The challenge of an inner city practice

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Just over eight years ago, I moved from a rural practice, to an inner city practice in the Crumlin Road area of North Belfast. Although there were many similarities, for example the routine of surgeries and home visits, there were also considerable differences. In some ways general practice in an inner city area may seem very unattractive, but it may equally be regarded as a challenge.

The term “inner city” has come to be synonymous with severe social deprivation with characteristics such as a high density of population, a high concentration of unskilled workers, high levels of unemployment and poor housing. These factors are all present to a greater or lesser extent in our area. Many inner cities also have problems due to a high percentage of people from ethnic minorities. In Belfast, instead of this, we have had considerable inter-community tension and, until recently, terrorist atrocities.

I propose to look at two aspects of the health of those living in an inner city area, and show how these contrast with the population as a whole. I will then look briefly at one of the most damaging social problems in such an area, the problem of unemployment and its implications for the health of those who are unemployed and also for their families. All this presents a challenge to those of us who are engaged in inner city practice, a challenge not only in dealing effectively with the health problems of our patients but also in coping with the stress which such work can have on ourselves, and on our own health. Finally, I will consider how we can address the problem of professional stress.

Up to 150 years ago, our practice area was an area of green fields, but in the 1840’s several buildings were erected on what was called the New Crumlin Road. One of these was the New Court House, although the present building includes some additions since those days. The architect was Charles Lanyon, best known for designing the main building of Queen’s University. He also designed the Crumlin Road Prison, reputedly along the same lines as Pentonville Prison in London. Further up the road 3 flax spinning mills were erected. On the right are the Brookfield Mill and the mill of William Ewart and Son. In passing I might add that partners in our own practice have had links with both these firms. My predecessor Dr John Brown was the son of the chief engineer in Ewart’s Mill and my own father, early in his career, worked in the shipping office of the Brookfield Mill in Donegal Street. Across the road, and established a few years later, is the imposing building of the Edenderry Spinning Company. Each of these mills continued to operate and was a major source of employment in the Crumlin Road area for over 100 years.
The linen industry became a major factor in Belfast around 1830 with the introduction of the first powered spinning mill, and by the end of the 19th century some 70,000 people were employed in the industry. Irish linen had a world-wide reputation. The factories prospered and with the prospect of employment many people came from the countryside to Belfast from the mid-19th century onwards. Houses were built for the workers and new streets appeared. Some street names reflected contemporary historical events, such as Crimea Street, while others reflected local industry, such as Flax Street between the Ewart’s and Brookfield mills.

The health of those involved in the linen industry was high on the agenda even in those early days. In 1867, the National Association for the Promotion of Social Science met in Belfast, and Dr John Moore speaking on the influence of flax spinning on the health of mill workers, drew attention to the large amount of sickness which prevailed. He noted that the exposure to dust and to particles of flax caused bronchial irritation, and also described the horrific injuries which occurred in the mills. However, Dr Moore considered that the main cause of the workers’ ill-health was not their occupation, but was related to their diet. He wrote, “Anyone who will take the trouble to visit some of our spinning mills at the approach of meal hours, and examine the food which has been brought to sustain them during the day, to look into the tin vessels and see the fluid, which can hardly be called tea, infused frequently from the evening before, allowed to remain all night in metallic vessels, warmed up again not only for breakfast but for the mid-day meal, [until] it comes at last to resemble tobacco water . . ., [will turn] away both sad and sickened.” He concluded, “Improvement of the food of the mill workers must underlie all attempts to improve their general health’. His concern was clearly shared by some in the industry because he later reports that through the provision of a ‘Cooking Depot’ some workers were able “to obtain good, nutritious, and well-cooked food, on more reasonable terms than they could themselves prepare it”. The provision of such food in the dining hall of the Brookfield Mill is an example of how a non-medical measure played a vital part in improving the health of the work force.1

It was around the time that Dr Moore was expressing his concerns about the health of mill workers that the building at the corner of the Crumlin Road and Albertville Drive was erected. Albertville Surgery occupies the whole ground floor and there is an extensive dental laboratory on the first and second floors. Built in the 1860s, some 30 years before the original Mater Hospital was opened, it was first inhabited by a linen manufacturer and then by a resident magistrate. Since 1911 it has been continuously occupied by a member of the medical profession, initially as a place of residence and surgery, and more recently, in common with the changing pattern of professional life, as a surgery only. Dr R M Quinn lived there from 1911. By 1920 the practice had been taken over by Dr McGaughey and about 1923 he was succeeded by Dr Fred Moffatt who continued in practice for 35 years and is still remembered by a number of the older patients.

