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Preventing radicalisation and terrorism: is there a GP response?

It was a few years into my 20-year stint as an inner-city GP that I realised we really were 'pillars of the community' when it came to preventing terrorism.¹ Of the distinct groups we served: one was a large Somali community. For many the escape from civil war made them especially appreciative of government services, of safety, of education. But there was also alienation.

Having worked in another country where Islam was the national religion, I had a feel for the reaction some had against aspects of Western culture. For example, modern dress codes with sexually provocative clothing, or atheism and prayerlessness (prayer is one of mankind's great duties and privileges according to Islam). The reaction they felt to some of these things was a sense of disgust, which generally they would be too polite to mention. If to this sense was added disappointment with British foreign policy, or perceived racial injustice in daily life, then anger was possible. But being able to express these feelings and mention faith to a supportive healthcare professional in a safe and confidential environment helped develop understanding and trust.² For example, I recall explaining why Jesus encouraged secret prayer, explaining the apparent paucity.

Sometimes our diagnoses and treatment actually saved lives. We were also modelling, perhaps unconsciously, a form of service that some of our young patients wanted to imitate. Our Somali patients told us they were praying for the success of the medical centre and supported us in any way they could. We saw the teenagers grow up, many into university places and the professions. They were able to share the difficulties they faced and were their advocates where possible.

In the end compassion wins. This is real terrorism prevention. Uncountable in statistical terms, it is building the sense of

mutual belonging together, which signals the end of tribalism, while treasuring multiculturalism: humanity at the heart of general practice.

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Migrant health

The articles in the recent *BJGP* 'Vulnerable people' themed issue highlight an issue of importance to UK practices serving diverse populations.^{1,2} Page Hall Medical Centre adopted an 'opt-out screening' process for blood-borne viruses (BBV) in 2007 as part of our 'new patient medical examination'. We undertook a prospective audit of the outcomes of this intervention, by self-assigned ethnicity, country of origin, and language spoken, and noted increased rates of hepatitis B virus (HBV) positive results (9.4%)³ from migrant workers who identify themselves as Roma Slovak. This contrasts strongly to the stated HBV prevalence in the wider Slovakian population (<0.6%).⁴ Our adoption of an 'opt out BBV screening' policy for all new patients has identified an at-risk group that would not have been screened had we strictly adhered to NICE guidance.⁵

Presentation of our audit data prompted the commissioning of a Local Enhanced Service to facilitate testing and contact tracing for HBV of the newly-arrived Slovakian citizens.

Our commitment to providing culturally congruent care alongside practice audit has led us to conclude that the stated background prevalence for certain countries may not accurately reflect the needs of distinct ethnic or disadvantaged groups that have recently arrived in the UK. A 'one-stop new patient medical' with 'opt-out' BBV screen allows a comprehensive health screen of new migrants and early BBV detection, intervention, and contact tracing for high-risk

vulnerable groups unaccustomed to NHS models of care.

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Risk stratification for free

Predicting risk is the new mantra for modern medicine. In 'After Achilles' the challenge is set — in the maelstrom that is primary care, we need all the risk stratification tools we can