Leave practice

David Snadden

General practice is changing: feelings about inadequate career structure and desires to develop professionally may well lead to greater career movement among general practitioners. The current situation, where general practice principal posts are seen as jobs for life, will change. This is already happening—Snowise found that 14% of newly appointed partners had already been principals in practice and that most advertised posts received applications from at least one established principal.[1] Trainees and retiring principals leave pratices every year, but little has been written about leaving patients, partners, and friends with sensitivity and minimal upset.

Leaving practice, in any circumstances, is a difficult time for anyone, bringing emotional and practical challenges. Emotional difficulties, once recognised and accepted, can be helped by dealing with the practicalities of leaving in a way that ensures a smooth transition within the practice.

This article is based on my recent leaving experience, a return visit to the practice some months later, and the reported experiences of other colleagues on their separation from practice. The return visit showed that the handover had gone very smoothly, with few problems being experienced by the practice. Careful preparation and attention to detail, particularly in giving accurate information to patients and staff, was crucial in achieving this.

The parting was amicable, though it has to be admitted that not all partings are. The main themes of this article, particularly in terms of the process of preparing the practice and its staff and patients for a smooth changeover, apply even when partnerships dissolve in a climate of animosity. It could be argued that in such circumstances attention to the details described here becomes even more important in allowing new relationships to get off to a good start.

Prepare yourself

Despite the wealth of literature available about the doctor-patient relationship and the importance of its integrity, few publications deal with its termination when a doctor leaves the practice. It is important not to underestimate the emotional impact that leaving may have on all concerned. The available literature suggests that feelings of agitation, depression, and anger in your patients will be common.[2] Denial and disappointment are not mentioned, though you are likely to find that they are fairly universal. These feelings may well be expressed in terms of loss and be little different from those of a grief reaction. They are best dealt with in the same way—by encouraging their open expression. If you do this effectively it will help your patients accept the situation, gradually fostering a climate of negotiation to allow care to be transferred in a way that satisfies them. In addition to this you may have to be prepared to deal with similar feelings in your partners, staff, friends, and self. It is easy to ignore these feelings, and it could be difficult to deal with them once you have left. Recognising that these feelings exist is a major part of being able to handle them. In the culture of general practice we mask the approach of change and uncertainty by retreating into activity. Prepare by finding extra time to sit and talk to people about what is happening in the practice, and how it affects them in various ways.

In a broader sense preparing yourself, in terms of learning to manage change, is not a feature of vocational training schemes and courses approved for postgraduate educational allowance. These have concentrated on the important areas of clinical care and maximising income, though at the expense of how to manage people and resolve conflict. Conflict is a normal part of any group or relationship, yet in medical education it is often ignored, and in many partnerships it is suppressed. Handy's text, *Understanding Organisations*,[3] will be of use to those who wish to study this subject further. Perhaps practice agreements need to be more open about how negotiations about change, in all its aspects, need to be faced up to—for example, by reviewing agreements and individuals' personal growth at regular intervals. Without regular review partnerships are likely to stagnate or dissolve.

Practical preparations

Check your practice agreement about the length of notice your partnership agreement requires

Find out how much notice your family health services authority or health board needs to process your resignation—normally three months, though this can be negotiable

You need to see your accountant to discuss the financial implications for the practice and for you

If you are leaving the NHS you need to get some advice on your superannuation position

Prepare your patients

Consider how to deal effectively with the emotions your departure will generate. Different patients will need to express themselves in a variety of ways. This takes time, and you should allow plenty of it once your leaving becomes public knowledge. It has been suggested that three months is reasonable,[2] and this seems appropriate in allowing adequate dissemination of the news, planned handover of care for certain patients, and time for your family health services authority or health board to make its arrangements. Three months, however, is a "long goodbye," and a shorter period might be less of a personal strain. All practices are unique: you need to compromise to fit the needs of your partners and staff, yourself, and your family.

Decide how you wish the message of your leaving to be given. Often doctors seem to allow a slow leak into the local grapevine, with the consequence of inaccurate rumours developing; you might decide to make a public announcement in some way, perhaps by placing notices in the waiting room announcing your departure, where you are going, and why. A practice notice costs little, heads off denial, and at least ensures that the grapevine starts with accurate information. Obviously it takes time for information to percolate in this way: an announcement in the local paper is probably the best way to reach people quickly. This may appear drastic,

Department of General Practice, University of Dundee, Westgate Health Centre, Dundee DD2 4AD
David Snadden, *senior lecturer*

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but if patients do not realise you are leaving until after the event they will often be angry; many choose to say goodbye in some special way if afforded an opportunity, and may continue to appear several months after your departure for this purpose. As is so often the case when dealing with people, open, honest, and accurate information given early saves trouble later on.

You will be surprised when you discover who has become attached to you. People will visit you, having not done so for years; your recollection will be that you did little for them. These people will be just as affected as your "regular" patients, and will need just as much time. "Just knowing there is someone there I can trust if I need them" will be how they see you. And the "regular" patients? It often seems that they couldn't care less. There is much we still don't understand about how patients view their doctors.