From the 1860s, the district grew and developed for over 100 years as a thriving area bursting with activity, and as such it is still remembered by many of the older people who continue to live there today. During the last 20 years or so there have been significant changes for two main reasons. Firstly the closure

62 The Ulster Medical Society, 1995.
of all three linen mills around the early 1970s created high levels of unemployment in the immediate area, and secondly most homes in the area have been affected by the troubles. Many people have had to move house because of intimidation. The memory of past tragedy and the legacy of fear lives on in both communities. The decline in business activity and the run down state of many of the buildings have cast a sense of gloom over the area in contrast to the prosperity which it previously enjoyed.

Now we turn to look at some aspects of the health of the local population. But how do we measure ‘health’? The Black report, produced in 1980 by a working group set up to study the inequalities of health in the United Kingdom, lists several significant indicators of health; 2 including mortality rates, acute and chronic morbidity rates, sickness absence rates and restricted activity rates. The report points out that each has its limitations, for example, an over-reliance on the first indicator, mortality, can induce indifference towards the third, chronic illness. I will take several of these indicators (chronic morbidity, both alone, and with reference to sickness absence, and then mortality) in our inner city area of Belfast, as well as in other inner city areas.

THE CHALLENGE OF CHRONIC ILLNESS AND DISABILITY

The percentage of people classified as long term ill or disabled is claimed to be a central indicator of the health of a population. 3 The 1991 Northern Ireland Census 4 gathered statistics on chronic illness and disability, allowing a comparison of the level in each electoral ward with the level in the ‘Belfast Urban Area’. (This term refers to the entire area of the Belfast District Council, together with certain adjacent electoral wards in the District councils of Castlereagh, Lisburn, Newtownabbey, Carrickfergus and North Down, with a total population of 476,000.) Our practice is situated in the centre of the Crumlin Ward which extends for about half a mile on either side of the Crumlin Road, from its junction with Agnes Street to a point beyond Tennant Street. In 1991 the population of the ward was 3876.

TABLE 1

|                  | Total population | Long term illness or handicap |
|------------------|------------------|------------------------------|
| **Belfast Urban Area** |                  |                              |
| Total            | 475,967          | 62,911 = 13.22%              |
| Female           | 250,935          | 35,994 = 14.34%              |
| Male             | 225,032          | 26,917 = 11.96%              |
| **Crumlin Ward** |                  |                              |
| Total            | 3,876            | 854 = 22.03% (+67%)          |
| Female           | 2,047            | 462 = 22.57% (+57%)          |
| Male             | 1,829            | 392 = 21.43% (+79%)          |

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The average figure for the prevalence of chronic illness and disability throughout the Belfast Urban Area, including the inner city area is 13.22 per 100 (Table 1). The level of long-term illness, health problems or handicap for the Crumlin Ward, at 22.03 per 100, is almost 70% greater than the Belfast Urban Area level. When male and female figures are separated the percentage increase for each is still substantially raised. The figures for females is 57% higher, and for males is 79% higher in the Crumlin Ward than in the Belfast Urban Area. This increase is not unique to the Crumlin Ward, the adjacent Shankill Ward has a figure of 21.26 per 100.

**Table 2**

*Long term illness, health problems or handicap identified in the 1991 Northern Ireland Census for the Belfast Urban Area and for the Crumlin Ward arranged by age group.*

| Age Group | Belfast Urban Area | Crumlin Ward |
|-----------|--------------------|--------------|
| 0-14 years| 2.34 per 100       | 3.54 per 100 (+ 51%) |
| 15-64 years| 10.24 per 100    | 20.01 per 100 (+ 95%) |
| 65+ years | 43.71 per 100      | 46.80 per 100 (+ 7%) |

The increased morbidity is not confined to a particular age group (Table 2). The rate for those under 15 years, is 3.54 per hundred for Crumlin Ward compared to 2.34 for the Belfast Urban Area: an increase of 51%. The increase is most marked in the age group 15 - 64 years, with Crumlin Ward having a rate of 20 per 100, compared with just over 10 for the Belfast Urban Area, an increase of almost 100%. Even in those over 65 there is still a slightly higher level compared with the Belfast Urban Area.

