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]

BRIAN O'MAHONY

Health Centre
Lismore
County Waterford, Ireland

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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.

C C DANIELS

Flat 4
12 St Gabriels Road, London NW2 4RY

Reference

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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.

NEIL SNOWISE

Combe Down House
Combe Down, Bath BA2 5EG

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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