then someone who knows the patients well—doctor or manager—should go to the primary care department's offices and negotiate the split and allocation. An example of this would be to place an alphabetical grouping containing an extended family with known strong views on the list of a well established partner rather than a new incoming partner. Primary care departments need time to do this; the more warning they have the better.

The sort of standard letter or notification that patients are likely to be sent by a family health services authority or health board is usually woefully inadequate and often incomprehensible. This will lead to a deluge of telephone calls from confused patients. If you can negotiate the inclusion of a letter from the practice outlining the reasons for the change, perhaps saying where you are going and why, or at least a reworking of the standard letter, the burden will be less. Remember too that this information is sent out only to patients registered with you, and not to those patients registered with other doctors but who regularly see you. In practices with small lists there is merit in notifying all households of the change. Although this seems expensive, it may cut down on confusion and work later on.

Living with the decision

Remember that leaving practice will invoke a mixture of reactions in your patients, your colleagues and, most importantly, yourself. These reactions are unpredictable; they stem from feelings of loss and therefore are little different from a grief reaction. Spending time in planning your departure effectively will minimise

Preparing others for your departure

Inform partners well in advance in order to plan how, and when, to tell staff, patients and others who need to be told personally

Allow at least four weeks' notice to patients given in some public way

Many patients consult just to say goodbye; some recognition of this in planning surgery time is needed

Be prepared to deal with feelings of anger, denial, guilt, and sadness in your patients, staff, colleagues, friends, and self

Be open in negotiating with patients how and with whom their care should continue

Give staff explicit advice on what to say to people requesting appointments after you have left, how patients' care will be continued, and how to help patients decide who they will consult in the future

these reactions for your colleagues and allow a successful transfer of care for your patients.

I am grateful to my former colleagues and staff and to John Bain, David Blaney, and Donald Mowat of the department of general practice at Dundee University for their invaluable help in preparing this article.

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Lesson of the Week

The first 15 cm are important in upper gastrointestinal endoscopy

A S Rai, H Steer

Always examine the fauces and the tonsillar bed when investigating upper gastrointestinal haemorrhage

Endoscopic examination is essential in the management of upper gastrointestinal haemorrhage. The fauces and the tonsillar bed can be examined endoscopically provided the endoscopist remembers to do so. We highlight the importance of this procedure.

Case report

A 62 year old man presented with a history of haematemesis of one litre of fresh blood and melaena. He had complained of poor appetite due to toothache and had taken 300 mg of aspirin twice daily for the previous six weeks. He had also complained of intermittent upper abdominal discomfort for two months before admission. There was no history of peptic ulcer disease but aortofemoral bypass surgery had been performed 10 years earlier. He smoked 20 cigarettes a day and drank eight units of alcohol per week.

On examination he was clinically shocked (blood pressure 70/40 mm Hg, pulse rate 140 beats/min). There were no signs of liver disease and results of routine blood tests were normal. Resuscitation was undertaken using plasma expanders and blood. Pre-operative upper gastrointestinal flexible endoscopy showed large amounts of fresh blood in the stomach, preventing visualisation of the duodenum. There was no evidence of oesophageal varices.

Despite transfusion of 16 units of blood the patient's

condition deteriorated and he underwent emergency laparotomy. At laparotomy a chronic posterior duodenal ulcer was found with no evident bleeding point or blood clot in the ulcer base. There was no evidence of any aortoenteric fistula. Further intra-operative oesophagoscopy and gastroscopy showed no abnormality, except for Barrett's oesophagus to 34 cm. The operation was then terminated.

The patient was taken back to theatre because of repeated haematemesis and hypovolaemic shock. Subsequent laryngoscopic examination showed an area of ulceration in the right tonsillar fossa which was actively bleeding. This bleeding was controlled by simply applying pressure with the index finger, and the patient was resuscitated, requiring a further six units of blood. The bleeding was ultimately controlled by local cautery. The ulcer was biopsied, and histological examination showed an invasive squamous cell carcinoma of the tongue.

Discussion

Investigations for the source of upper gastrointestinal bleeding must include a thorough examination of the oropharynx. The first 15 cm are important.

We have been unable to find a similar case report in the literature.

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