**Table 3**

*People unable to work because of long term sickness or disability identified in the 1991 Northern Ireland Census for the Belfast Urban Area and for the Crumlin Ward.*

| Total population | Long term illness or handicap |
|------------------|------------------------------|
| **Belfast Urban Area** |                             |
| Total            | 294,009                      |
| Female           | 152,482                      |
| Male             | 141,527                      |

| Total            | 18,528 = 6.30% |
| Female           | 8,178 = 5.36%  |
| Male             | 10,350 = 7.31% |

| Crumlin Ward     |                  |
|------------------|------------------|
| Total            | 2,259            |
| Female           | 1,142            |
| Male             | 1,117            |

| Total            | 291 = 12.88% (+ 104%) |
| Female           | 126 = 11.03% (+ 106%) |
| Male             | 165 = 14.77% (+ 102%) |
The Black report also identifies sickness absence rates as an indicator of health. To assess one aspect of this, the Northern Ireland census identifies those who are 16 years and over, and who are unable to work because of long term sickness and disability (Table 3). The combined male and female figure of those unable to work because of long term sickness and disability for the Belfast Urban Area is 6.3 per 100. The figure for the Crumlin Ward is more than twice that, 12.88 per 100, and this difference is maintained for males and females separately.

In general practice we also have the opportunity to identify patients who are unable to work because of chronic illness and disability because, in order to claim state benefits such as statutory sick pay or invalidity benefit, such patients require a medical certificate, now renamed a “statement of incapacity”. I identified all male patients of our own practice aged 16-64 years living in this ward, who on 1st April 1994 were in receipt of a statement of incapacity continuously for at least six months. On that date we had 184 male patients aged 16 to 64 years whose registered address was in the Crumlin Ward and 34 (18.48%) of these had been unfit for work for at least six months. Of these 29 (15.76%) were unfit for 12 months or more. Although not directly comparable with the census figure of 14.77%, because of the difference in how the figures were gathered, it does provide further evidence of the high percentage of persons unable to work because of chronic illness and disability. Twenty three of the total of 34 were aged 55-64 years. The most common causes of disability were orthopaedic (10) and cardiovascular problems (10), followed by psychiatric (7), respiratory (5) and central nervous disorders (4). Four patients suffered from more than one condition, either of which would have rendered them unfit for work. These figures are not just for men close to retiring age. Seven (more than 20%) were under 45 years of age which sadly includes one young man in his early 20’s whose severe injuries were due to a terrorist attack.

Here then is a challenge to provide continuing medical care for an increased proportion of patients with chronic illness. Medical care not only means periodic review of the patient, referring for further hospital based treatment when the condition deteriorates and providing and reviewing ongoing medication. It must also mean assessing and where possible treating the psychological consequences of such illness, not only overt anxiety and depression, but also the loss of self esteem and that feeling of despair that so often accompanies it.

The 1991 business plan of the North and West Belfast Community Unit included the very praiseworthy objective "To help people with a physical disability realise their full potential in life". But chronic illness also prevents many from realising their full potential. Their illness prevents them from achieving the satisfaction of normal work or even the opportunity to mix socially with their former work-mates. Some form of rehabilitation such as sheltered workshops could provide opportunity for some, to do limited work. For those less able, day centres could provide some social life. But what is happening? In 1991 there were a total of 3488 men and women in North Belfast who were unable to work because of long term sickness or disability. For the physically disabled there is one day centre (Woodlands) situated just off the Cliftonville Road, with 68...
patients, and a further 15 patients from North Belfast attend a day centre in Andersonstown. Of those who are mentally ill, about 45 from North Belfast attend an industrial therapy workshop in Duncrue Street and a further 90 attend the Everton Day Centre. All these together add up to less than 220. Thus only one in 16 attends a sheltered workshop or day centre and the majority of those who attend have mental health problems, whereas in our practice sample, about 80% of those unfit for work had physical health problems. The challenge is not only to provide continuing medical care for those suffering from chronic illness and disability but to enable them to live fulfilled lives, despite their illness and disability.

