, using *GOPHER* software, at the following Internet address: Uniform Resource Locator (URL) gopher://una.hh.lib.umich.edu/11/inetdirs. If this language does not make sense, then reading a basic book on the Internet will clear the confusion.[3]

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GP's role in bereavement

Sir,

The paper by Robinson and Stacy on setting guidelines for palliative care was interesting and thorough (October *Journal,* p.461). It raised the issue of care for the bereaved as an integral part of the terminal care of a patient.

A study was recently published which showed that in 54% of cases where a death had occurred in hospital, it took more than 10 days before the practice was notified.[1] However, the study also found that on many occasions when the practice had known about a death, contact with bereaved relatives had not been immediate. Many bereaved people who had been contacted by their general practitioner felt that they had benefited from the contact and so a suggested protocol for the practice was established. Each bereaved person was assigned a named practice partner whose role it was to perform a designated follow-up procedure. This included an initial telephone call or letter, to be followed by a visit 5–10 days after the death, and an appointment or visit 6–10 weeks later. One year later a card was sent, saying that the practice was thinking of the person and someone was available if needed.

I am sure that a system such as this offers valuable support, and creates better care for the bereaved.

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Shared care for hypertension

Sir,

The reported shared care scheme for hypertension in the Glasgow area undoubtedly offers high quality care for patients, alongside the other benefits described by the authors (October *Journal,* p.441). This scheme appears to be similar in many aspects to another previously described shared care scheme for hypertension in Scotland.[1,2]

However, the use of the term shared care may be slightly confusing. Shared care involves the joint management (including clinical assessment) of patients by specialists and general practitioners, who are both seeing the patient. This may be seen, for example, in diabetic care and antenatal care. In both the Aberdeen and Glasgow schemes, the vast majority of patients are solely looked after by their general practitioner and it is only the patients' records that are looked at in the hospital sector. This is not true shared care.

The authors may be unduly optimistic about the economic arguments that would allow this form of care to continue, if fundholding spreads in their area. Most fundholding general practitioners are probably happy to manage nearly all their hypertensive patients in the practice.

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Vaginal examination

Sir,

I read with interest the letter from A Michèle Arnot (October *Journal,* p.478). I have a particular interest in women's health in general practice and in teaching both nurses and doctors in this area. I understand there is considerable debate at this time as to whether nurses should be trained in bimanual vaginal examination.

The study reported in the letter makes a good case for not performing a bimanual examination when taking a routine cervical smear. In the study pelvic ultrasonography was performed. It was not stated whether this was abdominal or transvaginal ultrasonography. No mention was made of whether bimanual pelvic examination was performed and whether it produced the same results. Any screening test that produced only two positive results out of 168, and those of doubtful significance, cannot be seen as a suitable screening tool.

I have never heard a six week intrauterine pregnancy described as pelvic pathology before. In this case surely a detailed history and judicial use of a pregnancy test would have helped in the diagnosis. The author did not state whether this early pregnancy was detected by bimanual examination prior to the pelvic ultrasonography. I am sure that I would not be alone in admitting that although I have a fairly wide experience of vaginal examination I would not be confident of diagnosing a six week pregnancy in that way.

The other finding was an asymptomatic ovarian cyst of 7 cm diameter and again it was not stated whether this was found