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

before the ultrasound examination, nor was mention made of any sequelae to this finding.

The women may have been reassured that they had a healthy pelvis, but the only conclusion that can be drawn is contrary to that stated in the letter. It would appear that even when a detailed ultrasound was done only two variations on normality were found and it is likely that ultrasound would be more sensitive than bimanual examination. In the past bimanual vaginal examination in asymptomatic women has not been found to be of help in detecting significant pelvic pathology such as ovarian carcinoma.[1] Many research programmes have been undertaken to find a more sensitive screening test such as ultrasound or a tumour marker, but none so far fulfils the necessary requirements.[2-4]

In many ways this small study will reassure both general practitioners and practice nurses that they are unlikely to miss a serious problem by not performing a bimanual examination when taking a routine cervical smear.

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Right to receive treatment

Sir,

Julie Dawson's editorial 'Refusing to treat smokers: why this is untenable' (October *Journal,* p.435) criticizing surgeon colleagues and diverse persons speaking for them is itself based on a popular and false misconception.

Dawson refers to '...the National Health Service's philosophy of equity of access to services'. This is not so. Services are what shopkeepers provide. Professions only offer advice. The NHS is a political concept and every politician since Anuerin Bevan has referred, from time to time, to the principle of the NHS being access for all to medical advice, free of charge, at the time of need.

Confirming the relationship of the public to the NHS, on 17 October 1994 Mr Justice Auld upheld Sheffield Regional Health Authority's refusal to provide treatment for infertility to a woman aged 37 years who contested the medical advice given to the authority that she was not suitable for treatment (*Daily Mail,* 18 October 1994).

If a health system guaranteed equity of access to services, all could then decide for themselves their treatments, investigations and operations, and doctors would become mere ciphers with technical skills.

The public do not realize how few rights they have to the services in the NHS and it is their ever rising expectations and demands for service which are lowering the morale of general practitioners. The practice of general medicine is a lifelong joy. When colleagues indicate a desire to retire at 55 years old saying they wish they had never entered general practice, it is practice in the NHS, not general practice, which they regret.

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The *Journal*

Sir,

I frequently listen to criticism from members of the Royal College of General Practitioners regarding the standard and readability of the *British Journal of General Practice* and their questioning of its relevance to day-to-day general practice. I have tried to explain the academic nature of the *Journal,* the strict refereeing process which is carried out, and the difficult editorial decisions which have to be made in choosing between papers for publication.

I was delighted to read in the RCGP *Members' reference book 1994* that recent *Scientific citation index* data ranked the *Journal* 19th out of 120 in the world in the general and internal medicine category and that this was the highest ranking general practice journal.[1] This demonstrates the importance of the research published by the *Journal.* Long may this continue.

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Reference

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Hypertension in the very elderly trial

Sir,

Five major randomized trials have established that the treatment of hypertension in older patients up to the age of 80 years results in a 40%–50% reduction in stroke.[1-5] Stroke is a frequent cause of disability in older patients and it is therefore important to find out if the effectiveness of antihypertensive therapy extends to patients above the age of 80 years.

A new trial is being organized by the Division of Geriatric Medicine at the Hammersmith Hospital, London — the hypertension in the very elderly trial. The trial will run for seven years and will need to recruit 2100 patients who will be randomized into three groups of 700 patients, to make up the two treatment arms and one control arm of the trial. This will give the trial a 90% power of detecting a 40% reduction in stroke at the 1% significance level. One of the treatment regimens will be based on a diuretic and the other on an angiotensin converting enzyme inhibitor. The pilot stage of the trial is now under way and has been funded by the British Heart Foundation.

The organizers are anxious to recruit patients for this important trial. The salary of a nurse research worker will be paid at a rate of £44.00 per patient year to enable a nurse to be employed for a three-hour weekly session when 20 patients have been recruited.

Any practices interested in taking part should please write to: Professor C J Bulpitt or Dr Astrid Fletcher, Division of Geriatric Medicine, Department of Medicine, Royal Postgraduate Medical School, Hammersmith Hospital, Du Cane Road, London W12 0NN, and a full protocol of the trial will be sent to them.

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