THE CHALLENGE OF INCREASED PREMATURE MORTALITY

The second health indicator is the Mortality Rate. Here again I have compared rates in inner city areas with those for the population as a whole. Some striking figures have been published by Townsend looking at the relationship between deprivation and premature death in Greater Manchester. He calculated standardised mortality ratios (SMR) for each of the 216 wards in that city in the years 1981 to 1983. This is the ratio of the actual number of deaths to the number of deaths which would have been expected if the national level had prevailed, taking into consideration both the total population and age structure of the ward. The figure is then multiplied by 100. A figure greater than 100 indicated a higher than expected number of deaths. Townsend found that the SMR for the wards in Greater Manchester ranged from 69 to 225, and reported a very close correlation between wards which were severely deprived and those which had the highest standardised mortality ratio. Compared with the national norm, he found that in the 25 most deprived wards of the region between 1981 and 1983, there was 1445 more deaths than would have been expected. In contrast the 25 least deprived wards had 291 fewer deaths than would have been expected if the national norm had applied. Professor Brian Jarmin (a general practitioner, and head of the department of general practice at St Mary’s Hospital Medical School, London) claims that the mortality rate in inner London, up to retirement age, is 25% higher than in the rest of the country. His name is associated with the deprivation indicies familiar to inner city general practitioners.

But what about Belfast? Even if we just consider a single cause of death such as that of coronary heart disease, there is still a considerable contrast between the figures for our inner city area and those for Belfast and district.

The Belfast Monica project has been recording deaths due to coronary heart disease for more than ten years at ward level in the areas of Belfast, Ards, North Down and Castlereagh. The deaths of patients resident in the Crumlin Ward due to definite or possible myocardial infarction in the years 1983-89 have been compared with such deaths in the whole Monica Project area and the figures have been standardised for age and sex. Against a standard figure of 100 for the whole project area, the Crumlin Ward has an SMR of 158 for males and females combined. Even considering the small numbers involved this figure is significantly raised, and this is entirely due to the females (Table 4).
TABLE 4
Deaths from definite or possible myocardial infarction between 1983-89 in the Crumlin Ward, standardised for the Monica project area.

|       | Actual | Expected | SMR     |
|-------|--------|----------|---------|
| Total | 24     | 15.17    | 158 (p = 0.02338) |
| Male  | 12     | 11.65    | 103 (p = 0.92034) |
| Female| 12     | 3.52     | 341 (p = 0.00001) |

Because of the small numbers in a single ward, I have also compared the deaths in a group of eight adjacent inner-city wards in North and West Belfast with the deaths in the total Monica Project area. This time the combined SMR for males and females is 131 and because of the greater total numbers involved is even more significant. Again it is the ratio for females where significance is greatest (Table 5). An investigation into the relationship between social deprivation and premature mortality in electoral wards throughout England found that these were strongly linked. In the region with the highest SMR for coronary heart disease, the ratio for females (143) was higher than the ratio for males (121), confirming the trend which we observed in Belfast. Thus there is strong evidence that inner city areas whether in England or Belfast have a significantly increased mortality rate compared to the overall population.

TABLE 5
Deaths from definite or possible myocardial infarction between 1983-89 in eight inner city wards in North and West Belfast (Court, Shankill, North Howard, Woodvale, Crumlin, Cliftonville, Ardoyne and Ballysillan) standardised for the Monica project area.

|       | Actual | Expected | SMR     |
|-------|--------|----------|---------|
| Total | 235    | 179.35   | 131 (p = 0.00003) |
| Male  | 158    | 136.67   | 116 (p = 0.06803) |
| Female| 77     | 42.68    | 180 (p = 0.00000) |

So what can be done? Health promotion is now an established part of general practice, especially since the 1990 contract. Many different issues have been highlighted including smoking, alcohol, obesity, hypertension, raised cholesterol, unhealthy eating and lack of exercise. Of course some people just cannot be motivated to change, like the plump lady who had been given a strict diet. When asked by her friend if she was sticking to it she replied “I don’t see any point in starving to death just to live a little longer”.

The challenge is to decide how we can influence people with risk factors, in a situation where many of our patients suffer from multiple factors. If we attempt to concentrate on all the factors present, we dilute the impact we make on any one factor. We may have to set priorities, perhaps concentrating on only one.
factor per patient, and have to use our resources chiefly to deal with those risk factors which have been shown to have the greatest adverse effects on health. If all our patients who are hypertensive were identified and adequately treated, and if we were able to achieve complete cessation of smoking in all our patients who currently smoke, we would have made an enormous contribution to improving their life expectancy.