Those most deeply affected are likely to be the elderly patients. It can take years before some people feel that their doctor understands them, and, presumably, in the twilight of life, some may wonder if they have time to forge a trusting relationship again.

There will also be a particularly vulnerable group of people known to you whose care needs to be handled sensitively. These will be people with long term chronic problems and people who have relied on you for emotional and moral support. Your partnership needs to think about meeting as a group to hand over the care of these vulnerable, difficult patients and their families with sensitivity and effectiveness.

All these contacts require time and opportunity for airing feelings. The time involved is such that your last surgeries will be clogged with people saying goodbye: you will have to handle your patients' need to mark your departure in their various and personal ways. Whatever your feelings about this, you can expect cards, gifts, and personal letters, and you may well find yourself the recipient of a community collection and presentation. These are all important termination gestures for those involved and, like all parts of the grieving process, need time for expression. Equally, such gestures need to be acknowledged in some way by you: the easiest is often a public thank you notice in the local paper after you leave.

The question of trainees leaving practice every year does not seem to have been addressed by the profession. How many practices prepare their patients for this by giving adequate information about when trainees are leaving and why, and how many advise their trainee on how to prepare for parting not only from their patients, but from the practice too?

Prepare your staff

You need to think about breaking the news to your staff. Hearing it on the local grapevine is not ideal: you must find a way of letting them know individually. One option to consider is to brief them "officially," through a partner or the practice manager, about the change a few days before it becomes public, and then to chat informally to each of them. Simply telling them what is happening is inadequate as they will need information to deal with the bulk of patients' inquiries. They will need guidance on what to say when people ask why you are leaving and where you are going, when they telephone to make appointments after you have left, and when they try to make review appointments for several weeks away, again after your departure date.

Staff will also have to deal with some requests from patients to change from their newly allocated doctor. Even in practices that share patients, some will request a change of doctor, despite comprehensive explanations that they can see who they want. Some male patients seem to have great difficulty being registered with a female doctor. Staff will also need to prepare to answer questions about which doctor to see. The confusion arising from these situations can be minimised by partners discussing and agreeing a plan, and then teaching staff the importance of consistent information and how to deliver it efficiently.

The biggest administrative task for the staff will be changing computer and manual patient records to record patients' new general practitioner. Some computer systems can use records downloaded from the family health services authority or health board. Manual records must be converted by hand: your family health services authority or health board can usually supply patient labels for your NHS records. This laborious task can usefully be combined with clipping a new patient registration form to records when the patient's general practitioner has been changed, as these patients are eligible for a registration consultation for which the standard fee is claimable.

Tasks for the practice manager

- Negotiate with family health services authority or health board concerning division of list
- Negotiate with family health services authority or health board about information it will send to patients
- Prepare staff for relabelling of affected records
- Devise a system for claiming registration fees for patients allocated to another doctor within the practice

Prepare your partners

Your partners will need as much warning as possible to prepare for a major upheaval in the practice. Time is needed to find the most effective way to manage the coming change. Pringle's article and its associated series is helpful in dealing with some of the processes involved but scarcely mentions the emotional turmoil that can follow a decision to leave.[4] If, for any reason, practice staff cannot be told immediately, it is important to involve the practice manager at an early stage as he or she will carry most of the inevitable administrative burden.

Your practice will usually need to choose a new partner, decide on the best departure date, and decide when to tell key people such as the family health services authority or health board managers and the practice's accountant. You may have contractual obligations within your partnership agreement to fulfil. The more warning you give your partners the better; even hints of coming changes, before a firm decision to leave, can be helpful. People can then adjust and think about alternatives; often time allows for a replacement appointment and a mutually beneficial departure date. It is wise to consider at this time the administrative responsibilities of the outgoing partner and the impact of departure. For example, a practice losing the only person who understands the computer system faces several months of mayhem if this is not prepared for. There is considerable merit in leaving at the end of the practice's financial year, keeping accountant's costs, usually high during a partnership change, to a minimum. Negotiating a mutually convenient date is often more important than rigid enforcement of an agreement.

Talk to your family health services authority or health board—good relations with them are crucial to a smooth transition for the practice. A few days before your resignation date the board or authority will write to all your registered patients to tell them about alternative arrangements for their care. Your partners need to agree what will happen to your list: will it be shared among existing partners, or given to an incoming partner? If the decision is to split the list in some way

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

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

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1 Snowise NG. General practice partnerships: till death us do part. *BMJ* 1992;305:398-400.
2 MacAulay AD. Saying goodbye: termination of the doctor-patient relationship. *Fam Med* 1992;24:64-5.
3 Handy CB. *Understanding organisations.* 3rd ed. London: Penguin, 1985.
4 Pringle M. Managing change in general practice: introduction. *BMJ* 1992;304: 1357-8.

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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

Southampton General Hospital, Southampton SO9 4XY
A S Rai, *senior house officer, accident and emergency department*
H Steer, *consultant general surgeon*

Correspondence to:
Dr A S Rai, Royal Hampshire County Hospital, Winchester SO22 5DG.

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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. Preoperative 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 intraoperative 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 hypovoloaemic 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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