Levels of smoking are traditionally high in inner city areas. Our own figures, though not yet complete, indicate that the level of smoking in those over 16 years is around 37% against a United Kingdom average in 1992 of 29%. We have used various methods, from a nurse led 'stop-smoking' clinic to transdermal patches with regular doctor review, to encourage smokers to stop, but it remains an up-hill task. And yet regular gentle encouragement of patients does pay dividends. I was pleased recently to see an example of this when a local patient came to see me for holiday immunization. He was going to Egypt and when I enquired into his reasons for going, he told me he had stopped smoking and was off to Luxor on the Upper Nile with the money he had saved.

THE CHALLENGE OF UNEMPLOYMENT

In addition to the increased level of chronic illness and disability and the raised mortality rate, the level of ill health in the inner city area is further compounded by the problem of unemployment. Crumlin Ward has over 35% unemployed, more than double the 16.6% of the whole Belfast Urban Area. Unemployment is not just a social factor but one which quite independently has been found to have a significant influence on levels both of morbidity and mortality. Much work has been done on the subject of unemployment and health. Of 80 unemployed men in southeast London who were well at the time of job loss, over 30% had developed either anxiety or depression within six months of becoming unemployed. The association of unemployment with physical illness was strongly demonstrated by the British Regional Heart Study, a prospective study of cardiovascular diseases in over 7000 middle aged men, selected at random from general practices in 24 towns throughout the UK. After standardisation for age, social class, town of residence and smoking, the 'non-ill' group of unemployed, that is those who did not consider that their unemployment was in any way due to ill health, still had a significantly higher level of ischaemic heart disease than the employed, with a standardised figure of 16% against the employed figure of 10.

The implications of unemployment upon general practice workload was shown by Beale, in Wiltshire. In 1982 a long established factory there closed, making 302 workers redundant. It was found that 122 of these workers had been patients in the local health centre continuously from 1976-1986 and their records were reviewed. This ten year period was chosen because it covered four years of secure employment, two years of insecure employment and four years of redundancy. He found a significant increase in work load in both primary and secondary care as a result of redundancy. At the end of the four years of redundancy, those who had lost their job and not found re-employment, had consulted their general practitioner on average 57% more frequently, were referred to hospital outpatients departments 63% more often, and had attended hospital out-patient departments 208% more frequently, than those enjoying secure employment.

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Evidence that unemployment is associated with increased mortality, is provided by a study, carried out using data from the 1971 United Kingdom National Census. This showed that in the following 10 years, unemployed men had a significantly raised SMR at 121. But it was not just the men themselves who were at higher risk, as the SMR for wives of unemployed men was similarly raised at 120, and there was also an increase in perinatal and infant mortality in their children.

If the evidence so strongly suggests, unemployment is a cause of ill health, this is a double blow to the unemployed. In an age when social status and worth is so often related to ones occupation, the unemployed suffer not only a loss of self respect but also an increased risk of ill health. This is not just bad news for the patients themselves. In an era of purchasing of services by fund-holding practices and by Health and Social Services boards, additional ill health, because of unemployment, means additional costs for the purchasers of medical care.

The challenge may not chiefly be a medical one. Just as in the last century and the early years of this century when the most effective way of improving health was not better medicine but better housing and better hygiene, and in the case of the mill workers we referred to earlier, better food, we are again in an age where social factors may be having a greater impact on health than medical factors, and reducing unemployment may do more to improve health in this area than advances in therapeutics. We must ensure that we know the occupational histories of our patients, and so recognise those whose health problems are associated with unemployment. On a wider level, we may be able to raise awareness of the health consequences of unemployment. We may be able to assist some in finding re-employment by displaying, in our surgeries and health centres, information from our local job centre and local initiatives.

THE CHALLENGE OF PROFESSIONAL STRESS

I am aware that professional stress is not exclusive to inner city practice, nor indeed to general practice, it can effect any of us. Nevertheless some factors are present which make inner city practice a particularly high risk occupation. Stress throughout the medical profession is becoming increasingly recognised as a significant problem. In 1990 the BMA, at its Annual Representative Meeting, commissioned a report from its Board of Science and Education on stress and anxiety in various branches of the profession. The annual conference of the Northern Ireland Faculty of the Royal College of General Practitioners in 1994, spent half a day considering this subject. The BMA published a 100 page report entitled “Stress and the Medical Profession” in 1992. As well as identifying common causes of stress in each of the different branches of the profession, it makes some useful recommendations regarding its management and prevention.

What causes stress in general practice? Two studies were carried out a few years ago by members of a psychology department in Manchester to assess, among other things, the causes of stress in practice. The first obtained the response of 101 general practitioners to a questionnaire containing 32 possible sources of stress, asking them to give a score to each. Analysis revealed four major areas of stress, interruptions of various kinds, emotional involvement, administrative workload and work - home interface, and routine medical work.
The first three of these were also associated with job dissatisfaction. The second study used a confidential questionnaire to over 1800 general practitioners, and found that four job stressors were predictive of "high levels of job dissatisfaction and lack of mental well-being," – demands of the job and patients’ expectations, interference with family life, constant interruptions at work and home and practice administration. The last three of these factors were also identified in the first study. A study in Northampton assessed the factors which affected a general practitioner’s mood in the course of a working day. The responses of 44 general practitioners who completed self-monitoring diaries at hourly intervals revealed that the factors which led to the most lowering of mood were hassle at work, pressure of time, and domestic dissatisfaction. The factors which led to the greatest improvement in mood were "domestic happiness" and the satisfaction of working efficiently, and to time.

In inner city practices in Belfast I would suggest that certain pressures are present which exacerbate the stress on practitioners. The current terrorist situation has had a considerable impact on such practices. It has been said that terrorism had claimed more lives in North Belfast than in any other part of Ulster. Three years ago within the space of 12 months two of our patients, one from each side of the community, were murdered. Since then three further patients have been killed and others have been injured and I am sure most other practices in the area have had similar experiences. We have become all too familiar with the condition of Post Traumatic Stress Disorder.

A further factor is the increased work load. The higher incidence of chronic illness clearly increases the work load and we have shown that even among those who are apparently well, the high level of unemployment is itself associated with a significant increase in work load. In common with many inner city areas we have a higher than average percentage of elderly people, 21% compared with a regional average of about 14%. Often people who have lived their life time in the area continue to live on in retirement while the younger generations have moved out to the suburbs. There is also a demand for prescriptions for medicines which are also available for purchase over the counter, no doubt because the vast majority of people living in the area are exempt from prescription charges.

The 1990 Health Service reforms have had a profound affect in general practice but perhaps more so in inner-city areas where the effort needed to meet the various health targets has been, in general, much greater than elsewhere. Traditionally in these areas, levels of uptake of cervical cytology and even childhood immunizations have been much lower. For example in 1989, despite an active childhood immunization programme, our rates were only about 65%. It has taken and continues to take considerable effort by our medical and receptionist staff to reach and maintain the current levels of 97%. Health Promotion activities too, seem to require additional effort. Even when patients do make appointments there is a high level of non-attendance.

Violence or the threat of violence is becoming an increasing risk particularly in inner-city areas, although it is not unknown in other areas. The greatest danger appears to be when doing night calls and in some parts the demand for drugs is the chief motive for such attacks. Attacks can also occur on the premises and
within the past eight years our practice has suffered two such incidents. Receptionists are likely to experience more verbal abuse than anyone else in the practice, and they too can be at risk of physical violence. We have recently drawn up procedures for dealing with patients who threaten to be violent.

In the midst of these situations it is probably inevitable that we will at times feel stressed. How do we handle it? First let me give you some personal experiences. I find the ability to see humour in every-day situations a very effective antidote to stress. Our work does have its lighter moments, such as when the little old lady suffering from macrocytic anaemia, orders a repeat prescription for her “frolic acid” tablets, or when the patient explains in graphic terms that he was in such pain the previous night with his renal colic that he had to send for the “rotary doctor.” My mind pictured the North Belfast flying doctor service attempting a helicopter landing in his front garden. We have one elderly couple with the surname ‘King’. When I enquired of the gentleman what his name was he replied “George, George King”, and added “but I don’t mind if you call me King George”.

Religion has been blamed for much of our troubles in Northern Ireland. Professor Andrew Sims, until recently President of the Royal College of Psychiatrists, stated in his valedictory address to that college that although religious fervour can be an immense force for evil and destruction, religion can also be a protective factor in promoting good health.\(^{18}\) In the midst of stressful events I have found religious faith to be a major source of strength.

But that does not stop us from exploring all possible practical ways of handling stress. The Northampton study identified “pressure of time” as a major factor in lowering mood and that “working efficiently and to time” was associated with improvement in mood. Many of us can probably identify with these sentiments. Thus effective time management must be an important factor in reducing stress. We may have to be more realistic about giving adequate time for paperwork or about when we permit interruptions with telephone calls, etc. Of course a certain amount of our work is unpredictable, but “this unpredictability is the very thing that must be allowed for, with sufficient time being allowed for the extras”.\(^ {17}\)

Another source of stress is the high and at times unrealistic, expectation of patients. We all meet patients from time to time who are unreasonable in the service they expect either from ourselves or from other members of our practice team. Handling this successfully requires a high degree of social skill. Management and administration in a practice is becoming increasingly demanding and requires a high level of managerial skill. Training in both social and managerial skills has been widely adopted in many other work settings\(^ {16}\) and may need to be used more in general practice. When a major health promotion initiative was launched in 1989, the Eastern Board funded a two day residential seminar in Newcastle which gave many of us confidence in launching our own programmes. At a time when complying with the increasing demands of our contract requires a corresponding increase in the amount of management and administration, I suggest that a similar seminar in social and management skills should be offered, without the disincentive of heavy course fees, bearing in mind that we already have to provide cover for our own practices.
Although domestic problems were a significant cause of lowering of mood, “domestic happiness” was the chief single cause of improvement in mood.\textsuperscript{17} Perhaps we should all take this as a vital reminder to cherish and nourish our family relationships. Unfortunately despite all the efforts to cope with stress, there are times when we may become overwhelmed. Prolonged stress may lead to the syndrome of “burn out”. This has been defined as physical, emotional and mental exhaustion caused by long term involvement in situations which are emotionally demanding and very stressful, combined with high personal expectation of our performance. It presents as exhaustion with tiredness and irritability, depersonalisation when we treat patients and others as if they are objects and low productivity and feelings of low achievement.\textsuperscript{14} What can we do at such times? In many cases it is embarrassing to discuss the matter with partners or even other colleagues. It is a bit like the notice in the office which says “stress – you can’t have stress until everyone returns from sick leave”. It was to help in these and similar situations that the National Counselling Service for Sick Doctors, was set up in 1985. It receives 300-400 calls per year either from doctors who are themselves under stress or from a colleague of a stressed doctor. Problems dealt with include all forms of stress including marital tensions, drug and alcohol dependence and other forms of mental illness. The Counselling Service is able to give the name of an adviser in the same branch of medicine, or if appropriate in psychiatry, whom the caller may then contact.

A paper published by the Kings Fund a few years ago, on the health of doctors, highlighted the fact that contrary to what some patients imagine, doctors do get ill. It found that doctors were very reluctant to present themselves to colleagues with symptoms which might imply their inability to cope, like headaches or insomnia, and recommended that consideration be given to the establishment of a family doctor service for family doctors.\textsuperscript{19} It is to be hoped that such a service will be provided, and sooner rather than later.

Our response to the challenge of professional stress must be to ensure that those who suffer, receive all possible help, and that we all develop to the full those skills needed to deal successfully with factors causing stress. Moreover I believe that a profession where the morale is high is a profession where there is less stress. Morale is higher in general practice when we can give adequate time to caring for our patients. After all, the essential core of general practice is the consultation between the patient and the doctor. We may not feel that those in charge of the Health Service appreciate this work but our patients certainly do, and I believe that this is even more true in an inner-city practice where the higher level of illness gives us more opportunity to provide care.

**CONCLUSIONS**

I have tried to indicate what I see as the challenge of inner city practice;

- to provide an effective service for our patients and in particular to ensure that the best quality of life is provided for those with chronic illness, and disability,

- to concentrate on effective measures to reduce premature mortality and, until the situation changes,

- to reduce the morbidity stemming from high unemployment.

\textsuperscript{4} The Ulster Medical Society, 1995.
But equally importantly it is to take all possible steps to protect our own health especially in the area of stress.

As long as 15 years ago the importance of giving high priority to the medical needs of those living in inner-city areas was recognised. The report of the Royal Commission on the National Health Service under Sir Alec Merrison in 1979 stated that "improving the quality of care in inner-city areas is the most urgent problem which NHS Services in the community must tackle". Patients have been encouraged to change their life style, and further financial benefits have been provided for the disabled, but too often this has actually added to the work load of an already overburdened professional staff. Further resources are needed but these resources must now be focused on providing maximum support for the general practitioners so that all those working in inner-city areas can effectively, efficiently and enthusiastically rise to the challenge of inner-city practice.

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